First in a Series of Joint Webinars to Delta Dental Members

Is Your Organization Prepared to Comply With ACA-Mandated Operating Rules?

Tuesday, January 29, 2013
1:00 pm to 2:00 pm ET
Session Topics

• Welcome and Introductions
• Overview of CAQH CORE Operating Rules
• Affordable Care Act (ACA) Section 1104: Mandated Operating Rules
  – Timeline & Compliance
• Eligibility and Claim Status Operating Rule Requirements
• Implementing Operating Rules
  – Trading Partner Relationships
  – Measures of Success
  – Voluntary CORE Certification
  – Implementation Resources
• Questions and Answers
• Wrap-up
Participating in Today’s Interactive Event

- Download a copy of today’s presentation
- The phones will be muted throughout the presentation portion of the session
- During today’s session, you may communicate with our panelists via the WebEx
  - **By Web**: Enter your question into the Q&A pane in the lower right hand corner of your screen
- Panelists will address audience questions during the last fifteen minutes of the program
Overview of CAQH CORE Operating Rules
Committee on Operating Rules for Information Exchange

- A multi-stakeholder collaboration established in 2005
- **Mission**: To build consensus among healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between providers and health plans
  - Enable providers to submit transactions from the system of their choice (vendor agnostic) and quickly receive a standardized response
  - Facilitate administrative and clinical data integration
- Recognized healthcare operating rule author by NCVHS and HHS

CAQH CORE carries out its mission based on an integrated model
Purpose of Operating Rules

- The **Patient Protection and Affordable Care Act (ACA)** defines operating rules as “the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications”
- They address gaps in standards, help refine the infrastructure that supports electronic data exchange and recognize interdependencies among transactions; they do not duplicate standards
ACA Section 1104: Mandated Operating Rules

Timeline and Compliance
ACA Mandated Operating Rules Compliance Dates: Required for all HIPAA Covered Entities

Operating rules encourage an interoperable network and, thereby, are vendor agnostic

**Compliance in Effect as of January 1, 2013**
- Eligibility for health plan
- Claims status transactions
  
  *HIPAA covered entities comply with the CAQH CORE Operating Rules when conducting these transactions*

**Implement by January 1, 2014**
- Electronic funds transfer (EFT) transactions
- Health care payment and remittance advice (ERA) transactions

**Implement by January 1, 2016**
- Health claims or equivalent encounter information
- Enrollment and disenrollment in a health plan
- Health plan premium payments
- Referral certification and authorization
- Health claims attachments
### ACA Federal Compliance Requirements: 
*Highlights & Key Dates*

Three dates are critical for implementation of the first set of ACA mandated Operating Rules. There are two types of penalties related to compliance\(^1\)

<table>
<thead>
<tr>
<th>Key Area</th>
<th>HIPAA Mandated Implementation</th>
<th>ACA-required Health Plan Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dates</td>
<td>First Date: January 1, 2013</td>
<td></td>
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<tr>
<td></td>
<td>Compliance Date</td>
<td></td>
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<tr>
<td></td>
<td>Enforcement Date Extension</td>
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</tr>
<tr>
<td></td>
<td>March 31, 2013(^4)</td>
<td></td>
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<tr>
<td></td>
<td>Second Date: December 31, 2013</td>
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<tr>
<td></td>
<td>Health Plan Certification Date</td>
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<tr>
<td></td>
<td>Third Date: No Later than April 1, 2014</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health Plan Penalty Date</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Who: All HIPAA covered entities</td>
<td>Who: Health plans</td>
</tr>
<tr>
<td></td>
<td>Action: Implement CAQH CORE Eligibility &amp; Claim Status Operating Rules</td>
<td>Action: File statement with HHS certifying that data and information systems are in compliance with the standards and operating rules(^2)</td>
</tr>
<tr>
<td>Applicable Penalties</td>
<td>Amount: Due to HITECH, penalties for HIPAA non-compliance have increased, now up to $1.5 million per entity per year</td>
<td>Amount: Fee amount equals $1 per covered life(^3) until certification is complete; penalties for failure to comply cannot exceed on an annual basis an amount equal to $20 per covered life or $40 per covered life for deliberate misrepresentation</td>
</tr>
</tbody>
</table>

\(^1\) CMS OESS is the authority on the HIPAA and ACA Administrative Simplification provisions and requirements for compliance and enforcement. The CMS website provides information on the ACA compliance, certification, and penalties and enforcement process.

\(^2\) According to CMS, regulation detailing the health plan certification process is under development, and they will release details surrounding this process later this year; CAQH CORE will continue to offer its voluntary CORE Certification program and will share lessons learned with CMS as the Federal process is developed.

\(^3\) Covered life for which the plan’s data systems are not in compliance; shall be imposed for each day the plan is not in compliance

\(^4\) Per the Jan 2, 2013 CMS OESS announcement of the 90-day Period of enforcement extension Discretion for Compliance with Eligibility and Claim Status Operating Rules
Compliance with Eligibility & Claim Status Operating Rules: 90-Day Period of Enforcement Discretion

- On January 2, 2013 CMS OESS* announced a 90-Day Period of Enforcement Discretion to reduce the potential of significant disruption to the healthcare industry
  - Notwithstanding OESS’ discretionary application of its enforcement authority, the compliance date for using the operating rules remains January 1, 2013
- Enforcement action will begin March 31, 2013 with respect to HIPAA covered entities (including health plans, health care providers, and clearinghouses, as applicable) that are not in compliance with the Federally mandated Eligibility and Claim Status Operating Rules
- HIPAA covered entities that are prepared to conduct transactions using the adopted operating rules and all applicable covered entities that are preparing to do so, are encouraged to determine their readiness to use the operating rules as of January 1, 2013 and expeditiously become compliant
- OESS will accept complaints associated with compliance with the operating rules beginning January 1, 2013
  - If requested by OESS, covered entities that are the subject of complaints (known as “filed-against entities”) must produce evidence of either compliance or a good faith effort to become compliant with the operating rules during the 90-day period.

*Per the Jan 2, 2013 CMS OESS announcement of the 90-day Period of enforcement extension Discretion for Compliance with Eligibility and Claim Status Operating Rules
Compliance with Eligibility & Claim Status Operating Rules:
CMS OESS Complaint –Driven Enforcement Process

• OESS will accept complaints associated with compliance with the operating rules beginning January 1, 2013
  – If requested by OESS, covered entities that are the subject of complaints (known as “filed-against entities”) must produce evidence of either compliance or a good faith effort to become compliant with the operating rules during the 90-day period

• For more information review CMS’s Administrative Simplification Enforcement Tool (ASET), which is a web-based application where entities may file a complaint against a covered entity for potential non-compliance related to Transactions and Code Sets and Unique Identifiers
  – Anyone may use ASET to file a compliant
  – Each complaint is reviewed for validity and completeness by CMS OESS

* OESS is the U.S. Department of Health and Human Services’ (HHS) component that enforces compliance with HIPAA transaction and code set standards, including operating rules, identifiers and other standards required under HIPAA by the Affordable Care Act.
Mandated EFT & ERA Operating Rules: Status and Next Steps:

- This second set of operating rules has been proposed for Federal regulation
- Entities should be actively working towards the January 2014 adoption date
- CAQH CORE will offer EFT & ERA Operating Rule implementation tools
  - Analysis & Planning Guide for adoption of CAQH CORE EFT & ERA Operating Rules
  - Voluntary CORE Certification Test Site, jointly with CAQH CORE-authorized testing entity Edifecs
  - Repository of EFT & ERA FAQs based on lessons learned & industry questions received through CAQH CORE’s Formal Request Process
  - Formal multi-stakeholder CAQH CORE Code Combination Maintenance Process*
    - First compliance-adjustment and straw poll already conducted

* Applies to the CORE-required Code Combinations for CORE-defined Business Scenarios for CAQH CORE Rule 360
Third Set of Mandated Operating Rules: Status

• Remaining operating rule mandate, effective January 1, 2016, will address the following transactions:
  – Health claims or equivalent encounter information
  – Enrollment and disenrollment in a health plan
  – Health plan premium payments
  – Referral certification and authorization
  – Claims attachments

• Secretary of HHS recommended CAQH CORE as author for all remaining ACA mandated operating rules
  – CAQH CORE will use its open process to develop a set of draft rules for consideration to fulfill the third set of Federally mandated operating rules
  – Research and planning underway for rule development and activities including public surveys, in-depth interviews, summary of scope of current and draft standards and identification of potential rule opportunities/areas out scope
  – All CORE Guiding Principles will be followed, e.g., build on existing standards, align with other Federal health IT initiatives, address content and infrastructure.
CAQH CORE Rules Development Process: Third Set

- CAQH CORE will use its open process and a timeline to complement ACA needs:
  - **Q1 2013**: Key opportunities/out of scope areas will be identified via research, survey findings, and call discussions
  - **Q2 2013**: Potential rule options will be developed, reviewed, and agreed upon by CORE Subgroups and Work Groups
  - **Q3 2013**: CORE Subgroup and Work Group discussion and straw polling will be conducted
  - **Q4 2013**: Detailed documentation of draft rule requirements by CORE Participants
- CORE Participants are encouraged to identify internal subject matter experts to represent their organizations
  - Having experience with implementing the first and second rule sets will be very useful

*All* industry stakeholders are invited to complete the [CAQH CORE Industry Survey of Potential Operating Rule Opportunity Areas for ACA Section 1104 Third Set](#) and share their organizations’ priorities for the third set of ACA-mandated operating rules
Polling Question #1: Operating Rule Readiness

Which answer best describes the status of your organization’s progress towards implementing the CAQH CORE Eligibility and Claim Status Operating Rules?

- Just Started/Early Phases
- Fully Underway/Over the Hump
- Nearing Completion/Done
- Not Applicable
CAQH CORE
Eligibility and Claim Status Operating Rules
Mandated Eligibility & Claim Status Operating Rules:
Scope – Effective as of January 1, 2013

### Mandated Eligibility & Claim Status Operating Rules

**Scope**
- Effective as of January 1, 2013

**Enforcement Action Begins**
- March 31, 2013

#### Type of Rule

<table>
<thead>
<tr>
<th>Addresses</th>
<th>CAQH CORE Eligibility &amp; Claim Status Operating Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Content: Eligibility</strong></td>
<td>Need to drive further industry value in transaction processing</td>
</tr>
<tr>
<td><strong>Infrastructure: Eligibility and Claim Status</strong></td>
<td>Industry needs for common/accessible documentation</td>
</tr>
<tr>
<td></td>
<td>Industry-wide goals for architecture/performance/connectivity</td>
</tr>
</tbody>
</table>

**More Robust Eligibility Verification Plus Financials**

**Enhanced Error Reporting and Patient Identification**

**Companion Guides**

**System Availability**

**Response Times**

**Connectivity and Security**

**Acknowledgements**

*Please Note: In the Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction, CORE 150 and CORE 151 are not included for adoption. HHS is not requiring compliance with any operating rules related to acknowledgement, the Interim Final Rule.*

**Voluntary Eligibility & Claim Status Operating Rule**

“We are addressing the important role acknowledgements play in EDI by strongly encouraging the industry to implement the acknowledgement requirements in the CAQH CORE rules we are adopting herein.”

HHS Interim Final Rule
Federally Mandated Data Content Operating Rules: 
ASC X12 Standards as Foundation

Building on the requirements of the ASC X12 standards and industry neutral standards, CAQH CORE Operating Rules add value as industry stakeholders gain the additional benefits of using a consistent infrastructure to deliver and receive robust and important patient eligibility and benefit data.

**ASC X12 270/271 Requirements in v5010**

- Eligibility Status (yes/no)
- Date
- Health Plan Name (if known)

**CAQH CORE Rule Requirements**

- Health Plan Name*
- Patient financials (deductible, co-pay, co-insurance)
  - In and out of network variances
  - Family and individual
  - Health Plan and benefit variances
- Enhanced Patient Name Verification
- Standard use of AAA Error Codes

* If available in responding system

Note: PLUS infrastructure operating rules to generate data flow: response time, connectivity, system availability
CAQH CORE Rules 154 and 260 require that health plans and information sources that create a 271 response to a generic 270 inquiry must include:

- The **name of the health plan** covering the individual (if available)

- Provide **patient financials** for the static financials of co-insurance, co-payment, and deductible, and return the remaining deductible amount; include in-network and out-of-network coverage and financials for **48 required service types (benefits)**

  *For more detail, see CORE Rules 154 and 260*

CAQH CORE Rule 258 requires health plans to **normalize submitted and stored last name** before using the submitted and stored last names:

- If normalized name validated, return 271 with CORE-required content
- If normalized name validated but un-normalized names do not match, return last name as stored by health plan and specified INS segment
- If normalized name not validated, return specified AAA code

  *For more detail, see CORE Rule 258*

CAQH CORE Rule 259 requires health plans to return a **unique combination of one or more AAA segments along with one or more of the submitted patient identifying data elements** in order to communicate the specific errors to the submitter.

The receiver of the 271 response is required to detect all error conditions reported and display to the end user text that uniquely describes the specific error conditions and data elements determined to be missing or invalid.

  *For more detail, see CORE Rule 259*
An ASC X12 271 eligibility response to a *generic & explicit* ASC X12 270 eligibility request must include health plan name and patient financials for co-insurance, co-payment, base & remaining deductibles (with network variance if applicable), e.g.,

- Must return CORE-required data for explicit inquiry requests including one of 51 total CORE-required Service Type Codes (STCs):

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medical Care</td>
<td>48</td>
<td>Hospital – Inpatient</td>
</tr>
<tr>
<td>2</td>
<td>Surgical</td>
<td>50</td>
<td>Hospital – Outpatient</td>
</tr>
<tr>
<td>4</td>
<td>Diagnostic X-Ray</td>
<td>51</td>
<td>Hospital – Emergency Accident</td>
</tr>
<tr>
<td>5</td>
<td>Diagnostic Lab</td>
<td>52</td>
<td>Hospital – Emergency Medical</td>
</tr>
<tr>
<td>6</td>
<td>Radiation Therapy</td>
<td>53</td>
<td>Hospital – Ambulatory Surgical</td>
</tr>
<tr>
<td>7</td>
<td>Anesthesia</td>
<td>61</td>
<td>MRI/CAT Scan</td>
</tr>
<tr>
<td>8</td>
<td>Surgical Assistance</td>
<td>65</td>
<td>Newborn Care</td>
</tr>
<tr>
<td>12</td>
<td>Durable Medical Equipment Purchase</td>
<td>68</td>
<td>Well Baby Care</td>
</tr>
<tr>
<td>13</td>
<td>Facility</td>
<td>73</td>
<td>Diagnostic Medical</td>
</tr>
<tr>
<td>18</td>
<td>Durable Medical Equipment Rental</td>
<td>76</td>
<td>Dialysis</td>
</tr>
<tr>
<td>20</td>
<td>Second Surgical Opinion</td>
<td>78</td>
<td>Chemotherapy</td>
</tr>
<tr>
<td>33</td>
<td>Chiropractic</td>
<td>80</td>
<td>Immunizations</td>
</tr>
<tr>
<td>35</td>
<td>Dental Care</td>
<td>81</td>
<td>Routine Physical</td>
</tr>
<tr>
<td>40</td>
<td>Oral Surgery</td>
<td>82</td>
<td>Family Planning</td>
</tr>
<tr>
<td>42</td>
<td>Home Health Care</td>
<td>86</td>
<td>Emergency Services</td>
</tr>
<tr>
<td>45</td>
<td>Hospice</td>
<td>88</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>47</td>
<td>Hospital</td>
<td>93</td>
<td>Podiatry</td>
</tr>
<tr>
<td>98</td>
<td>Professional (Physician) Visit – Office</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Health plan must normalize submitted and stored last names; if normalized name is not validated, must return a specified AAA code
- Health plans must return specified AAA Error Codes with submitted patient identifying data elements to communicate certain error conditions
Mandated Eligibility 271 Response Requirement: Benefits of Generic and Explicit Eligibility Inquiry

• Assures a minimum level of transaction data is returned to the dental provider in the 271 eligibility response
  – A single eligibility request returns more than a Yes/No response; it includes 51 service type codes that must be supported for explicit inquiry and 12 service types for a generic request
• Ability to check insurance eligibility verification at the time of registration; obtain uniform responses
• Predetermination of patient financials
• Fewer follow-up inquiries to get data
• Fewer phone calls to the payer
• Improved revenue cycle management
CAQH CORE Eligibility & Claim Status: 
*Federally Mandated Infrastructure Operating Rules*

Mandated infrastructure requirements apply to both ASC X12 270/271 eligibility and ASC X12 276/277 claim status transactions

• **Companion Guide**
  – Specify flow and format in health plan companion guide following the CORE v5010 Master Companion Guide Template

• **Response Time**
  – Require entities to conduct real-time processing; Batch processing is optional; however, if entity performs batch processing, then they must conform to requirements for batch
  – Specify maximum response time for both real-time and batch processing
    • Real-time: Maximum response time from submission must be 20 seconds (or less)
    • Batch: Response to transaction submitted by 9 pm E.T. must be returned by 7AM E.T. on the following business day

• **System Availability Rule**
  – Require minimum of 86 percent system availability per calendar week

• **Connectivity Rules**
  – Establish “Safe Harbor” connectivity rule using internet as delivery option to standardize transaction flow between health plan and provider; common transport and envelope standards

**NOTE:** Many of the Federally mandated CAQH CORE Infrastructure Rules also apply to the ASC X12 v5010 835 per [CMS-0028-IFC](#).
Implementing Operating Rules
Implementing Mandated Operating Rules: The Importance of Trading Partner Collaboration

- Dental providers, dental plans and clearinghouses may work together in a variety of ways to exchange transaction data.
- The scope of a dental plan’s operating rules implementation project will depend upon the electronic data flows between its trading partners; understand your agreements.
- Vendors play a crucial role in enabling dental providers to realize the benefits of industry adoption of CAQH CORE Operating Rules; engage them.
The Business Case: Providers

The CAQH CORE Operating Rules for the Eligibility transaction result in an optimization of provider financial workflows

• Providers that adopt Phase I CAQH CORE Operating Rules reported significant improvements in access at or before the time of service to:
  – Health plan eligibility
  – Benefit coverage
  – Patient financials

• Results achieved by early-adopter providers/hospitals working with vendors and health plans that have implemented the CAQH CORE Operating Rules* include:
  – **Primary benefits**
    • Decrease in claim denials (related to eligibility) 10-12%
    • Percent increase in electronic eligibility verifications 24%
    • Save 7 minutes per electronic verification $2.60 per verification
  – **Secondary benefits**
    • Time saved in registration and billing
    • Reduced transaction fees and connectivity costs

* IBM assessed results achieved by Phase I CAQH CORE Operating Rules early adopters (represents 33 million covered lives and 1.2 million providers)
Trading Partner Relationships:  
*Dental Plan Examples*  

- The scope of a dental plan’s implementation of mandated operating rules will depend upon the extent to which they work with clearinghouses, e.g.,  
  - Dental Plan A  
    - Dental plan implements CAQH CORE Operating Rules in their entirety  
    - Dental plan’s implementation is independent of any clearinghouse relationship  
  - Dental Plan B  
    - Infrastructure and connectivity rules requirements outsourced to a clearinghouse  
    - Both dental plan and clearinghouse pursue implementation activities  
    - Dental plan-facing clearinghouse acts as a proxy for agreed upon functions  
  - Dental Plan C  
    - Eligibility and benefit verification (and/or claim status) rules requirements outsourced to a clearinghouse, including data hosting  
    - Clearinghouse supports Phase I and/or Phase II CAQH CORE Operating Rules in their entirety  
    - Clearinghouse’s implementation is independent of its relationship to health plan  
    - Dental plan-facing clearinghouse acts as a proxy for agreed-upon functions
Voluntary CORE Certification

• Since its inception, CAQH CORE has offered a voluntary CORE Certification to health plans, vendors, clearinghouses, and providers
  – Learn more about voluntary CORE Certification here
  – Voluntary CORE Certification provides verification that your IT systems or product operates in accordance with the federally mandated operating rules

• Recently completed and committed CORE Certifications include:
  – DoradoSystems - Completed Phase I & II certification as a clearinghouse
  – HealthFusion completed Phase II certification for HealthFusion® Real-Time
  – Blue Cross Blue Shield of Nebraska (Phase I & II: Q2 2013)
  – Rocky Mountain Health Plans (Phase I & II: Q1 2013)
  – Kaiser Permanente Colorado (Phase I: Q1 2013)
  – Office Ally, Office Ally Clearinghouse (Phase II: Q1 2013)
  – Smart Data Solutions, Smart Data Stream Clearinghouse (Phase I & II: Q1 2013)
  – Loxogon, Loxogon Alloy™ (Phase I: Q1 2013)
  – NextGen Healthcare, Real-Time Transaction Server (RTS) (Phase I & II: Q1 2013)
  – RelayHealth, RelayExchange™ (Phase II: Q1 2013)
  – GE Healthcare, Centricity Business Version 5.0 Claim Status (Phase I & II: Q1 2013)
Voluntary CORE Certification: Overview of Certification Process

- CAQH CORE certifies four types of entities that create, transmit or use eligibility and claim status data: health plans, providers, vendors and clearinghouses (includes HIEs)

- Certification and testing are *separate activities*
  - Testing is completed by *CORE-authorized testing entities* and occurs on-line based on stakeholder-specific test scripts; test scripts developed by CORE participants
  - Cost of testing and certification is extremely low or free

- CORE Certification is a 4-step process:
  1. **Pre-certification Planning and Systems Evaluation:**
     - Understand requirements of the CORE Operating Rules and scope your internal efforts to adopt rules
     - CORE has free gap analysis tool; email CORE@CAQH.org
  2. **Sign and Submit the CORE Pledge:**
     - Formally communicate your intent to pursue CORE Certification
  3. **CORE Certification Testing:**
     - Comprised of three phases: Pre-testing, Testing and Post-testing
     - Testing is by stakeholder-specific test scripts by rule
  4. **Apply For the CORE Certification Seal:**
     - Entities successfully achieving CORE Certification will receive a CORE “Seal” from CAQH that corresponds with the CORE Phase and stakeholder-type
CAQH CORE Implementation Tools and Key Steps

**Stakeholder & Business Type Evaluation:**
**Objective:** Understand what aspects of your business and/or outsourced functions are impacted by the CAQH CORE Operating Rules (e.g. products, business lines, etc.)

**Inventory & Impact Assessment Worksheet:**
**Objective:** Understand how many of your systems/products are impacted by each CAQH CORE Operating Rule and understand with which vendors you will need to coordinate.

**Gap Analysis Worksheet:**
**Objective:** Understand the level of system(s) remediation necessary for adopting each CAQH CORE Operating Rule requirement; results of completed *Gap Analysis Worksheet* will allow for development of a detailed project plan.

Each of the above tools can be found in the CAQH CORE *Analysis & Planning Guide*. © 2012 CORE. All rights reserved.
CAQH CORE Implementation Tools: Examples

- **CORE Operating Rule Readiness:** If you are ready to test your implementation of operating rules with trading partners, then, **take 5 minutes** and tell others about your readiness
  - *Add your organization* to the **CORE Partner List** located on the **CAQH** website
  - *It take 5 minutes!*

- **Request Process:** Contact technical experts as needed at **CORE@caqh.org**

- **FAQs:** CAQH CORE has a list of FAQs to address typical questions regarding the operating rules; updated FAQs being loaded to website on a regular basis

- The **Analysis & Planning Guide for Adopting the CAQH CORE Eligibility & Claim Status Operating Rules** provides guidance for Project Managers, Business Analysts, System Analysts, Architects, and other project staff to complete systems analysis and planning

- **Voluntary CORE Certification: Phase I & Phase II**
  - Learn more about *voluntary* CORE Certification [here](#)
  - *Voluntary* CORE Certification provides verification that your IT systems or product operates in accordance with the federally mandated operating rules
Q&A

Please submit your question:

• **Via the Web:** Enter your question into the Q&A pane in the lower right hand corner of your screen
Free 2013 CAQH CORE Education

- Mark your calendars & join us again at an upcoming webinar
  - **NACHA and CAQH CORE Webinar: Learn from the Experts- Mandated Electronic Funds Transfer (EFT) Standard and Healthcare Operating Rules for EFT and Electronic Remittance Advice (ERA)**
    - Thursday, February 7, 2013 from 1:00 pm - 2:00 pm ET
  - **InstaMed and CAQH CORE Webinar: EFT and ERA Implementation Insights- Models to Deliver EFT and ERA**
    - Tuesday, February 12, 2013 from 3:00 pm – 4:00 pm ET
  - **CMS OESS Open Mic: Ask Your Compliance Questions - Implementing ACA-Mandated Eligibility and Claim Status Operating Rules**
    - Wednesday, February 20, 2013 from 2:00 pm - 3:00 pm ET
  - **CAQH CORE Town Hall** – a bi-monthly information session open to the public
    - March 12, 2013, 3:00 pm - 4:00 pm ET
- Visit Us at CAQH CORE Booth # 2468 at the upcoming HIMSS Annual Conference, March 3-7, 2013
Available CMS OESS Implementation Tools:

Examples

- **HIPAA Covered Entity Charts**
  - Determine whether your organization is a HIPAA covered entity
- **CMS FAQs**
  - Frequently asked questions about the ACA, operating rules, and other topics
- **Affordable Care Act Updates**
  - Updates on operating rules; compliance, certification, and penalties; and engagement with standards and operating rules
- **Additional Questions**
  - Questions regarding HIPAA and ACA compliance can be addressed to:
    - Chris Stahlecker, OEM/OESS/ASG Acting Director, Administrative Simplification Group, Christine.Stahlecker@cms.hhs.gov
    - Geanelle Herring, Health Insurance Specialist, Geanelle.Herring@cms.hhs.gov
Mandated Eligibility & Claim Status Operating Rules

CAQH CORE Eligibility & Claim Status Operating Rules were initially developed in two phases; for ease of use the rules are presented here by transaction addressed and rule type rather than by phase.

- Rules Addressing the **ASC X12 270/271 Eligibility & Benefits Transactions**
  - Data Content Related Rules
    - CAQH CORE 154 & 260: Eligibility & Benefits Data Content Rules
    - CAQH CORE 258: Normalizing Patient Last Name Rule for Eligibility
    - CAQH CORE 259: AAA Error Code Rule for Eligibility
  - Infrastructure Related Rules
    - CAQH CORE 150: Batch Acknowledgements Rule for Eligibility (999)*
    - CAQH CORE 151: Real Time Acknowledgements Rule for Eligibility (999)*
    - CAQH CORE 152: Companion Guide Rule
    - CAQH CORE 155: Batch Response Time Rule for Eligibility
    - CAQH CORE 156: Real Time Response Rule for Eligibility
    - CAQH CORE 157: System Availability Rule
    - CAQH CORE 153 & CAQH CORE 270: Connectivity Rules

- Rules Addressing the **ASC X12 276/277 Claim Status Transactions**
  - CAQH CORE 250: 276/277 Claim Status Infrastructure Rule*

*NOTE: In the Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction, requirements pertaining to use of Acknowledgements are NOT included for adoption. Although HHS is not requiring compliance with any operating rule requirements related to Acknowledgements, the Final Rule does note "we are addressing the important role acknowledgements play in EDI by strongly encouraging the industry to implement the acknowledgement requirements in the CAQH CORE rules we are adopting herein."
Thank You for Joining Us