An Open Mic Session with ASC X12 and CAQH CORE

Implementing CAQH CORE Eligibility Data Content Operating Rules and an In-Depth Look at the ASC X12 270/271 Eligibility Transaction

January 31, 2013
12pm - 1pm
Participating in Today’s Interactive Event

• Download a copy of today’s presentation
• The phones will be muted upon entry and during the presentation portion of the session
• At any time throughout today’s session, you may communicate with our panelists via the web
  – Submit your questions on-line at any time by entering them into the Q&A panel on the right-hand side of the WebEx desktop
• The majority of today’s webinar will be focused on responding to questions from the audience
  – On-line questions will be addressed first
  – The audience will be invited to submit questions through the telephone
  – Ask your question by phone at the designated time by pressing * followed by the number one(1) on your keypad
Session Topics

• Welcome and Introductions
• ASC X12 Overview and the ASC X12 270/271 Transaction Standard
• ACA Section 1104: Compliance with Mandated Operating Rules
• Relationship Between the Mandated ASC X12 v5010 270/271 TR3 and Mandated CAQH CORE Operating Rules
• Audience Question & Answer
  – ASC X12 270/271 Transaction Standards
  – CAQH CORE Eligibility Data Content Operating Rules
  – Implementation Considerations – ASC X12 Standards and CAQH CORE Eligibility Data Content Operating Rules
• Wrap-up and Available Resources
Polling Question #1: 
*Implementation Readiness*

Which answer best describes the status of your organization’s Eligibility and Claim Status Operating Rules implementation effort?

– Just Started/Early Phases
– Fully Underway/Over the Hump
– Nearing Completion/Done
– Not Applicable
ASC X12 Overview
Who is ASC X12?

• Chartered and accredited by the American National Standards Institute (ANSI) more than 30 years ago
• The Accredited Standards Committee (ASC X12) develops and maintains electronic data interchange (EDI) standards, technical reports, and XML schemas which drive business processes globally
• ASC X12 membership includes technologists and business process experts, encompassing many industries
• ASC X12 develops and publishes the HIPAA mandated technical reports (TR3s) for 9 transactions - commonly called Implementation Guides
  – Current mandated version is 5010
  – Visit [www.x12.org](http://www.x12.org) for more information
ASC X12 and HIPAA-adopted EDI Transaction Standards

• Most HIPAA-adopted EDI transaction standards are ASC X12 standards
  – Current mandated version is ASC X12 5010; mandated as of January 2012
  – ASC X12 standards are based on the principle of electronic message exchange between communicating parties
  – Each ASC X12 EDI message unit is a set of data segments used for a single business transaction
  – For each standard, ASC X12 Technical Report Type 3 (TR3) specifies:
    • Data segments to be used
    • Segment sequence, whether segments are mandatory or optional, when segments can be repeated
    • How loops are structured and used
The Health Care Eligibility and Benefit transactions are designed so that inquiry submitters (information receivers) can determine:

- Whether an information source organization has a particular subscriber or dependent on file
- The healthcare eligibility and/or benefit information about that subscriber and/or dependent(s)

Data available through these transaction sets is used to verify an individual’s eligibility and benefits.

The 270 Inquiry drives what content will be returned on the 271 Response:

- Generic versus explicit
- Insured versus dependent
Health Care Eligibility/Benefit Inquiry and Response (270/271) – About the Transaction Standard

- HIPAA Mandated ASC X12 5010 270/271 Transaction Standard
  - Eligibility for a Health Plan
  - The ASC X12N 005010X279 (5010 270/271) transaction is the standard upon which the current CAQH CORE Eligibility and Benefit Data Content Operating Rules are based
- The 270 Inquiry drives what content will be returned on the 271 Response:
  - Some of the required content:
    - Plan dates (vs. Eligibility Dates of Service)
    - Multiple plans and coordination of benefits
    - Primary Required and Required Alternate Search Options
  - Possible additional content:
    - Patient Financial Responsibility
    - Streamlining responses to fit the person’s age/gender, date of service or benefit inquiry date
ACA Section 1104: ACA Mandated Eligibility and Claim Status 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>
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</thead>
<tbody>
<tr>
<td><strong>Dates</strong></td>
<td><strong>First Date</strong> January 1, 2013 <strong>Compliance Date</strong></td>
<td><strong>Second Date</strong> December 31, 2013 <strong>Health Plan Certification Date</strong></td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>Who: All HIPAA covered entities <strong>Action</strong>: Implement CAQH CORE Eligibility &amp; Claim Status Operating Rules</td>
<td>Who: Health plans <strong>Action</strong>: File statement with HHS certifying that data and information systems are in compliance with the standards and operating rules (^2)</td>
</tr>
<tr>
<td><strong>Applicable Penalties</strong></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>

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\(^1\) 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.
ACA Mandated EFT & ERA Operating Rules: Status and Next Steps:

Implement by January 1, 2014

- Electronic funds transfer (EFT) transactions
- Health care payment and remittance advice (ERA) transactions

- This second set of operating rules pertaining to EFT and ERA Operating Rules has been adopted by CMS OESS Interim Final Rule
- 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
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.

* 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.
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 complaint
  - 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.
ACA 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**
- 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
### ACA Mandated CAQH CORE Operating Rules: Requirements Scope for HIPAA Covered Entities

Current healthcare operating rules build upon a range of standards – healthcare specific (e.g., ASC X12) and industry neutral (e.g., OASIS, W3C, ACH CCD+).

<table>
<thead>
<tr>
<th>Rule Types</th>
<th>Transactions</th>
<th>Rule Areas</th>
<th>CAQH CORE Rule Numbers</th>
<th>Key Considerations</th>
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<td>Response Time Rules (Batch &amp; Real-Time) &amp; System Availability Rule</td>
<td>155, 156, 157, &amp; 250*</td>
<td>Interdependencies of the CAQH CORE Infrastructure Rules must be considered during implementation</td>
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<td></td>
<td></td>
<td>Connectivity Rules</td>
<td>153, 270 &amp; 250*</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Companion Guide Rule</td>
<td>152 &amp; 250*</td>
<td></td>
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<tr>
<td><strong>Data Content</strong></td>
<td>X12 270/271 Eligibility &amp; Benefits</td>
<td>Patient Financial Data Content Rules</td>
<td>154 &amp; 260</td>
<td>Data Content Rules apply only to the Eligibility &amp; Benefits transaction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Normalizing Patient Last Name &amp; AAA Error Code Reporting Rules</td>
<td>258 &amp; 259</td>
<td></td>
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</tbody>
</table>

*CAQH CORE Rule 250 applies the CAQH CORE Infrastructure Rules to the X12 276/277 Claims Status transaction.
Q & A: Ground Rules and Focus of Interactive Session

Health Care Eligibility/Benefit Inquiry and Response

• ASC X12 270/271 Transaction Standard
  – Determination of Subscriber/Dependent Eligibility
  – Eligibility and/or Benefit Information (Required v Optional Content)
  – Primary Required and Required Alternate Search Options
  – RFI Process

• ACA mandated Eligibility Response Requirement
  – Generic and Explicit Inquiries
  – Required Content
    • Patient Financials
    • Service Type Codes (STC) Codes
  – Last name normalization
  – AAA Error Code reporting

• Implementation Considerations
  – ASC X12 Standards and CAQH CORE Eligibility Data Content Operating Rules
  – CAQH CORE Infrastructure Rules*

* Further questions related to other infrastructure operating rules can be submitted to CAQH@CORE.org
** Acknowledgements standards or the operating rules for those standards are not Federally mandated by HIPAA; CORE operating rules have always included and supported the use of acknowledgements.
Q&A

ASC X12 270/271 Transaction Standard:
Healthcare Eligibility/Benefit Inquiry & Response

Please submit your question:
• **Via the Web:** Enter your question into the Q&A pane in the lower right hand corner of your screen
• **By Phone:** Press * followed by the number one (1) on your keypad
CAQH CORE Operating Rules Working in Unison With ASC X12 270/271 Standard

<table>
<thead>
<tr>
<th>Type of Rule</th>
<th>Addresses</th>
<th>CAQH CORE Eligibility &amp; Claim Status Operating Rules</th>
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<tr>
<td><strong>Data Content:</strong></td>
<td></td>
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<tr>
<td><em>Eligibility</em></td>
<td>Transaction Value</td>
<td>• More Robust Eligibility Verification Plus Financials</td>
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<tr>
<td></td>
<td></td>
<td>• Enhanced Error Reporting and Patient Identification</td>
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<tr>
<td></td>
<td></td>
<td><strong>“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.”</strong></td>
</tr>
<tr>
<td><strong>Infrastructure:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Eligibility and Claim Status</em></td>
<td>Common/ accessible documentation</td>
<td>• Companion Guides</td>
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<tr>
<td></td>
<td></td>
<td>• System Availability</td>
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<tr>
<td></td>
<td>Architecture/ performance/ connectivity</td>
<td>• Response Times</td>
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<td></td>
<td></td>
<td>• Connectivity and Security</td>
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<td></td>
<td></td>
<td><strong>Acknowledgements</strong>*</td>
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*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.*
Q&A

CAQH CORE Eligibility Data Content Operating Rules

• Eligibility Verification
• Patient Financials, e.g. copayments, deductibles, etc.
• Enhanced Error Reporting
• Patient Identification

Please submit your question:
• **Via the Web:** Enter your question into the Q&A pane in the lower right hand corner of your screen
• **By Phone:** Press * followed by the number one (1) on your keypad
CAQH CORE Eligibility & Claim Status:  
ACA Mandated Infrastructure Operating Rules

- **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.
Q&A

Implementation Considerations: ASC X12 Standards and CAQH CORE Eligibility Data Content Operating Rules

• Implementation challenges
• ACA-mandated Infrastructure Operating Rules
  – Connectivity & Security, Companion Guide
  – System Availability, Response Time
  – Acknowledgements

Please submit your question:
• Via the Web: Enter your question into the Q&A pane in the lower right hand corner of your screen
• By Phone: Press * followed by the number one (1) on your keypad
Thank You for Joining Us
Resources
Technical or Implementation questions may be submitted to ASC X12. Such a question is called a Request for Interpretation (RFI).

Submit an RFI at:
www.x12.org/x12org/subcommittees/x12rfi.cfm

An RFI and the associated response is reviewed and approved at several levels before being published as a final ASC X12 interpretation.
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

- **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

- **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
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); Register
    - Thursday, February 7, 2013 from 1:00 - 2:00 pm ET
  - InstaMed and CAQH CORE Webinar: EFT and ERA Implementation Insights- Models to Deliver EFT and ERA; Register
    - Tuesday, February 12, 2013 from 3:00 – 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 2:00pm-3:00pm ET
  - CAQH CORE Town Hall – a bi-monthly information session open to the public
    - March 12, 2013, 3-4 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](mailto:Christine.Stahlecker@cms.hhs.gov)
    - Geanelle Herring, Health Insurance Specialist, [Geanelle.Herring@cms.hhs.gov](mailto:Geanelle.Herring@cms.hhs.gov)
Appendix
ASC X12 v5010 270/271
TR3  1.4.7.1
Minimum Requirements for Implementation Guide Compliance
1 - Medical Care
33 – Chiropractic
35 – Dental Care
47 – Hospital
86 - Emergency Services
88 - Pharmacy
98 - Professional (Physician) Visit - Office
AL - Vision (Optometry)
MH - Mental Health
UC - Urgent Care

CORE 154 Rule, 1.2, 1.2.1, 1.2.2, and 1.2.3
Requires support for a generic inquiry:
1 – Medical Care
33 – Chiropractic
35 – Dental Care
47 – Hospital
48 – Hospital Inpatient*
50 – Hospital Outpatient*
86 – Emergency Services
88 – Pharmacy
98 – Professional (Physician) Visit – Office
AL – Vision (Optometry)
MH – Mental Health.
UC – Urgent Care

*Goes beyond ASC X12 v5010 270/271 TR3 by requiring 2 additional Service Type Codes be returned in response to a generic inquiry

A health plan’s response to a generic provider inquiry must include the status of benefit coverage for required Service Type Codes.
ACA Mandated Eligibility 271 Response Requirement: *Explicit Inquiry – Service Type Codes*

ASC X12 Standards + CAQH CORE Operating Rules = Admin Simplification

**ASC X12 v5010 270/271**

*Implementation-Compliant Use of the 270/271 Transaction Set*

- Recommends that health plans support an explicit inquiry (not required if the system is not capable of handling it)

**CORE 154 Rule, 1.4**

CORE 260 Rule, 4.1.1.1

Requires support for an **explicit inquiry** for a combined set of 51 Service Type Codes, building off of 12 that are required in the CORE 154 Rule (see code list on next page)

Expands access to status of benefit coverage and patient financials for Service Types

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ACA Mandated CAQH CORE Eligibility Operating Rules: Data Content From Health Plans and Information Sources

- An explicit ASC X12 270 inquiry with 51 CORE–required service type codes must be supported; ASC X12 271 response to explicit ASC X12 270 inquiry must include Patient financials for base and remaining deductible, co-insurance and co-payment for each of 51 CORE-required service type codes when amounts are different than for Service Type Code 30 – Health Plan Coverage, plus any in/out of network variances

- 1 – Medical Care
- 2 – Surgical
- 4 – Diagnostic X–Ray
- 5 – Diagnostic Lab
- 6 – Radiation Therapy
- 7 – Anesthesia
- 8 – Surgical Assistance
- 12 – Durable Medical Equipment Purchase
- 13 – Facility
- 18 – Durable Medical Equipment Rental
- 20 – Second Surgical Opinion
- 33 – Chiropractic
- 35 – Dental Care
- 40 – Oral Surgery
- 42 – Home Health Care
- 45 – Hospice
- 47 – Hospital

- 48 – Hospital – Inpatient
- 50 – Hospital – Outpatient
- 51 – Hospital – Emergency Accident
- 52 – Hospital – Emergency Medical
- 53 – Hospital – Ambulatory Surgical
- 62 – MRI/CAT Scan
- 65 – Newborn Care
- 68 – Well Baby Care
- 73 – Diagnostic Medical
- 76 – Dialysis
- 78 – Chemotherapy
- 80 – Immunizations
- 81 – Routine Physical
- 82 – Family Planning
- 86 – Emergency Services
- 88 – Pharmacy
- 93 – Podiatry

- 98 – Professional (Physician) Visit – Office
- 99 – Professional (Physician) Visit – Inpatient
- A0 – Professional (Physician) Visit – Outpatient
- A3 – Professional (Physician) Visit – Home
- A6 – Psychotherapy
- A7 – Psychiatric Inpatient
- A8 – psychiatric Outpatient
- AD – Occupational Therapy
- AE – Physical Medicine
- AF – Speech Therapy
- AG – Skilled Nursing Care
- AI – Substance Abuse
- AL – vision (Optometry)
- BG – Cardiac Rehabilitation
- BH – Pediatric
- MH – Mental Health
- UC – Urgent Care
ACA Mandated Eligibility 271 Response Requirement: Return of Patient Financials

ASC X12 v5010 270/271 TR3 1.4.7.2

Recommended Additional Support
Highly recommends response include any known patient financial responsibility for benefits being described

CORE 154 Rule, 1.2, 1.2.1, 1.2.2, and 1.2.3 & CORE 260 Rule 4.1.3.1, 4.1.3.2, and 4.1.3.3

Requires co-insurance, co-payment, base and remaining deductible be returned for each Service Type Code included in response

Requires benefit-specific (i.e., Service Type Code) patient financial responsibility to be returned only when different than for health plan, i.e., 30 – Health Plan Benefit Coverage

If out of network differs from in-network, it must also be returned

Supports timely access to patient financial responsibility information
Less hassle for patients and improves providers revenue cycle
Enhances member / provider interaction

PAC X12
The Accredited Standards Committee

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ACA Mandated Eligibility 271 Response Requirement: Return of Deductibles

ASC X12 Standards + CAQH CORE Operating Rules = Admin Simplification

ASC X12 v5010 270/271 TR3 1.4.7.2

Recommended Additional Support
Highly recommends response include any known patient financial responsibility for benefits being described

CORE 260 Rule, 4.1.3.1.1, 4.1.3.1.2, 4.1.4, 4.1.5

Base and remaining health plan deductible for either individual or family coverage health plan as specified in 270 inquiry is required to be returned in 271 response

When Health Plan Base Deductible Date is not the same as the Health Plan Coverage Date, begin date for deductibles must be returned

When the Benefit-specific (Service Type Code) Deductible Date is not the same as the Health Plan Coverage Date, begin date for Benefit-specific deductibles must be returned

Access to more timely information about patient financial responsibility facilitates revenue cycle improvements

Enhances the quality of the member/provider interaction
Concept not addressed in the TR3

CORE 154 Rule, 1.2, 1.2.1, 1.2.2, and 1.2.3 and CORE 260 Rule 4.1.3

The rules allow discretionary reporting for patient financial responsibility for CORE-required Service Type Codes (STCs) that address sensitive, carve-out and general benefits data, e.g.: STCs 1, 35, 88, A6, A7, A8, Al, AL, and MH

Example: A code is too general for a response to be meaningful (e.g., 1 – Medical); a “carve-out” benefit (e.g., AL – Vision) where the specific benefit information is not available to the health plan or information source; or a code is related to behavioral health or substance abuse (e.g., AI - Substance Abuse) where privacy issues may impact a health plan or information source’s ability to return information.

Building awareness of need to have accurate data while protecting patient privacy and security, and supporting delivery of data needed to assist provider and patient before or at time of service.
ACA Mandated Eligibility 271 Response Requirement: Receiver Requirements

- **ASC X12 Standards** + **CAQH CORE Operating Rules** = **Admin Simplification**

**Receiver Requirements**

Not a concept outlined in detail in the TR3

**CORE 260 Rule, 4.2**

Receiver of a v5010 271 (the system originating the 270) is required to detect and extract all data elements to which this rule applies as returned by the health plan in the 271.

Receiver must display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the 271 data content.

Provider will have all of the information from the 271 Response displayed or made available to them.

Enhances the quality of the member/provider interaction.

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ACA Mandated Eligibility 271 Response Requirement: Normalize Patient Last Name

**CORE 258 Rule**

Remove specified suffix and prefix character strings, special characters and punctuation

If normalized name validated, return ASC X12 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

Increases the chance of a subscriber/dependent match at the health plan and therefore increases the chance of returning benefit and financial data

The rule also allows for the health plan to inform the provider of the last name stored in their system

Not a concept provided in the TR3
ACA Mandated Eligibility 271 Response Requirement: AAA Error Code Reporting

ASC X12 v5010 270/271 TR3_1.4.8
Establishes AAA Error codes that can be used when processing a transaction, but doesn’t require it

CORE 259 Rule
Requires health plans return a unique combination of one or more AAA segments along with the associated patient identification data element(s) received and used for the subscriber or dependent

The receiver of the ASC X12 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 patient identification data elements determined to be missing or invalid

Informs providers which data elements are in error so that specific corrections can be made for future transactions
Addresses gaps and ambiguities in data related to eligibility verification for the subscriber or dependent
ACA Mandated Eligibility 271 Response Requirement: Past/Future Dates & Time Period

**ASC X12 Standards** + **CAQH CORE Operating Rules** = **Admin Simplification**

**ASC X12 v5010 270/271**

TR3 1.4.7.1

*Minimum Requirements for Implementation Guide Compliance*

TR3 allows responder to select from a long list of Time Period Qualifiers

*See Note on page 19 of TR3 indicating that plan dates returned in the 271 response do not have to represent the historical beginning of eligibility for the plan*

**CORE 154 Rule, 1.3 & CORE 260 Rule, 4.1.3.1.1**

Health Plan Benefit Coverage Dates for 12 months in the past and up to the end of the current month

Recommends use of 3 Time Period Qualifiers out of allowed set in TR3

Able to respond to requests for Past & Future Dates Coverage

Access to additional coverage information saves research & manual administrative work