CAQH CORE and ASC X12
Open Mic Session: Fourth in a Series

Ask the Experts About the Electronic Exchange of Healthcare Eligibility Data

March 26, 2013
2pm - 3pm ET
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 Introduction (5 minutes)
- Overview and Level Setting (15 minutes)
  - ACA-Mandated Eligibility and Claim Status Compliance and Enforcement
  - HIPAA Mandated v5010 ASC X12 270/271 Transaction Standards
  - CAQH CORE Eligibility and Claim Status Operating Rules
- Implementation Question and Answer (40 minutes)
  - Questions asked but not publicly addressed during previous CAQH CORE and ASC X12 Joint Education Sessions
  - On-line Submitted via WebEx
  - Via Phone
- Wrap-up and Available Resources
Audience Profile: Assumptions

- This session assumes attendees:
  - Have an advanced knowledge of the v5010 ASC X12 270/271 Eligibility Transaction Standard
  - Have an advanced knowledge of CAQH CORE Eligibility and Claim Status Operating Rules (Reminder: v5010 is needed to complete ICD-10 conversion)
  - Work at, or support, organizations that have completed their v5010 ASC X12 implementation
  - Have an awareness of ACA Section 1104 compliance timeline and the benefits of implementing operating rules
  - Are with or support organizations that are well underway (or have completed) their Operating Rule implementation, and, thus, you have specific questions based upon your implementation process
Polling Question: *Implementation*

Which aspects of the CAQH CORE Eligibility Operating Rules related to Data Content do you find the most challenging to implement?

a) Implementing the Service Type Codes for (STCs) Generic and/or Explicit Eligibility Inquiry/Response requirements

b) How to take advantage of the Last Name Normalization Operating Rule and its relation to the Error Code-related Operating Rule

c) Meeting the 20-second Real-time Response Time requirement while simultaneously supplying the robust data content required by the Operating Rules

d) Determining if your vendor/clearinghouse partner(s) is compliant with the CAQH CORE Operating Rules requirements, including delivery of the data content, e.g. YTD deductibles

e) Other
ACA Section 1104:
ACA Mandated Eligibility and Claim Status Operating Rules

Compliance and Enforcement
ACA-mandated Operating Rule 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 conduct these transactions using the CAQH CORE Operating Rules

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

Rule requirements available.
ACA Federal Compliance Requirements Highlight: Eligibility and Claim Status Transactions

<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</td>
<td>January 1, 2013</td>
</tr>
<tr>
<td></td>
<td>Compliance Date</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enforcement Date Extension</td>
<td>March 31, 2013$^4$</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></td>
<td>Description</td>
<td>Who: Health plans</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.

- 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 mandated Eligibility and Claim Status Operating Rules.

- OESS began accepting complaints associated with compliance beginning January 1, 2013.
  - 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.

* 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.
HIPAA Mandated v5010
ASC X12 270/271 Transaction Standards
HIPAA-adopted EDI Transaction Standards and ASC X12

- **HIPAA**: Requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers.

- **Most HIPAA-adopted EDI transaction standards are ASC X12 standards**
  - Current mandated version is ASC X12 5010; mandated as of January 2012
  - 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
Health Care Eligibility/Benefit Inquiry and Response (270/271) – About the Transaction

- 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 ASC X12 standard supported by the current CAQH CORE Eligibility and Benefit Data Content Operating Rules

• 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
CAQH CORE Eligibility and Claim Status
Operating Rule Requirements
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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</thead>
<tbody>
<tr>
<td><strong>Infrastructure</strong></td>
<td>X12 270/271 Eligibility &amp; Benefits &lt;br&gt; and &lt;br&gt; X12 276/277 Claims Status</td>
<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>
</tr>
<tr>
<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>
</tr>
<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>
</tr>
</tbody>
</table>

*CAQH CORE Rule 250 applies the CAQH CORE Infrastructure Rules to the X12 276/277 Claims Status transaction.
CAQH CORE Eligibility & Claim Status

Data Content Operating Rules – Key Requirements

- 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>Service Type Code</th>
<th>Service Type Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Medical Care</td>
<td>48 – Hospital – Inpatient</td>
</tr>
<tr>
<td>2 – Surgical</td>
<td>50 – Hospital – Outpatient</td>
</tr>
<tr>
<td>4 – Diagnostic X-Ray</td>
<td>51 – Hospital – Emergency Accident</td>
</tr>
<tr>
<td>5 – Diagnostic Lab</td>
<td>52 – Hospital – Emergency Medical</td>
</tr>
<tr>
<td>6 – Radiation Therapy</td>
<td>53 – Hospital – Ambulatory Surgical</td>
</tr>
<tr>
<td>7 – Anesthesia</td>
<td>62 – MRI/CAT Scan</td>
</tr>
<tr>
<td>8 – Surgical Assistance</td>
<td>65 – Newborn Care</td>
</tr>
<tr>
<td>12 – Durable Medical Equipment Purchase</td>
<td>68 – Well Baby Care</td>
</tr>
<tr>
<td>13 – Facility</td>
<td>73 – Diagnostic Medical</td>
</tr>
<tr>
<td>18 – Durable Medical Equipment Rental</td>
<td>76 – Dialysis</td>
</tr>
<tr>
<td>20 – Second Surgical Opinion</td>
<td>78 – Chemotherapy</td>
</tr>
<tr>
<td>33 – Chiropractic</td>
<td>80 – Immunizations</td>
</tr>
<tr>
<td>35 – Dental Care</td>
<td>81 – Routine Physical</td>
</tr>
<tr>
<td>40 – Oral Surgery</td>
<td>82 – Family Planning</td>
</tr>
<tr>
<td>42 – Home Health Care</td>
<td>86 – Emergency Services</td>
</tr>
<tr>
<td>45 – Hospice</td>
<td>88 – Pharmacy</td>
</tr>
<tr>
<td>47 – Hospital</td>
<td>93 – Podiatry</td>
</tr>
<tr>
<td>98 – Professional (Physician) Visit – Office</td>
<td></td>
</tr>
<tr>
<td>99 – Professional (Physician) Visit – Inpatient</td>
<td></td>
</tr>
<tr>
<td>A0 – Professional (Physician) Visit – Outpatient</td>
<td></td>
</tr>
<tr>
<td>A3 – Professional (Physician) Visit – Home</td>
<td></td>
</tr>
<tr>
<td>A6 – Psychotherapy</td>
<td></td>
</tr>
<tr>
<td>A7 – Psychiatric Inpatient</td>
<td></td>
</tr>
<tr>
<td>A8 – Psychiatric Outpatient</td>
<td></td>
</tr>
<tr>
<td>AD – Occupational Therapy</td>
<td></td>
</tr>
<tr>
<td>AE – Physical Medicine</td>
<td></td>
</tr>
<tr>
<td>AF – Speech Therapy</td>
<td></td>
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<tr>
<td>AI – Substance Abuse</td>
<td></td>
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<tr>
<td>AL – vision (Optometry)</td>
<td></td>
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<tr>
<td>BG – Cardiac Rehabilitation</td>
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<tr>
<td>BH – Pediatric</td>
<td></td>
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<tr>
<td>MH – Mental Health</td>
<td></td>
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<tr>
<td>UC – Urgent Care</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
ACA Mandated Data Content Operating Rules:
Support Use of ASC X12 Standards

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

PLUS infrastructure operating rules to generate data flow:
response time, connectivity, system availability

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CAQH CORE Eligibility & Claim Status: ACA Mandated Infrastructure Operating Rules

ACA 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.
Q & A: Discussion Framework:
Health Care Eligibility/Benefit Inquiry and Response

• **Understanding the Mandate**
  – ACA Compliance
  – CMS OESS Enforcements

• **Data Content: Specifications and Requirements of the Eligibility Inquiry and Response**
  – HIPAA-mandated v5010 ASC X12 270/271 Eligibility Transaction Standard Specifications
  – ACA-mandated Eligibility Response Requirements
  – Relationship between CAQH CORE Eligibility Data Content Operating Rules and the v5010 ASC X12 Standard

• **Infrastructure: Operating Rule Considerations**
  – Infrastructure, e.g. Real-time

• **Working with Trading Partners**
  – Working with Vendors and Clearinghouses
Q&A

Understanding the Mandate

• ACA Compliance
• CMS OESS Enforcement

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
Q: Can HIPAA covered entities outsource CORE-required functions to a business associate?

A: Yes, HIPAA covered entities may outsource some or all of their covered functions to a business associate. It is the responsibility of the HIPAA covered entity to ensure that their business associates are HIPAA-compliant. How implementers work with their trading partners to execute the CAQH CORE requirements are their individual business decisions.
Q&A

Data Content: Specifications and Requirements of the Eligibility Inquiry and Response

- HIPAA-mandated v5010 ASC X12 270/271 Eligibility Transaction Standard Specifications
- Relationship between CAQH CORE Eligibility Data Content Operating Rules and v5010 ASC X12 Standard

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
Sample Audience Question:
v5010 ASC X12 270/271 Transaction Standard Spec

Q: If an inquiry is made on a service type for which you do not configure benefits (i.e. a co-pay does not apply to oncology, perhaps), what is the correct response?

A: If a benefit does not have patient financial responsibility then the response would include a “0” in EB07 for that amount as required by the TR3 Section 1.4.9.
Sample Audience Question: *Mapping Benefit Plan Eligibility*

**Q:** Does CAQH CORE provide guidance on how to map our internal benefit codes to the Service Type Codes?

**A:** A CAQH CORE Operating Rule cannot change or modify the meaning or definition of any X12 standard or code. To assist the industry with a common understanding of some of the CORE-required STCs, CAQH CORE developed supplemental descriptions. These supplemental descriptions are for guidance only to aid in a common industry understanding of the STCs, as noted in Footnote #2 in Table 4.1.1.1 of the rule. Clarification or interpretation of the definition of a Service Type Code can be obtained from ASC X12 via its online ASC X12 Interpretation Portal.
Sample Audience Question:

*Preparing for the Impact of Name Normalization*

**Q:**
Do we need to return two AAA*73 if both the first and last names are missing on the 270 Inquiry as the AAA Error Code 73 is not specific to which name?

**A:**
The CAQH Rule identified a variety of error conditions that may occur when a health plan attempts to detect all error conditions and report each found. Some of the error conditions apply before the health plan attempts to search for the member (a pre-query lookup) and some after (a post-query look-up). In the case of a missing first and last name it would be necessary to return a AAA*73 for each missing name- one for the first and one for the last name. This will allow the sender of the 270 Inquiry to correct both missing name fields on the inquiry. Section 3.5 assumes that the submitter of the 270 Inquiry knows which data elements were submitted in the 270 (i.e., member identifier, first name, last name, date of birth).
Q&A

Infrastructure Operating Rule Considerations

- *Infrastructure, e.g. Real-time*

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
Sample Audience Question: Working with Clearinghouses

Q: The industry will not be able to make the 20 second turn around time if the trading partners are using the internet and clearinghouse mode of exchange - do you have any idea when the requirement might be updated to allow for these models?

A: The CORE OR require that real time transaction meet the 20-second turn around time as specified. To ensure that handoff between providers, clearinghouses, and health plans meet the turn around times, the CORE Operating Rules require HIPAA covered entities to capture, log, audit, match, and report the date, time, and control numbers from their own internal systems, and corresponding data received from their trading partners. The auditing requirement is included so that each entity will have the log of data to be used to resolve any issues or concerns. For the 20-second maximum real time response requirement, this log could also be used to identify where a bottleneck may be occurring.
Q&A

Working with Trading Partners

• *Working with Vendors and Clearinghouses*

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
Upcoming CAQH CORE Education Sessions

• Join us for a free CAQH CORE webinar
  – NACHA: “Save the Date” for an in-depth look at the EFT Standard and EFT & ERA Operating Rules
    • Tuesday, April 10, 2013 from 2:00 - 3:00 pm ET
• Hear More about Operating Rules at an industry event
  – GE Centricity Live: 2013, April 14 – April 17
  – NACHA: Payments 2013, April 21 – April 24
• Visit the CORE Education Events page of the CAQH website
  – Access free recordings of previous education events & stay informed of upcoming joint webinars with key partners such as NACHA, ASC X12, vendors and provider associations
Resources
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](#)
• Contact technical experts as needed at [CORE@caqh.org](mailto: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

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ASC X12’s Interpretation Process

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](http://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.
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)