Implementing ACA Mandated Operating Rules Related to Data Content

Health Care Eligibility Benefit Inquiry and Response: The Relationship Between Standards and Operating Rules

November 28, 2012
2:00pm – 3:30pm
Participating in Today’s Interactive Event

- Download a copy of today’s presentation
- The phones will be muted upon entry and during the speaker portion of the session
- At any time throughout today’s presentation, you may communicate with our panelists via the web
  - Submit questions directly through the Q&A pane located at the bottom right hand corner of your screen
- Panelists will address audience Q&A for approximately 40 minutes of today’s session
  - Ask your question by phone at the designated time by pressing * followed by the number one (1) on your keypad
  - Ask your question via the web at any time by entering it into the Q&A pane in the lower right hand corner of your screen
Session Topics

• Welcome and Introductions
• ASC X12 Overview
• CAQH CORE Overview
• ACA Section 1104: Mandated Operating Rules
• Health Care Eligibility / Benefit Request and Response
• Eligibility for a Health Plan - HIPAA-adopted Standards and CAQH CORE Operating Rules Work In Unison
• Audience Question & Answer
  – Web-initiated
  – Operator Assisted / Phone
• Wrap-up and Available Resources
Polling Question #1:

Operating Rule Implementation Status

Which answer best describes the status of your organization’s progress toward implementing the mandated January 1, 2013 operating rules?

– 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 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
CAQH CORE
Overview
Committee on Operating Rules for Information Exchange

- A multi-stakeholder collaboration of over 130 participating organizations established in 2005 that is developing industry-wide operating rules

- **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
What are 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”
  - Operating rules address gaps in standards, help refine the infrastructure that supports electronic data exchange, and recognize interdependencies among transactions; they do not duplicate standards
  - Operating rules and standards work in unison; 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+) – and support the national HIT agenda
- Operating rules encourage an interoperable network and, thereby, are vendor agnostic

Operating Rules: Key Components

- Rights and responsibilities of all parties
- Security
- Exception processing
- Transmission standards and formats
- Error resolution
- Response Times
- Liabilities

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ACA Section 1104: Mandated Operating Rules
Administrative Simplification: ACA Section 1104

- HIPAA mandates adoption of standards for electronic healthcare administrative and financial transactions
- Section 1104 of the ACA (H.R.3590)
  - Establishes new requirements for administrative transactions
  - Requires all HIPAA covered entities be compliant with applicable HIPAA standards and associated operating rules
- The first set of mandated operating rules for Eligibility and Claim Status has been adopted into Federal regulation: 34 Days Until Compliance Date
  - December 2011, CMS adopted CMS-0032-IFC as a Final Rule; industry implementation efforts underway for the January 1, 2013 effective date
    - Adopted Phase I and II CAQH CORE Operating Rules for the Eligibility & Claim Status transactions, except for rule requirements pertaining to Acknowledgements*
    - Highlights CORE Certification is voluntary; further defines relationship between standards and operating rules and analysis of ROI from operating rules implementation

The complete set of CAQH CORE Eligibility & Claim Status Operating Rules are available free of charge HERE.

*On September 22, 2011, NCVHS issued a letter recommending Acknowledgements be adopted as formally recognized standards and the CAQH CORE Operating Rules for these standards also be recognized.
ACA Mandated Operating Rules Compliance Dates: Required for all HIPAA Covered Entities

Implement by January 1, 2013

Operating Rules for:
- Eligibility for health plan
- Claims status transactions

Implement by January 1, 2014

Operating Rules for:
- Electronic funds transfer (EFT) transactions
- Health care payment and remittance advice (ERA) transactions

Implement by January 1, 2016

Operating Rules for:
- Health claims or equivalent encounter information
- Enrollment and disenrollment in a health plan
- Health plan premium payments
- Referral certification and authorization
- Health claims attachments

NOTE: Operating rules apply to HIPAA covered entities; beyond HIPAA compliance penalties, certification penalties for health plans will apply.
### ACA Federal Compliance Requirements: Highlights & Key Dates

**Three dates** are critical for industry implementation of the first set of ACA mandated Operating Rules.  

There are two types of penalties related to compliance:

<table>
<thead>
<tr>
<th>Key Area</th>
<th>HIPAA Mandated Implementation</th>
<th>ACA-required Health Plan Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dates</strong></td>
<td>First Date</td>
<td>Second Date</td>
</tr>
<tr>
<td></td>
<td>January 1, 2013</td>
<td>December 31, 2013</td>
</tr>
<tr>
<td><strong>Who:</strong></td>
<td>All HIPAA covered entities</td>
<td>Health plans</td>
</tr>
<tr>
<td><strong>Action:</strong></td>
<td>Implement CAQH CORE Eligibility &amp; Claim Status</td>
<td>File statement with HHS certifying that data and information systems are in compliance with the standards and operating rules.</td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>Operating Rules</td>
<td></td>
</tr>
<tr>
<td><strong>Applicable Penalties</strong></td>
<td>Due to HITECH, penalties for HIPAA non-compliance have increased, now up to $1.5 million per entity per year</td>
<td>Amount: $1 per covered life until certification is complete; penalties for failure to comply cannot exceed 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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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.
Health Care Eligibility Benefit Inquiry and Response (270/271)
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 and individual’s eligibility and benefits
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 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
• Implementation Scope
• Business Usage
  – Information Flows
  – Trading Partner Agreements
• Business Terminology
  – Transactions types
  – Explicit versus Generic Inquiry
    ✔ Generic Request is an Eligibility/Benefit Inquiry with a Service Type Code (EQ01)
      30- Health Benefit Plan Inquiry will trigger a response including 10 service type
codes if the service type codes are part of the subscriber/dependent ‘s plan or
benefit package
    ✔ Explicit Request is an Eligibility/Benefit Inquiry with a Service Type Code of a value
other than 30 (and 60). This will allow the provider to request the details of more
specific service type codes
  – Some overlap conformity with the concept of a Generic Request and an
    Explicit Request
  – Information Source vs. Information Receiver
  – Role Patient/Subscriber
Health Care Eligibility/Benefit Inquiry and Response (270/271) – ASC X12 TR3 In-Depth

- Paired nature between the 270 inquiry & 271 response.
- What makes a 271 Response “robust”?
  - May depend on what was sent on the 270 Inquiry such as Diagnosis Codes, Procedure Codes, Provider Role/Taxonomy codes. Place of Treatment, Additional Subscriber Information-such as the group or policy
  - Use of the Coverage Level Code, Place of Treatment, Authorization/Certification Indicator, Network Indicator, Patient Financial responsibility/Remaining, Number of Covered Visits/Remaining
The Relationship Between the ASC X12N Transaction Standard and Operating Rule Requirements

- The ASC X12N 004010X092 (4010 270/271) transaction was the standard upon which the initial set of CAQH CORE Eligibility and Benefit Data Content Operating Rules were built to support.

- When ASC X12N 005010X279 (5010 270/271) was mandated under HIPAA, some CAQH CORE Eligibility and Benefit Data Content Operating Rule requirements were removed from the operating rules and incorporated into this new/revised version of the TR3.
  - Requirements from operating rules regarding data content are reviewed on a case by case basis and must be approved at multiple levels before being finalized in a TR3 publication.
  - The Operating Rules never repeat the standards and are updated as standards evolve.
Eligibility for a Health Plan: Response Requirements

HIPAA-adopted Standards and CAQH CORE Operating Rules

Work In Unison
Applying CAQH CORE Operating Rules

- Healthcare operating rules pair data content and infrastructure operating rules to help data flow consistently in *varied settings and with various vendors*

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“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

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.
Mandated Eligibility 271 Response Requirements: Health Plan Name

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

Health plan name if one exists

CORE 154 Rule, 1.1

Health plan name if one exists **within its own system** – not required to go outside its own system (responding system) to obtain name

Supports automated administrative processing

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Mandated Eligibility 271 Response Requirement: 
*Past/Future Dates & Time Period*

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

**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
Mandated Eligibility 271 Response Requirement:

**Generic Inquiry – Service Type Codes**

**ASC X12 Standards**

**CAQH CORE Operating Rules**

**Admin Simplification**

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**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.
Mandated Eligibility 271 Response Requirement: *Explicit Inquiry – Service Type Codes*

ASC X12 Standards + CAQH CORE Operating Rules = Admin Simplification

**ASC X12 v5010 270/271 TR3 1.4.7**

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

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)

**CORE 154 Rule, 1.4**

**CORE 260 Rule, 4.1.1.1**

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

Explicit Inquiry
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
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

Patient Financials
Mandated Eligibility 271 Response Requirement: Return of Deductibles

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, AI, 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.
Mandated Eligibility 271 Response Requirement: Receiver Requirements

ASC X12 Standards + CAQH CORE Operating Rules = Admin Simplification

Receiver Requirements

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

Not a concept outlined in detail in the TR3
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
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
Applying CAQH CORE Operating Rules

• Healthcare operating rules pair data content and infrastructure operating rules to help data flow consistently in varied settings and with various vendors.

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Q & A: Ground Rules and Focus of Interactive Session

• Health Care Eligibility/Benefit Inquiry and Response
  – Types of Inquiries
    • Generic Inquiry
    • Explicit Inquiry
  – Patient Financials
  – Service Type Codes (STC) Codes
  – Last name normalization
  – AAA Error Code reporting

• Questions related to infrastructure operating rules can be submitted to CAQH@CORE.org or one can attend an upcoming December CORE education program on Infrastructure Operating Rule implementation

*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.
Available Resources
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

An RFI and the associated response is reviewed and approved at several levels before being published as a final ASC X12 interpretation.
ASC X12 Standards for EDI Technical Report Type 3 Change Request Submission

- If you are seeking changes to:
  - ASC X12 TR3
    - Submit requests to changerequest.x12.org
    - Or request a change via the Designated Standard Maintenance Organizations (DSMO) process www.hipaa-dsmo.org
    - Same request can be submitted into both the ASC X12 and DSMO change request systems; a change submitted in either process will get appropriately routed between the organizations
  - ASC X12 Internal Code List (Part of the ASC X12 Standard), e.g. AAA Error codes, Service Type Codes
    - Submit a Data Maintenance work request or Code Maintenance Request through the www.X12.org.
  - External Codes Lists (Not owned or maintained by ASC X12), e.g. CPT codes, ICD10 codes
    - Contact the owner of an External Code Set directly for instructions on revisions to that code set as ASC X12 does not control the revision processes for the External Code Sets utilized in the ASC X12 Standards.
Examples: CAQH CORE Implementation Tools

• **Trading Partner Testing Readiness Site:** Which organizations are ready to test their implementation of operating rules with trading partners?
  – *If you are ready to do testing with your trading partners – add the name of your organization today…adding your name takes less than five minutes!*

• **FAQs:** CAQH CORE has a list of FAQs to address typical questions regarding the operating rules; updated FAQs being loaded to website as appropriate given mandates

• **Request Process:** After reviewing FAQs, contact experts as needed at CORE@caqh.org

• **Voluntary CORE Certification:** Phase I & Phase II CORE Certification Master Test Suites provide guidance on the stakeholder types to which the rules apply and working with trading partners; enables conformance testing for implementers
CAQH CORE Upcoming Education Programs

• View the upcoming Free CAQH CORE Education Events
  – Standards and Operating Rules Working in Unison
    • CAQH CORE and NACHA “Alignment of Financial Services and Healthcare: The EFT Standard and Operating Rules for EFT & ERA”, Thursday, November 29, 2012 | 2:00pm ET - 3:00pm ET
  – CAQH CORE Town Hall Call – December 11, 2012
  – Other joint CAQH CORE Education Sessions
    • InstaMed, “Working with Trading Partners”, Tuesday, December 4, 2012 | 2:00pm – 3:00pm ET
    • “Ask Any Question: Open Mic Q&A”, December (date To be Announced; will include CMS OESS as a panelist)
    • WEDI, Wednesday, December 12, 2012 | 2:00pm - 3:30pm ET
    • NeHC, Tuesday, December 18, 2012 | 3:00pm - 4:30pm ET
Thank You for Joining Us
Appendix:
FAQ Examples
FAQs: Data Content Operating Rules
Patient Financial Responsibility Requirements

• **Question:** How should my health plan conform to the CAQH CORE Rule 260 Section 4.1.3 requirements for plans to return patient financial responsibility for base and remaining deductible (health plan and benefit-specific), co-insurance, and co-payment if the plan does not include patient financials?

• **Answer:**
  – As the CAQH CORE rules require the return of specific patient financial data, including co-payment, co-insurance, base and remaining deductible, etc., if the benefit plan for the member does not have these patient financials, the health plan would return a “0” (zero) in the required financial fields
    • E.g. the health plan would be required to return Health Plan Base Deductible (0), Health Plan Remaining Deductible (0), Benefit Specific Co-Pay (0), and Benefit Specific Co-Insurance (0)
  – The ASC X12N v5010 270/271 Technical Report Type 3 (TR3) specifies what data should be returned when a patient has no financial responsibility for a benefit/service type
**FAQs: Data Content Operating Rules**  
*Service Type Codes (STCs)*

- **Question:** Does CAQH CORE provide guidance on how to map our internal benefit codes to the Service Type Codes? Is it possible to get additional clarity on the Service Type Code definition to better understand what services should be provided?

- **Answer:**
  - CAQH CORE does not provide guidance on how a health plan may map its internal codes to the STC codes. This is an implementation decision made by each health plan.
  - For the v5010 X12 270/271 transactions the Service Type Codes (STCs) and corresponding definitions are specified in the v5010 X12 270/271 Technical Report Type 3 (TR3). CAQH CORE does not redefine the STCs. However, for some codes CAQH CORE has included “supplemental descriptions” in CAQH CORE Rule 260. These definitions are for guidance only to aid in a common industry understanding as noted in Footnote #2 in Table 4.1.1.1. Information related to the meaning, use, and interpretation of ASC X12 Standards, Guidelines, and Technical Reports, including implementation guidance for the ASC X12N v5010 270/271 can be obtained from ASC X12 via its online ASC X12 Interpretation Portal.
Legal Disclaimer

This presentation is for informational purposes only.
• The content should not be construed as legal advice.
• If you have questions regarding:
  – ASC X12 transactions or SDO activities, please email info@x12.org
  – CAQH CORE Operating Rules, please email CORE@caqh.org
• Take advantage of the many industry references available at www.x12.org and www.caqh.org