Committee on Operating Rules For Information Exchange (CORE®)

"Open Mic" Session on the Federally Mandated Eligibility and Claim Status Operating Rules

August 30, 2012
## Agenda

<table>
<thead>
<tr>
<th>Topic</th>
<th>Time</th>
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<tbody>
<tr>
<td>Introduction to Operating Rules</td>
<td>2 minutes</td>
</tr>
<tr>
<td>Overview of ACA Section 1104</td>
<td>3 minutes</td>
</tr>
<tr>
<td>Implementing the Federally Mandated CAQH CORE Eligibility &amp; Claim Status Operating Rules</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Interactive Q&amp;A on Federally Mandated Eligibility &amp; Claim Status Operating Rules by Rule Area</td>
<td>Brief review of each rule area followed by a 10 minute Q&amp;A session; questions may be submitted via the chat function</td>
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**Eligibility & Benefits and Claim Status Infrastructure Rules**

1. Response Time Rules (Batch & Real-Time) & System Availability Rule
2. Connectivity Rules
3. Companion Guide Rule

**Eligibility & Benefits Data Content Rules**

4. Patient Financial Data Content Rules
5. Normalizing Patient Last Name Rule & AAA Error Code Reporting Rule

Stay Involved with CAQH CORE                                           | 2 minutes  |
Snapshot of Call Participants

- More than 100 individuals representing more than 55 CORE Participating Organizations
  - All key stakeholder groups including:
    - Health Plans
    - Providers
    - Vendors
    - Clearinghouses
    - Government Entities
    - Associations
  - Range of technical and non-technical experts, examples of titles include:
    - EDI Director
    - IT Manager
    - Developer
    - Project Manager
    - Business Analyst/Consultant
    - Compliance Analyst
    - Product Manager
    - Policy Analyst
Introduction to Operating Rules
What Are Operating Rules?

- The Patient Protection and Affordable Care Act (ACA) of 2010 amended HIPAA; its Section 1104 introduced healthcare operating rules.
- The 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.
  - 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 and Standards Work in Unison: 
Both Are Essential

• Operating rules always support standards; entities have been voluntarily implementing them together without conflict since 2006

• Benefits of operating rules complementing standards are evidenced in other industries
  – Various sectors of banking (e.g., credit cards & financial institutions)
  – Different modes of communications and transportation

• Operating rules are built to be adaptive and responsive to administrative simplification needs before, during and after versions of standards are formally adopted
ACA Section 1104: Mandated Operating Rules
Section 1104 of the ACA (H.R.3590)

“…Establishes new requirements for administrative transactions that will improve the utility of the existing HIPAA transactions and reduce administrative costs”

**Highlights**

- Updates initial August 2000 HIPAA regulation for transaction standards and code sets given landscape has significantly changed, and unnecessary healthcare costs/burden must be removed from the system
- Requires Department of Health and Human Services (HHS) to appoint a “qualified non-profit entity” to develop a set of operating rules for the conduct of electronic administrative healthcare transactions
- Administrative and financial standards and operating rules must:
  - Enable the determination of eligibility and financial responsibility for specific services prior to or at the point of care
  - Be comprehensive, requiring minimal augmentation by paper or other communications
  - Provide for timely acknowledgment, response, and status reporting
- HIPAA covered entities and business associates engaging in HIPAA standard transactions on behalf of covered entities must comply
- Health plans must file a statement with HHS confirming compliance; financial penalties for health plans are significant
ACA Mandated Operating Rules Compliance Dates:
Required for all HIPAA Covered Entities

Compliance Dates for ACA Mandated Operating Rules

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.
Status of Mandated Eligibility & Claim Status Operating Rules: *Four Months Until Compliance Date*

- **Status:** The first set of operating rules has been adopted into Federal regulation
  - 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
  - ACA Section 1104 requires all HIPAA covered entities be compliant with applicable HIPAA standards and **associated operating rules**

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The complete set of CAQH CORE Eligibility & Claim Status Operating Rules are available free of charge [HERE](#).

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*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 Federal Compliance Requirements: Highlights & Key Dates

**Three dates** are critical for industry implementation of the first set of Federally 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><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></td>
<td>Compliance Date</td>
<td>Health Plan Certification Date</td>
</tr>
<tr>
<td><strong>Description</strong></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 rules²</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 life³ 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](https://www.cms.gov/) and [enforcement process](https://www.cms.gov/).

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](https://www.caqh.org/) 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.

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Implementing the CAQH CORE Eligibility & Claim Status Operating Rules
Implementation Process: Where Organizations Should be

Implementation Stages for Eligibility and Claim Status Operating Rules

- Have Not Started
- Analysis and Planning (budgeted, resources assigned, impact analysis)
- Systems Design (software or hardware upgrades identified, coordinating with vendors)
- Systems Implementation (software/hardware and vendor services upgrades fully implemented)
- Integration & Testing (internal and trading partners testing)
- Deployment/Maintenance (full production use with one or more trading partners)
Implementing CAQH CORE Operating Rules: The Importance of Trading Partner Collaboration

• All HIPAA covered entities involved in the electronic exchange of eligibility or claim status transactions will play a role in the adoption of the first set of operating rules.

• Trading partners work together in a variety of ways to exchange administrative data:
  – Understand electronic flows and data content needs associated with your trading partner agreements
  – Identify the role and responsibility of each entity in the chain of data exchange

• Clearinghouses and practice management system vendors (PMS) play a key role in supporting health plans and providers in conforming with the mandated operating rules.
Implementing CAQH CORE Operating Rules: Trading Partner Roles and Responsibilities

- The applicability of a mandated operating rule or a specific rule requirement depends upon the nature of the entity’s trading partner relationship; e.g.,
  - Provider submits an eligibility request to a health plan directly through its Practice Management System (PMS)
  - Health Plan responds to an eligibility request submitted by a clearinghouse
  - Clearinghouse responds to a Claim Status request submitted by a provider client
- Identify your role in the conduct of the eligibility and claim status transaction and understand how the mandated operating rules apply to your role and the specific operating rule requirement in question

<table>
<thead>
<tr>
<th>ROLES</th>
<th>Information Source</th>
<th>Information Requestor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health Plans or Clearinghouses</td>
<td>Providers, Clearinghouses or Vendors</td>
</tr>
<tr>
<td>Store eligibility, benefit and claim history data</td>
<td>Request eligibility, benefit and claim status data</td>
<td></td>
</tr>
<tr>
<td>Receive Eligibility and Benefit 270 Inquiries and provide 271 Responses</td>
<td>Send 270 Eligibility and Benefit Inquiries and receive 271 Responses</td>
<td></td>
</tr>
<tr>
<td>Receive Claim Status 276 Requests and provide 277 Responses</td>
<td>Send 276 Claim Status Requests and receive 277 Responses</td>
<td></td>
</tr>
</tbody>
</table>

- In some cases clearinghouse may offer full outsourcing services for eligibility and benefit verification (and/or claim status) functions, inclusive of data hosting.
Preparing for the January 2013 Mandate:
CAQH CORE Implementation Tools

• Per the integrated model, CAQH CORE is committed to supporting industry implementation of the mandated operating rules and coordinating with CMS and others on such efforts. The following resources are available from CAQH CORE*:
  – **Analysis & Planning Guide for Adopting the CAQH CORE Eligibility & Claim Status Operating Rules**: Provides guidance for Project Managers, Business and System Analysts, and other project staff to complete systems analysis and planning; includes a Stakeholder & Business Type Evaluation, Systems Inventory & Impact Assessment Worksheet, and Gap Analysis Worksheet
  – **Phase II CORE Certification Master Test Suite**: Initially developed for voluntary CORE Certification but same concepts, e.g., role of trading partners, apply for general adoption of the CAQH CORE Operating Rules
  – 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
  – General/Interpretation Questions:
    • After reviewing other tools & resources, information requests can be submitted to the CAQH CORE Request Process at [CORE@caqh.org](mailto: CORE@caqh.org)
  – Organizations who pursue voluntary CORE Certification are invited to participate in an implementation cost/effort and impact (ROI) study

* Similar resources are being developed to support implementation of the CAQH CORE EFT & ERA Operating Rules
Preparing for the January 2013 Mandate:  
Voluntary CORE Certification

- **Voluntary CORE Certification:**
  - Provides verification that your IT systems or product operates in accordance with the federally mandated operating rules
  - Available to health plans, vendors, clearinghouses and providers who are implementing the operating rules and conducting testing using a CORE-authorized testing vendor
  - Encourages trading partners to work together on data flow and content needs
  - Facilitates maximum ROI when all entities in data exchange conform

- **Key guiding principles of CORE program:**
  - Certification and testing are done by separate entities; CORE-authorized testing vendors build web-based Test platform, and site is alpha/beta tested by CORE participants
  - Multi-stakeholder CORE process approves Test Suite for each rule set, including test scripts by stakeholder type
  - Free or very low-cost – and easily accessible to all parties
  - Does not replace internal or trading partner testing
Q&A Session

(Q&A Format: Brief review of each rule area followed by a 10 minute Q&A session; questions may be submitted via the chat function)
Mandated CAQH CORE Eligibility & Claim Status Operating Rules: “Open Mic” Session

- **Goal of Q&A:** Answer attendee questions related to operating rule interpretations and technical rule requirements
  - Questions can also be submitted offline to core@caqh.org

<table>
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<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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<tbody>
<tr>
<td><strong>Infrastructure</strong></td>
<td>X12 270/271 Eligibility &amp; Benefits and X12 276/277 Claims Status</td>
<td>1. 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>2. Connectivity Rules</td>
<td>153, 270 &amp; 250*</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. 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>4. 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>5. 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 Response Time Rules (Batch & Real-Time)

• **Problem addressed by rules**
  – Lengthy and/or unpredictable eligibility and benefits response times impacts workflow, practice productivity and patient experience

• **Scope of the rules**
  – Apply when an entity uses, conducts or processes the X12 270/271 Eligibility & Benefits and X12 276/277 Claim Status transactions

• **High-level rule requirements**
  – Real-Time Response
    • Maximum: 20-second round trip
  – Batch Response (only applies if batch offered by entity)
    • Receipt by 9:00 p.m. Eastern Time requires response by 7:00 a.m. Eastern Time the next business day
  – Conformance with this rule will be considered achieved if entities meet these measures 90 percent of the time within a calendar month
CAQH CORE System Availability Rule

• **Problem addressed by rule**
  – Limited system availability impacts workflow and reduces productivity

• **Scope of the rule**
  – Apply when an entity uses, conducts or processes the X12 270/271 Eligibility & Benefits and X12 276/277 Claim Status transactions

• **High-level rule requirements**
  – Minimum of 86 percent system availability (per calendar week)
    • Publish regularly scheduled downtime
    • Provide one week advance notice on non-routine downtime
    • Provide information within one hour of emergency downtime
Example of Interdependencies between Rules

**Question:** How should we track and audit the X12 270/271 & X12 276/277 transactions to meet the 20 second response time requirement?

**Answer:**

- The CAQH CORE Eligibility & Benefits Batch & Real-Time Response Time Rules (CAQH CORE Rules 155 & 156) require entities capture, log, audit, match, and report the date, time, and control numbers from its own internal systems, and corresponding data received from its 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 and to identify where a bottleneck may be occurring that is impacting the 20 second response time. The requirement was purposefully specified in the rules at a high level so each entity along the transaction pathway can design and develop its own process for audit handling.
  - Note that these same requirements are also specified in CAQH CORE 250: Claim Status Rule for the X12 276/277 transactions.

- In CAQH CORE 270: Connectivity Rule Section 4.3.4, addressing audit handling, the rule requirements are also specified at a high level. The rule section notes that to comply with CAQH CORE Rules 155, 156, and 250 message receivers must track the date, time, and payload ID of any received inbound messages and respond with the outbound message for that payload ID. Additionally, message senders must include the CORE Envelope Metadata element Time Stamp (as specified in Rule 270 Section 4.1.2).
10 Minute Q&A:
CAQH CORE Response Time Rules (Batch & Real-Time) & System Availability Rule
CAQH CORE Connectivity Rules

• **Problem addressed by rules**
  – Multiple methods for exchanging eligibility and benefits data both manually and/or electronically drive elevated transaction costs and increase operational complexity

• **Scope of the rules**
  – Using the internet as a delivery option, establishes a “Safe Harbor” connectivity rule which standardizes the flow of administrative transactions between health plan and provider
    • Rule 270 builds on Rule 153 to include more prescriptive submitter authentication, envelope specifications, etc.
    • Safe Harbor applies when an entity uses, conducts or processes the X12 270/271 Eligibility & Benefits and X12 276/277 Claim Status transactions
      – Applies to information sources performing the role of an HTTP/S server and information receivers performing the role of an HTTP/S client
      – Applies to both batch and real time transactions
      – **Does not** require trading partners to remove existing connections that do not match the rules
• The connectivity requirements that a trading partner must use if requested by another trading partner are described in the CAQH CORE Connectivity Rules as the CORE Connectivity Safe Harbor

• **CAQH CORE Rule 270** Section 5, *CORE Safe Harbor*, defines the CAQH CORE Connectivity Safe Harbor
  
  – The CAQH CORE Connectivity Safe Harbor specifies connectivity methods that application vendors, providers, and health plans can be assured will be supported by any HIPAA covered entity, meaning that the entity is capable and ready at the time of the request by a trading partner to exchange data using the CAQH CORE Connectivity Rule

  – The rule does not require entities to remove existing connections that do not match the rule, nor does it require that all covered entities use this method for all new connections. In some circumstances, you and your trading partners may decide to continue to use your current connection; however *you must implement the capability to use the CORE Connectivity Safe Harbor when requested*
## High-Level Rule Requirements

<table>
<thead>
<tr>
<th>CAQH CORE Connectivity Rule Area</th>
<th>CAQH CORE Connectivity Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network</td>
<td>Internet</td>
</tr>
<tr>
<td>Transport</td>
<td>HTTP</td>
</tr>
<tr>
<td>Transport Security</td>
<td>SSL, TLS <em>(optional)</em></td>
</tr>
<tr>
<td><strong>Submitter (Originating System or Client) Authentication</strong></td>
<td>Name/Password</td>
</tr>
<tr>
<td></td>
<td><em>X.509 Certificate (subject to conformance requirements)</em></td>
</tr>
<tr>
<td><strong>Envelope and Attachment Standards</strong></td>
<td><em>SOAP 1.2 + WSDL and MTOM (for Batch) or HTTP+MIME (subject to conformance requirements)</em></td>
</tr>
<tr>
<td><strong>Envelope Metadata</strong></td>
<td>*Metadata defined (Field names, values)</td>
</tr>
<tr>
<td></td>
<td><em>New PayloadTypes for HIPAA and non-HIPAA Payloads</em></td>
</tr>
<tr>
<td><strong>Message Interactions/ Routing</strong></td>
<td>Real time</td>
</tr>
<tr>
<td></td>
<td><em>Batch (Optional if used)</em></td>
</tr>
<tr>
<td><strong>Acknowledgements, Errors</strong></td>
<td>Specified</td>
</tr>
<tr>
<td><strong>Basic Conformance Requirements</strong></td>
<td>Specified</td>
</tr>
<tr>
<td><strong>Response Time</strong></td>
<td>Specified</td>
</tr>
<tr>
<td><strong>System Availability</strong></td>
<td>Specified</td>
</tr>
<tr>
<td><strong>Companion Implementation Guide</strong></td>
<td>Specified</td>
</tr>
</tbody>
</table>
10 Minute Q&A:

CAQH CORE Connectivity Rules
CAQH CORE Companion Guide Rule

• **Problem addressed by rule**
  – Formats across the country used by health plan for their specific companion guides vary significantly and thus introduce an added layer of administrative cost and operational complexity for trading partners

• **Scope of the rule**
  – Applies to health plans or information sources that publish companion guides (does not require that entities publish companion guides)
  – Developed with input from multiple health plans, system vendors, provider representatives and healthcare/HIPAA industry experts

• **High-level rule requirements**
  – Companion Guides covering the X12 270/271 Eligibility & Benefits and X12 276/277 Claim Status transactions must follow the format and flow of the CAQH CORE v5010 Master Companion Guide Template
  – Companion Guide Template organizes information into distinct sections
    • General Information
    • Transaction-Specific Information
    • Appendix
  – Allows health plans (information sources) to tailor the document to meet their particular needs while still maintaining a standard template/common structure
10 Minute Q&A:

CAQH CORE Companion Guide Rule
CAQH CORE Patient Financial Data Content Rules

• **Problem addressed by rules**
  – Minimal delivery of eligibility information including variable support for service type requests; limited patient eligibility and benefits information at the point of service; constrains design of all payer solutions

• **Scope of the rules**
  – Apply when an entity uses, conducts or processes the X12 270/271 transactions; X12 271 response relates to both generic and explicit inquiries
  – The requirements specified in these rules address certain situational elements and codes and are in addition to requirements contained in the v5010 X12 270/271 Implementation Guides

• **High–level rule requirements**
  – For health plans and information sources:
    • X12 271 response to a *generic* X12 270 inquiry must include:
      – The name of the health plan covering the individual (if available)
      – Patient financials for the static financials of co–insurance, co–payment, and base and remaining deductibles for **13** total CORE-required service type codes
        • 1 – Medical Care
        • 30 – Health Benefit Plan Coverage
        • 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
CAQH CORE Patient Financial Data Content Rules
cont’d

– For health plans and information sources (cont’d):
  • Must also support an explicit X12 270 inquiry for 51 CORE–required service type codes
  – X12 271 response to explicit X12 270 inquiry must include patient financials for the static financials of co–insurance, co–payment, and base and remaining deductibles for:

- 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
CAQH CORE Patient Financial Data Content Rules

cont’d

– For health plans and information sources (cont’d):

  • For both *generic* & *explicit* X12 270 inquiries, return of patient financial responsibility is discretionary when reporting on these CORE-required service type codes:

    – 1 – Medical Care
    – 35 – Dental Care
    – 88 – Pharmacy
    – A6 – Psychotherapy
    – A7 – Psychiatric Inpatient
    – A8 – psychiatric Outpatient
    – AI – Substance Abuse
    – AL – Vision (Optometry)
    – MH – Mental Health

  • For all responses, if financial responsibility is different for in–network vs. out–of–network, must return both amounts

– High–level rule requirements for providers, provider vendors and information receivers:

  • Detect and extract all data elements to which this rule applies as returned by the health plan (or information source) in the X12 271

  • Display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the X12 271 data content
10 Minute Q&A:
CAQH CORE Patient Financial Data Content Rules
CAQH CORE Normalizing Patient Last Name Rule

- **Problem addressed by rule**
  - Transactions may be rejected when demographic data submitted by the healthcare provider does not match similar demographic data held by the health plan

- **Scope of the rule**
  - Applies to the X12 270/271 transaction and specifies requirements for a health plan (or information source) to normalize a person’s last name during any name validation or matching process by the health plan (or information source)

- **High-level rule requirements**
  - Requires health plans to normalize submitted and stored last name before using the submitted and stored last names:
    - Remove specified suffix and prefix character strings, special characters and punctuation
    - If normalized name validated, move forward
    - 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
CAQH CORE AAA Error Code Reporting Rule

- **Problem addressed by rule**
  - Lack of specificity and standardized use of AAA error codes; providers inability to determine which information is missing or incorrect when an eligibility and benefits inquiry does not return a valid match

- **Scope of the rule**
  - Defines a standard way to report errors that cause a health plan (or information source) not to be able to respond with an X12 271 showing eligibility information for the requested patient or subscriber

- **High-level rule requirements**
  - 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 (*designed to work with any search and match criteria or logic*)
  - The receiver of the 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 data elements determined to be missing or invalid
10 Minute Q&A:
CAQH CORE Normalizing Patient Last Name Rule & AAA Error Code Reporting Rule
Thank You for Joining Us: *Stay Involved*

• **Get Ready!** Ensure your organization is prepared by **January 1, 2013**, the Mandated Eligibility & Claim Status Operating Rules deadline:
  
  – Encourage *voluntary [CORE Certification](#)* and [CORE Certification Testing](#)
    
    • CORE Certification is voluntary but testing the use of the standards and operating rules is important and should be included in implementation planning

  – Learn more about the rules: [HIPAA v5010 Phase I & II CAQH CORE Eligibility & Claim Status Rules](#)

• Take advantage of *free* education opportunities listed at the [CAQH CORE Events](#) webpage &/or upcoming *in-person presentations* including:
  
  – Upcoming CAQH CORE Town Hall calls
    
    • Next call: Tuesday, September 11\(^{th}\), 3:00 – 4:00 pm ET

  – Archived materials from past education sessions