Committee on Operating Rules
For Information Exchange
(CORE®)

Public Town Hall Call

March 13, 2012

Additional information/resources available at www.caqh.org
Agenda

• Brief Overview of CAQH CORE
  – For more information contact Omoniyi Adekanmbi at oadekanmbi@caqh.org

• Update on Mandated Healthcare Operating Rules
  – ACA Section 1104 Highlights and Timeline
  – Eligibility and Claim Status Operating Rules
  – EFT & ERA Operating Rules
    • Financial Services and the EFT
  – Future ACA Operating Rules Mandates

• Overview of Federal Regulations on HIPAA Compliance
  – Presented by Denise M. Buenning, MsM, Director, Administrative Simplification Group, CMS Office of E-Health Standards and Services (OESS)

• Stay Involved with CAQH CORE
Brief Overview of CAQH CORE
CAQH® and Its Initiatives

CAQH, a nonprofit alliance of health plans and trade associations, is a catalyst for industry collaboration on initiatives that simplify healthcare administration for health plans and providers, resulting in a better care experience for patients and caregivers.

Multi-stakeholder collaboration of more than 130 participating organizations that is developing industry-wide operating rules, built on existing standards, to streamline administrative transactions. Cover 75% of the commercially insured, plus Medicare and some Medicaid.

An industry utility that replaces multiple health plan paper processes for collecting provider data with a single, electronic, uniform data-collection system (i.e., credentialing). Over 990,000 providers self-report their information to UPD and over 650 organizations access the system, including a range of public and private entities.
Committee on Operating Rules for Information Exchange

• CAQH CORE is a multi-stakeholder collaboration developing industry-wide operating rules, built on existing standards, to streamline administrative transactions
  – Integrated model: Rule writing, certification and testing, and outreach/education
• 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
  – Enable stakeholders to implement in phases that encourage feasible progress in resolving industry business needs while minimizing barriers to adoption
  – Facilitate administrative and clinical data integration
• CAQH CORE is not:
  – Replicating the work being done by standard-setting bodies, e.g., ASC X12, HL7, OASIS, W3C
  – Developing software or building a database
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
  - 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 and Standards Work in Unison: 
Both Are Essential

• Operating rules always support standards – they already are being adopted together in today’s market and have been since 2006
  – The two should and can be implemented together without conflict

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

• Healthcare operating rules address and support a range of standards
  – Healthcare-specific standards, e.g., require non-mandated aspects of v5010 ASC X12 given data such as in/out of network patient responsibility are critical to administrative simplification
  – Industry-neutral standards, e.g., SOAP, WSDL, ACH CCD+

• Focus is ROI: Operating rules are built to be adaptive and responsive to administrative simplification needs before, during and after versions of standards are formally adopted
  – Coordination between operating rules and standards will be iterative as already demonstrated, e.g. new operating rules may be issued using the same version of a standard and items required by the operating rules will, in some instances, be moved into the next version of a standard and removed from rules
Mandated Operating Rules:
ACA Section 1104
ACA Mandated Operating Rules Approach

Operating rule writing and mandated implementation timeframe per ACA legislation

Adoption deadlines to finalize operating rules

- **July 2011**: Eligibility and Claim Status
- **July 2012**: Claims payment/advice and electronic funds transfer (plus health plan ID)
- **July 2014**: Enrollment, Referral authorization, attachments, etc.

Effective dates to implement operating rules

- **January 2013**:
- **January 2014**:
- **January 2016**:

NOTES:

1. NCVHS is the body designated by HHS to make recommendations regarding the operating rule authors and the operating rules.
2. Statute defines relationship between operating rules and standards.
3. Operating rules apply to HIPAA covered entities; beyond HIPAA compliance penalties, certification penalties for health plans.
4. Per statute, documentation of compliance for health plans may include completion of end-to-end testing (i.e., certification and testing).
Mandated Operating Rules:
Eligibility & Claim Status
**Mandated Eligibility & Claim Status Operating Rules**

- **Status and Next Steps**: The first set of operating rules have been adopted into Federal regulation
  - July 2011, CMS published [CMS-0032-IFC](#) with the following key features:
    - Adopted Phase I and II CAQH CORE Operating Rules, except for Acknowledgements*
    - Highlights CORE Certification is *voluntary*; further defines relationship between standards and operating rules and analysis of ROI from operating rules implementation
  - December 2011, CMS adopted above as a Final Rule; industry implementation efforts underway for the **January 1, 2013 compliance date**
    - CAQH CORE is committed to assisting with roll-out of the Final Rule and continuing to support maintenance of the rules, e.g., coordinating with CMS on FAQs, hosting education sessions
    - CAQH CORE is working with users to identify future optimal packaging of CAQH CORE rules for ease of use that supports both mandated and voluntary efforts; packaging will not change the rule requirements

*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.*
# CAQH CORE Eligibility & Claim Status Operating Rules: Mandated Overview

<table>
<thead>
<tr>
<th>Rules</th>
<th>High-Level Phase I &amp; II CAQH CORE Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Content</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Eligibility &amp; Benefits</strong></td>
<td>Respond to generic and explicit inquiries for a defined set of 50+ high volume services with:</td>
</tr>
<tr>
<td></td>
<td>• Health plan name and coverage dates</td>
</tr>
<tr>
<td></td>
<td>• Static financials (co-pay, co-insurance, base deductibles)</td>
</tr>
<tr>
<td></td>
<td>• Benefit-specific and base deductible for individual and family</td>
</tr>
<tr>
<td></td>
<td>• In/Out of network variances</td>
</tr>
<tr>
<td></td>
<td>• Remaining deductible amounts</td>
</tr>
<tr>
<td><strong>Infrastructure</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Eligibility &amp; Benefits</strong></td>
<td>• Connectivity via Internet and aligned with NHIN direction, e.g., supports plug and play method (SOAP and digital certificates and clinical/administrative alignment)</td>
</tr>
<tr>
<td></td>
<td>• Companion Guide – common flow/format</td>
</tr>
<tr>
<td></td>
<td>• Real-time and batch turnaround times (e.g., 20 seconds or less for real time and next day for batch)</td>
</tr>
<tr>
<td></td>
<td>• System Availability service levels – minimum 86% availability per calendar week</td>
</tr>
<tr>
<td></td>
<td>• Enhanced Patient Identification and Error Reporting requirements</td>
</tr>
<tr>
<td></td>
<td>• Acknowledgements (transactional)*</td>
</tr>
<tr>
<td><strong>Claim Status</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Connectivity via Internet</td>
</tr>
<tr>
<td></td>
<td>• Real-time and batch turnaround times</td>
</tr>
<tr>
<td></td>
<td>• System Availability</td>
</tr>
<tr>
<td></td>
<td>• Companion Guide flow/format</td>
</tr>
<tr>
<td></td>
<td>• Acknowledgements (transactional)*</td>
</tr>
</tbody>
</table>

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

The complete Phase I & II CAQH CORE Rules are available [HERE](#).
FAQs: CAQH CORE has a list of FAQs to address typical questions regarding the operating rules, and is in the process of reviewing these FAQs and updating as appropriate given mandates.

Education Sessions: CAQH CORE holds frequent sessions with partners (WEDI, CHIME, and Medicaid) and many include speakers from organizations that have already implemented the rules; past sessions available for download on CAQH CORE website.

Checklists
- Step 1 – Systems Readiness Assessment: Identifies systems/software gaps to determine organization’s ability to adopt and implement the Phase I & II CAQH CORE Rules; key is identifying applicability of rules to your organization.
- Step 2 – Gap Analysis: Includes checklists that outline the system and business requirements necessary to implement each Phase I & II CAQH CORE Rule that apply to your organization; Checklists specify each individual rule requirement within a given rule for entities implementing the Federally mandated Phase I & II Rules.

General/Interpretation Questions: Email CORE@caqh.org with requests for interpretations or general questions; formal request process in place to provide prompt responses.

Voluntary CORE Certification: On-line, free or low-cost tool tailored for use by stakeholder types.

All CAQH CORE Operating Rules are available free at www.caqh.org.
Mandated Operating Rules:

EFT & ERA
EFT & ERA:
Healthcare and Financial Services Collaboration

• The Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) healthcare operating rules mandate has encouraged coordination between healthcare and financial services

• NACHA – The Electronic Payments Association
  – Established in 1974; a financial services entity whose rules are used by 15,000 banks; *NACHA Operating Rules* are used by bank throughout the country
  – NACHA manages the development, administration and governance of the ACH Network, the backbone for the electronic movement of money and data
  – The ACH Network is a batch processing, electronic payments system governed by the *NACHA Operating Rules*; it provides for the interbank clearing of electronic payments for participating depository financial institutions

• CAQH CORE has and continues to be coordinating with NACHA
  – Began working together in 2005; began coordinating operating rule writing in 2010
  – CAQH CORE participants identified in the CORE rules key areas where new or modified *NACHA Operating Rules* could address current issues in use of NACHA CCD+ transaction for EFT healthcare payments over the ACH Network
Mandated EFT & ERA Operating Rules

• **Status**
  – Spring 2011: NCVHS recommended:
    • NACHA as healthcare EFT SDO and ACH CCD+ as standard EFT format
    • CAQH CORE, in collaboration with NACHA, as author for EFT and ERA operating rules (pharmacy to be addressed as appropriate)
  – September 2011: Draft CAQH CORE EFT & ERA Operating Rules approved by CAQH CORE Rules Work Group and NCVHS updated on rules’ status
    • Nov 2011: CAQH CORE Technical Work Group approved voluntary CORE Certification Test Suite
  – December 2011: NCVHS issued a letter recommending HHS adopt the five Draft CAQH CORE EFT & ERA Operating Rules
  – January 2012, CMS released Interim Final Rule for the EFT standard
    • CAQH CORE commented on IFC for the health care EFT standard (model letter shared with participants)

• **Next Steps**
  – Healthcare: Issue final rule on EFT standard and finalize CORE EFT/ERA rules; CMS will determine appropriateness for healthcare mandate
  – Financial services operating rules: Coordination with NACHA on edits to NACHA Operating Rules due to future use by healthcare of ACH CCD+
Draft CAQH CORE EFT & ERA Operating Rules: *Overview*

<table>
<thead>
<tr>
<th>Draft Rule</th>
<th>High-Level Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Uniform Use of CARCs and RARCs (835) Rule</strong></td>
<td>Identifies a <em>minimum</em> set of four CAQH CORE-defined Business Scenarios with a <em>maximum</em> set of CAQH CORE-required code combinations that can be applied to convey details of the claim denial or payment to the provider</td>
</tr>
<tr>
<td><strong>EFT Enrollment Data Rule</strong></td>
<td>Identifies a maximum set of standard data elements for EFT enrollment • Outlines a straw man template for paper and electronic collection of the data elements • Requires health plan to offer electronic EFT enrollment</td>
</tr>
<tr>
<td><strong>ERA Enrollment Data Rule</strong></td>
<td>Similar to EFT Enrollment Data Rule</td>
</tr>
<tr>
<td><strong>EFT &amp; ERA Reassociation (CCD+/835) Rule</strong></td>
<td>Addresses provider receipt of the CAQH CORE-required Minimum ACH CCD+ Data Elements required for reassociation • Addresses elapsed time between the sending of the v5010 835 and the CCD+ transactions • Requirements for resolving late/missing EFT and ERA transactions • Recognition of the role of NACHA Operating Rules for financial institutions</td>
</tr>
<tr>
<td><strong>Claim Payment/Advice (835) Infrastructure Rule</strong></td>
<td>Specifies use of the CAQH CORE Master Companion Guide Template for the flow and format of such guides • Requires entities to support the Phase II CAQH CORE Connectivity Rule • Includes Batch Acknowledgement Requirements • Defines a dual-delivery (paper/electronic) to facilitate provider transition to electronic remits</td>
</tr>
</tbody>
</table>

The Draft CAQH CORE EFT & ERA Operating Rules are available [HERE](#).
Health Care **EFT Standard IFC:**

**HHS Public Comment Period**

- **HHS IFC,** *CMS-0024-IFC: Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice*
  - Key focus is adopting standards for EFTs and remittance advice: NACHA ACH CCD+ Addenda is new formal standard for healthcare
    - *Adopted for the initiation of a healthcare claims payment* (i.e., health plan's authorization to financial institution to make payment, called Stage 1)
    - Provided a 60 day comment period; comments were due to CMS by March 12th
- **CAQH CORE actions:**
  - Conducted analysis of the proposed regulation, identified substantive areas for comment and prepared draft model comment letter
  - February 10th: Shared draft letter with CORE Participants to solicit feedback for incorporation into final model letter
  - March 7th: Shared **final model letter** with both CORE and non-CORE Participants for use in developing organizational comments for direct submission to CMS
    - Four main comments, e.g. Ensure that the references in the HHS regulation to the versions of the *NACHA Operating Rules & Guidelines* are updated so they align with the health care operating rules and standards
    - If interested in CAQH CORE final model comment letter email zfithian@caqh.org
NACHA Request for Comment

Proposed Modifications to NACHA Operating Rules

- March 12th NACHA released a Request for Comment (RFC) on potential modifications to the NACHA Operating Rules for healthcare payments and remittance processing
  - Public comments due April 27th 2012 from both healthcare and financial services industries; NACHA Request for Comment can be accessed HERE
- RFC includes proposed adjustments from both the healthcare industry and financial services industry
  - Proposed modifications include:
    - Three options for supporting electronic delivery of the CORE-required Minimum CCD+ Reassociation Data Elements to providers within two banking days of settlement
    - Identification of, and formatting requirements for, healthcare EFT payments transmitted via the ACH Network
- Next steps
  - CAQH CORE will hold an open call to solicit feedback on the RFC from the healthcare industry and submit comments to NACHA
    - Entities can also submit individual comments
  - Comments will be reviewed by NACHA to determine if there is sufficient support for a ballot (only financial institutions participate in ballot)
Mandated Operating Rules:
Claims Attachments, Enrollment, Prior Authorization
Mandated Operating Rules: Claim Attachments, Enrollment, Prior Authorization and Referrals

- **Status**
  - November 2011: NCVHS began holding hearings
    - CAQH CORE provided testimony on all three topics and stated interest in serving as operating rule author, key points included:
      - **Claim Attachments**: Communicated current industry landscape implies clinical and administrative coordination is critical, provided examples of potential areas for operating rules; highlighted standards and operating rules will need to work together more than ever if the industry is to meet deadline
      - **Provider Enrollment**: Outlined lessons learned from the CAQH Universal Provider Datasource (UPD) as well as CORE EFT/ERA work
      - **Maintenance of Standards & Operating Rules**: Discussed how these processes can be improved moving forward
  - March 1-2, 2012: NCVHS held hearing
    - Reviewed draft HHS update letters; approved revisions & submission of revised letters
      - **Claim Attachments Letter**
      - **Administrative Simplification Provisions in ACA Section 10109 Letter**
      - **Update and Maintenance Process of Standards and Operating Rules Letter**

- **Next steps**
  - Spring 2012: NCVHS to make a recommendation on timing and process for identifying author
Overview of HIPAA Compliance

Denise M. Buenning, MsM
Director, Administrative Simplification Group
Office of E-Health Standards and Services
Centers for Medicare & Medicaid Services
Statutory Authority for HIPAA Enforcement

- The Secretary delegated CMS the authority to investigate complaints of noncompliance with, and to make decisions regarding the interpretation, implementation, and enforcement of certain regulations adopting administrative simplification standards.
- This delegation is known as the Transaction and Code Set Rule (TCS), 65 FR 50312 (August 17, 2000).
- It also applies to the National Employer Identifier Number (EIN) Rule, 67 FR 38009 (May 31, 2002), the National Provider Identifier Rule, 69 FR 3434 (January 23, 2004), and the National Plan Identifier Rule (currently under development).
- It also applies to Operating Rules (the Affordable Care Act of 2010).
- This does not include authority for the Security Rule (as of July 27, 2009) and the Privacy Rule, both delegated to the HHS Office for Civil Rights.
HIPAA TCS Enforcement Authority

- OESS is limited in its authority to enforce HIPAA transaction and code set violations.
- Limited to enforcement of only those transactions for which the Secretary has adopted a standard.
  - Our authority does NOT extend to business practices of trading partners
    - Example: a payer chooses to discontinue dial-up services for transmission of electronic health care transactions
The HIPAA “Firewall”

• OESS has authority for enforcement of transaction and code set violations for all HIPAA covered entities, including the Medicare and Medicaid programs.

• We conduct enforcement activities for these programs as we would any other HIPAA covered entity in the commercial health care world.

• We maintain an “arm’s length” approach
  – Example: OESS’ recent announcement of an enforcement discretion period for Version 5010/D.0 compliance specifically did NOT include information on strategy/plans developed by Medicare or Medicaid.
What Does HIPAA Compliance Mean?

• When we say “HIPAA Compliant” we mean that a covered entity can demonstrate the ability to both send and receive the applicable transactions for which the Secretary has adopted a standard/operating rule/identifier using the adopted vehicle.

• This means ALL its parts, no “cherry picking”
What are the HIPAA Standards?

<table>
<thead>
<tr>
<th>Standard</th>
<th>Transaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASC X12 837 D</td>
<td>Health care claims – Dental.</td>
</tr>
<tr>
<td>ASC X12 837 P</td>
<td>Health care claims – Professional.</td>
</tr>
<tr>
<td>ASC X12 837 I</td>
<td>Health care claims – Institutional.</td>
</tr>
<tr>
<td>NCPDP D.0</td>
<td>Health care claims – Retail pharmacy drug.</td>
</tr>
<tr>
<td>ASC X12 837 P and NCPDP D.0</td>
<td>Health care claims – Retail pharmacy supplies and professional services.</td>
</tr>
<tr>
<td>NCPDP D.0</td>
<td>Coordination of Benefits – Retail pharmacy drug.</td>
</tr>
<tr>
<td>ASC X12 837 D</td>
<td>Coordination of Benefits – Dental.</td>
</tr>
<tr>
<td>ASC X12 837 P</td>
<td>Coordination of Benefits – Professional.</td>
</tr>
<tr>
<td>ASC X12 837 I</td>
<td>Coordination of Benefits – Institutional.</td>
</tr>
<tr>
<td>ASC X12 270/271</td>
<td>Eligibility for a health plan (request and response) – dental, professional, and institutional.</td>
</tr>
<tr>
<td>NCPDP D.0</td>
<td>Eligibility for a health plan (request and response) – Retail pharmacy drugs.</td>
</tr>
<tr>
<td>ASC X12 276/277</td>
<td>Health care claim status (request and response).</td>
</tr>
<tr>
<td>ASC X12 834</td>
<td>Enrollment and disenrollment in a health plan.</td>
</tr>
<tr>
<td>ASC X12 835</td>
<td>Health care payment and remittance advice.</td>
</tr>
<tr>
<td>ASC X12 820</td>
<td>Health plan premium payment.</td>
</tr>
<tr>
<td>ASC X12 278</td>
<td>Referral certification and authorization (request and response).</td>
</tr>
<tr>
<td>NCPDP D.0</td>
<td>Referral certification and authorization (request and response) – retail pharmacy drugs.</td>
</tr>
<tr>
<td>NCPDP 5.1 and D.0</td>
<td>Retail pharmacy drug claims (telecommunication and batch standards).</td>
</tr>
<tr>
<td>NCPDP 3.0</td>
<td>Medicaid pharmacy subrogation (batch standard).</td>
</tr>
</tbody>
</table>
The HIPAA TCS Enforcement Process

- HIPAA transaction and code set complaint process is complaint-driven.
  - Complaints can be generated by one HIPAA covered entity against another, either anonymously or otherwise
  - Complaint process currently is reactive versus proactive
  - All HIPAA TCS complaints are registered into the ASET intake system – we do not accept phone calls, e-mails, etc. so that each complaint is properly documented and assigned a number.
The ASET System
The ASET System
The ASET System
The ASET System

New Complaint - Complaint Information

Enter details about the complaint below. Limit your complaint to one issue. For multiple issues, repeat the complaint process and add a new complaint for any new issues. Please do not use Protected Health Information (PHI).

The * denotes a required field.

1. Subject*
   D.0 Violation
   (max. 200 characters)

2. Description*
   Plan will not accept D.0 standard
   (max. 500 characters)

3. On what date did this alleged incident occur?*
   01/15/2012

4. Which part of the Transaction and Code Sets Rule is being violated in this complaint?
   - Non-Compliant Transaction Received
     You received a non-compliant HIPAA transaction from a covered entity.
   - Compliant Transaction Sent and Rejected
     A covered entity rejected your compliant HIPAA transaction.
   - Invalid Companion guide
     A covered entity rejects data or receive data from requires uses of a non-compliant companion guide. For example, a companion guide must not specify additional fields beyond those specified by HIPAA.
   - Code Set Received or Sent and Rejected
     Either or both of these examples apply: (1) A covered entity sent you a non-compliant HIPAA code within an electronic transaction.
     (2) A covered entity rejected a compliant HIPAA code that you sent within an electronic transaction.
   - Other
     You have another type of complaint against a covered entity.
   (max. 25 characters)
The ASET System
Complaint is validated as a TCS compliant
Both complainant and filed-against entities receive letters – one confirming and the other asking for response/additional information
Filed-against entity may be granted a maximum six-month, NON-EXTENDABLE time period during which to demonstrate compliance
OESS monitors progress, confirms compliance and closes case.
There is no provision in the statute for an appeal of an OESS TCS enforcement determination, unless/until the civil money penalty phase is entered.

At that point, only an administrative law judge can make a determination.
HIPAA TCS Civil Money Penalties

- Old Structure: OESS could levy civil money penalties for non-compliance with transaction and code sets of up to a maximum of $25,000 per year.
- New Structure: As of HITECH in November 2010, OESS can now levy civil money penalties for non-compliance of up to $1.5 million per entity per year.
The Affordable Care Act makes significant changes to transaction and code set enforcement.

By December 2013 (and again in 2015), health plans must certify that they are compliant with ALL HIPAA transactions, code sets, identifiers and operating rules in effect at that time.

Failure to certify has SIGNIFICANT monetary penalties.
The Affordable Care Act calls for penalties for failure to certify of $1 to $20 per covered life per day. This applies to certification only, not for HIPAA transaction and code set violations.

- Fines jump to $40 per covered life per day for misrepresentation/fraud in certification
- Regulation detailing the health plan certification process is under development
OESS’ mandate is to work with both the complainant and filed-against entity to achieve compliance.

We have not up to the point levied any civil monetary penalty for failure to comply because our enforcement process focuses on compliance, not punitive actions.

However, certification will result in higher stakes for all health plans and more scrutiny.

- Enhanced HIPAA enforcement to include pro-active, random audits for transaction and code set, operating rules and identifier violations.
Go to www.cms.gov/enforcement for a complete overview of HIPAA transaction, code set, operating rules and identifier enforcement.
Questions?

Denise.Buenning@cms.hhs.gov
Stay Involved with CAQH CORE
Thank You For Joining Us: Stay Involved

- Ensure your organization is ready for the January 2013 Mandated Eligibility & Claim Status Operating Rules deadline:
  - HIPAA v5010 Phase I & II CAQH CORE Rules
  - Phase I & II CAQH CORE FAQs
- Join us at another CAQH CORE Education Event:
  - Upcoming CAQH CORE Educational Events
    - Joint CAQH/WEDI Webinar: Preparing Your Organization to Adopt Mandated Healthcare Operating Rules (March 14th, 2:00-3:30 pm ET, Register Now)
    - For CAQH CORE Participating Entities: Preparing to Implement the Mandated CAQH CORE Eligibility & Claim Status Operating Rules (March 2012 - registration email forthcoming)
  - Upcoming Public CAQH CORE Town Halls (click to add to Outlook Calendar)
    - April 24th, 3:00-4:00 pm ET
    - June 12th, 3:00-4:00 pm ET
- Learn the basics of voluntary CORE Certification
- Contact CORE@caqh.org regarding rule interpretations or to submit requests for information/clarification

*NOTE: In the Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction, requirements pertaining to Acknowledgements are not included for adoption.