simplifying healthcare administration

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Committee on Operating Rules For Information Exchange (CORE®)

Provider and Delivery Systems:
The Fundamentals of Healthcare Operating Rules

March 20, 2013
2:00 pm – 3:00 pm 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 during 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
- This education session will offer two (2) Q&A sessions
  - On-line questions will be addressed first
  - The audience will also 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

Agenda

- Welcome and Session Overview
- An Introduction to ACA Section 1104
  - Fundamental Terms, Concepts and Applicability
- ACA-mandated Operating Rules: Overview and Compliance Topics
  - Question & Answer
- CAQH CORE Operating Rule Requirements
  - Eligibility and Claim Status Operating Rules
  - Electronic Fund Transfer(EFT) & Electronic Remittance Advice(ERA)
- Introduction to Operating Rule Implementation Resources
- Question & Answer
- Wrap-Up

Polling Question #1:
Progress Toward Compliance

Select the response that best describes the status of your provider organization's efforts to comply with ACA-mandated Eligibility and Claim Status Operating Rules?

- Awareness: Building awareness; familiar with HIPAA and ACA-mandated Operating Rule requirements
- Getting Started: Assessing compliance status of trading partners
- Fully Underway: Currently working with our Practice Management System vendors, clearinghouses and health plans to implement Eligibility and Claim Status Operating Rules
- Completed: Both Provider Group/Delivery System and our trading partners are meeting operating rule requirements
- None of the Above

An Introduction to ACA Section 1104

Level Set on Fundamental Terms, Concepts and Applicability

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CMS OESS Overview

- Centers for Medicare & Medicaid (CMS) Office of e-Health Standards and Services (OESS)
  - Role within HHS
  - Examples of current areas of focus, e.g. ICD-10, operating rules, health plan identifier

Overview of ACA Section 1104
An Amendment to HIPAA

- **HIPAA**
  - The Health Insurance Portability and Accountability Act (HIPAA) of 1996
  - *Administrative Simplification Provisions*
    - ***Requires the establishment of national standards*** for electronic health care transactions and national identifiers for providers, health insurance plans, and employers
- **ACA Section 1104**[1]
  - *Section 1104 of the Administrative Simplification provides of the Patient Protection and Affordable Care Act (ACA) established, among a number of things, new requirements for administrative transactions that will improve the utility of the existing HIPAA transactions and reduce administrative costs*
  - *In Section 1104(b)(2) of the ACA, Congress **required the adoption of operating rules for the healthcare industry** and directed the Secretary of Health and Human Services to "adopt a single set of operating rules for each transaction"…with the goal of creating as much uniformity in the implementation of the electronic standards as possible."*

[1] Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions; Interim Final Rule Federal Register / Vol. 76, No. 131 / Friday, July 8, 2011 / Rules and Regulations

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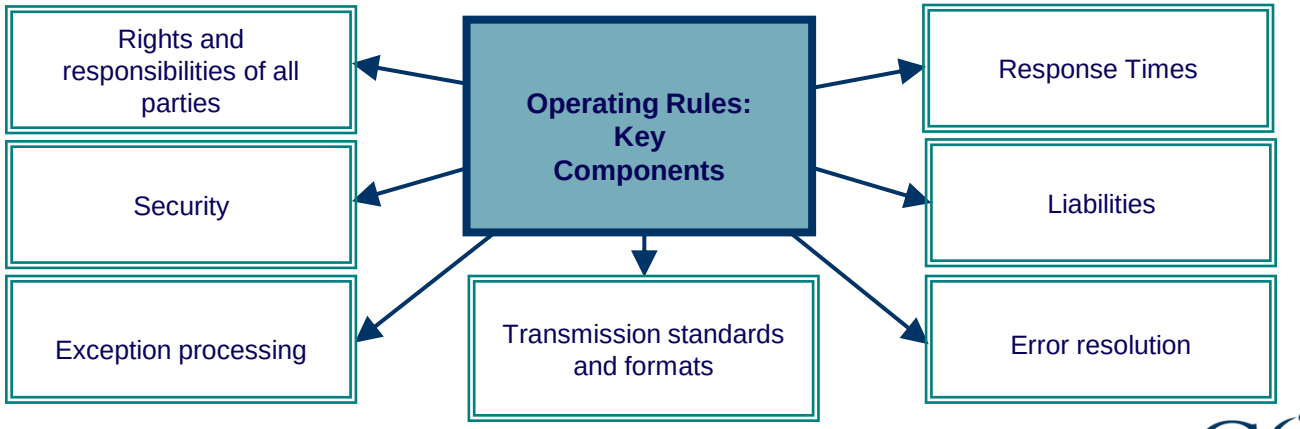
Who Must Comply With ACA Section 1104?
Required of all HIPAA Covered Entities[1]

- ACA Section 1104 mandates that all HIPAA covered entities comply with *healthcare operating rules*; additional guidance on HIPAA covered entity designations may be found HERE
- HIPAA Administrative Simplification standards, requirements and implementation specifications apply to[2]:
  - Healthcare Providers: *Any person or organization who furnishes, bills, or is paid for healthcare in the normal course of business*[3].
    - Covered ***ONLY*** if ***they transmit protected health information electronically (directly or through a business associate) in connection with a transaction covered by the HIPAA Transaction Rule***[2].
    - Examples include but are not limited to: Doctors, Clinics, Psychologists, Dentists, Chiropractors, Nursing Homes, and Pharmacies
  - Health Plans
  - Health Care Clearinghouses

[1] Understanding HIPAA Privacy: For Covered Entities and Business Associates
[2] HIPAA Administrative Simplification: 45 CFR 160.102, 164.500
[3] HIPAA Administrative Simplification: 45 CFR 160.103

What are Healthcare Operating Rules?
What does it mean beyond the recent ASC X12 v5010?

- 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



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Introduction to Operating Rules

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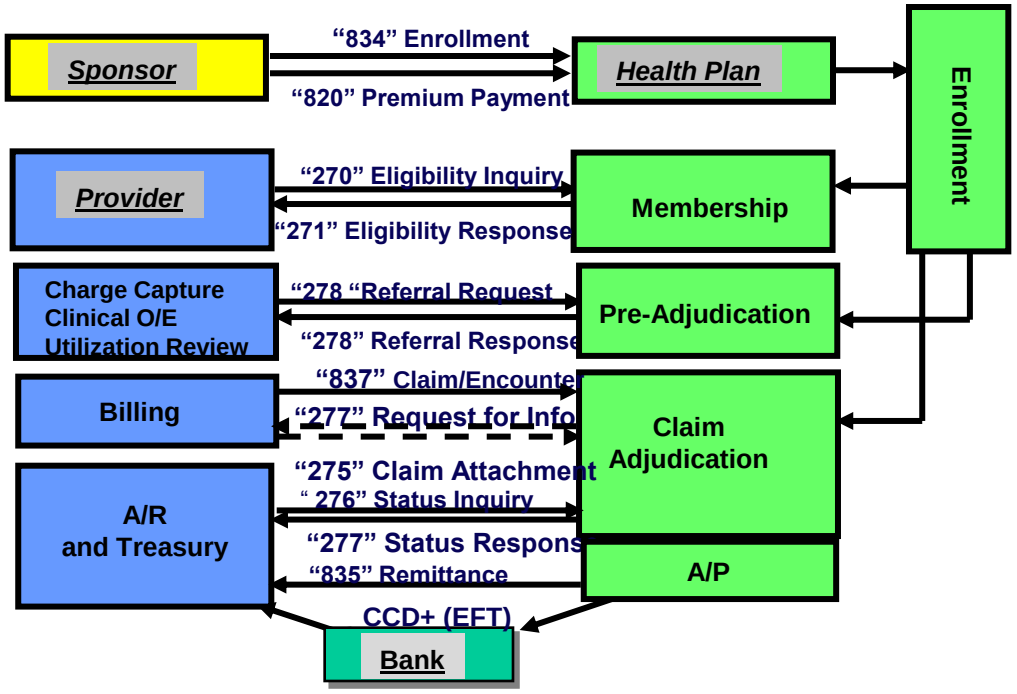
Industry Context:
Federally Mandated Operating Rules

- Today, operating rules support existing standards in many high-volume industries, e.g. cellular phones, financial services ...*Consider the ATM*
- Prior to 2005, national operating rules for medical administrative transactions did not exist in healthcare outside of individual trading partner relationships
- In 2005 CAQH CORE began facilitating voluntary development of industry-wide healthcare operating rules
- In 2010, Section 1104 of the Patient Protection and Affordable Care Act (ACA) required that *all HIPAA covered entities* be compliant with applicable HIPAA standards **and associated operating rules**

The effective date for the first set of ACA mandated operating rules was January 2013; additional deadlines follow through 2016.

Transformation of Administrative Data Exchange: *A Spectrum of Change For Providers*

- Overarching goal is to generate a responsive, and adaptive, system-wide approach to administrative IT adoption that aligns with other U.S. healthcare strategic initiatives
- Each major transaction was addressed by HIPAA in 1996, but standards alone were not enough to achieve industry Administrative Simplification
- Due to the ACA and other market pressures, the revenue cycle process is experiencing significant transformation.



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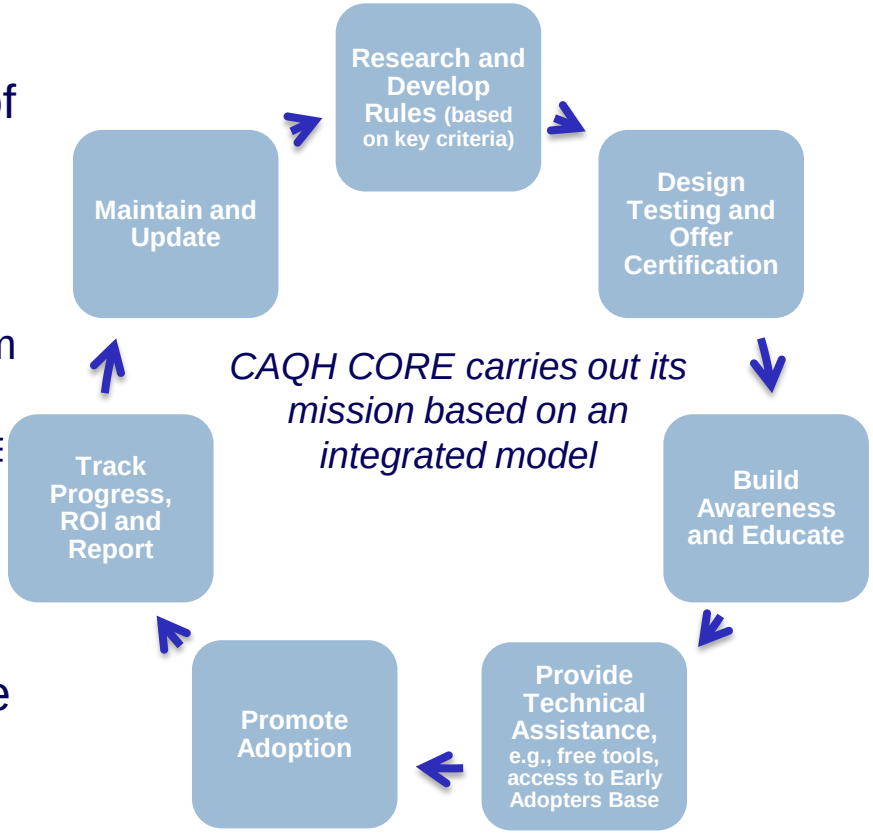
CAQH CORE Background

- A multi-stakeholder collaboration established in 2005
- ***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 HHS and the National Committee on Vital and Health Statistics (NCVHS)



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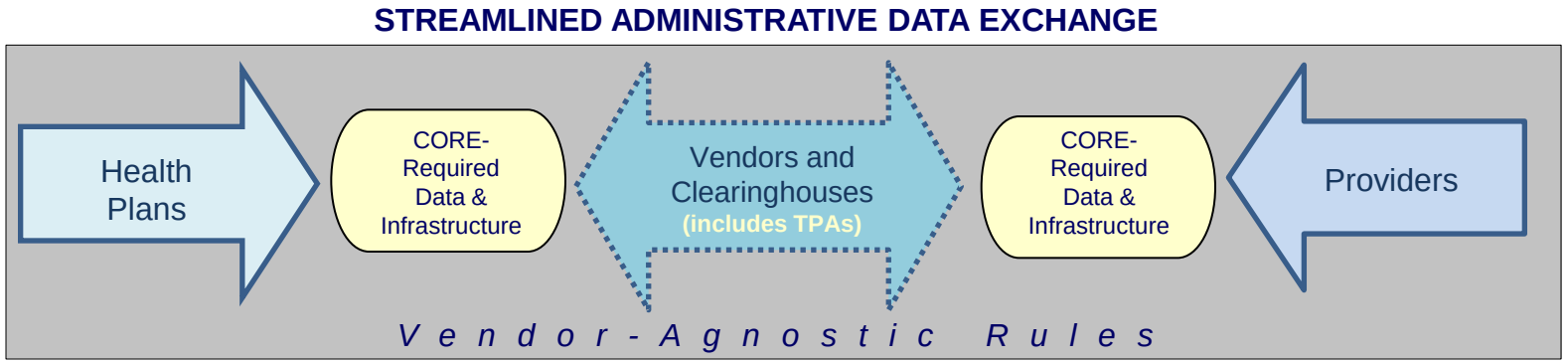
The Importance of Working with Trading Partners: *Streamlining Electronic Transactions*



- HIPAA-covered entities work together to exchange transaction data in a variety of ways
- Understand your electronic data flows associated with your administrative agreements
- Vendors play a crucial role in enabling provider clients to realize the benefits of industry adoption of CAQH CORE Operating Rules; engage them
  - Small providers rely on their vendors/PMS to achieve their administrative cost saving goals
  - Large providers can work with their vendors to obtain CORE Certification and achieve end-to-end interoperability

ACA Section 1104:
Mandated Operating Rules

Scope and Compliance

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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.

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ACA Federal Compliance Requirements Highlight: *Eligibility and Claim Status Transactions*

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

*There are **two types of penalties** related to compliance*[1]

Applies to all HIPAA covered entities- Includes providers

Key Area	HIPAA Mandated Implementation	ACA-required Health Plan Certification	
Dates	**First Date** January 1, 2013 *Compliance Date* **Enforcement Date Extension March 31, 2013**[4]	**Second Date** December 31, 2013 *Health Plan Certification Date*	**Third Date** No Later than April 1, 2014 *Health Plan Penalty Date*
Description	**Who:** All HIPAA covered entities **Action**: Implement CAQH CORE Eligibility & Claim Status Operating Rules	**Who:** Health plans **Action:** File statement with HHS certifying that data and information systems are in compliance with the standards and operating rules[2]	**Who:** Health plans **Action:** HHS will assess penalties against health plans that have failed to meet the ACA compliance requirements for certification and documentation[2]
Applicable Penalties	**Amount:** Due to HITECH, penalties for HIPAA non-compliance have increased, now up to $1.5 million per entity per year	**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	

[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

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Compliance with Eligibility & Claim Status Operating Rules: *90-Day Period of Enforcement Discretion*

- On January 2, 2013 CMS OESS* announced a 90-Day Period of *Enforcement Discretion* to reduce the potential of significant disruption to the healthcare industry
  - Notwithstanding OESS' discretionary application of its enforcement authority, **the compliance date for using the operating rules remains January 1, 2013**
- Enforcement action will begin March 31, 2013 with respect to HIPAA covered entities (including health plans, health care providers, and clearinghouses, as applicable) that are not in compliance with the Federally mandated Eligibility and Claim Status Operating Rules
- HIPAA covered entities that are prepared to conduct transactions using the adopted operating rules and all applicable covered entities that are preparing to do so, are encouraged to determine their readiness to use the operating rules as of January 1, 2013 and expeditiously become compliant

* OESS is the U.S. Department of Health and Human Services' (HHS) component that enforces compliance with HIPAA transaction and code set standards, including operating rules, Identifiers and other standards required under HIPAA by the Affordable Care Act.

Compliance with Eligibility & Claim Status Operating Rules: *CMS OESS Complaint-Driven Enforcement Process*

- OESS will accept complaints associated with compliance with the operating rules beginning January 1, 2013
  - If requested by OESS, covered entities that are the subject of complaints (known as "filed-against entities") must produce evidence of either compliance or a good faith effort to become compliant with the operating rules during the 90-day period
- For more information review CMS's Administrative Simplification Enforcement Tool (ASET), which is a web-based application where entities may file a complaint against a covered entity for potential non-compliance related to Transactions and Code Sets and Unique Identifiers
  - Anyone may use ASET to file a complaint
  - Each complaint is reviewed for validity and completeness by CMS OESS
- You can also submit an inquiry to the Office of OESS about health plan certification and audits of certification, when those proposed approaches are issued during 2013

Available CMS OESS 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
    - Geanelle Herring, Health Insurance Specialist, Geanelle.Herring@cms.hhs.gov

Q&A

ACA Section 1104:
Mandated Operating Rules

Scope and Compliance

Please submit your question:

- By Phone: Press * followed by the number one (1) on your keypad
- Via the Web: Enter your question into the Q&A pane in the lower right hand corner of your screen

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CAQH CORE Eligibility and Claim Status Operating Rule Requirements

Introduction

How Will Operating Rules Impact Providers?
Example: Eligibility and Claim Status

The ACA mandated Eligibility & Claim Status Operating Rules ensure real-time access to robust eligibility and claim status data for providers

- ***More accurate patient eligibility verification*:**
  - Real-time information on health plan eligibility and benefit coverage before or at the time of service
    - Providers experienced a 24% increase in electronic eligibility verifications*
- ***Improved point of service collections*:**
  - Real-time provider access to key patient financials including YTD deductibles, co-pays, coinsurance, in/out of network variances via the ASC X12 v5010 270/271 transactions
- ***Decrease in claim denials*:**
  - Real-time claim status data ensures provider is aware of status in billing process
    - Providers experienced a 10-12% reduction in denials related to eligibility*

* Based on the CAQH CORE Phase I Measures of Success Study when working with Phase I CORE Certified health plans.

Mandated Eligibility & Claim Status Operating Rules: *Scope –Effective as of January 1, 2013*

Enforcement Action Begins March 31, 2013

Mandated Eligibility & Claim Status Operating Rules
Compliance date January 1, 2013

Voluntary Eligibility & Claim Status Operating Rule

Type of Rule	Addresses	CAQH CORE Eligibility & Claim Status Operating Rules		
Data Content: ***Eligibility***	Need to drive further industry value in transaction processing	More Robust Eligibility Verification Plus Financials	Enhanced Error Reporting and Patient Identification	"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*
Infrastructure: ***Eligibility and Claim Status***	Industry needs for common/ accessible documentation	Companion Guides	System Availability	
	Industry-wide goals for architecture/ performance/ connectivity	Response Times	Connectivity and Security	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.

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CAQH CORE Eligibility & Claim Status: *Infrastructure Operating Rules*

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.

CAQH CORE Eligibility & Claim Status:
Data Content Operating Rules – Building on 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/receive robust and important data.

ASC X12 270/271 Requirements in v5010

- Eligibility Status (yes/no)
- Date
- Health Plan Name (if known)

CAQH CORE Rule Requirements

- Health Plan Name (if available in responding system)
- Patient financials (deductible, co-pay, co-insurance)
  - YTD and base levels
  - In and out of network variances
  - Family and individual
  - Health Plan and benefit variances
- Enhanced Patient Name Verification
- Standard use of AAA Error Codes

NOTE: Additional data is aided by infrastructure rules, which help improve data flow, e.g. response time

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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):

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

- 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

CAQH CORE EFT and ERA Operating Rule Requirements

Introduction

EFT and ERA: Level-Set on Key Considerations

- EFT: Electronic Funds Transfer
  - *Are you using paper checks or are you receiving payments electronically?*
  - *Did you know in 2014 Medicare will require EFT?*
- ERA: Electronic Remittance Advice
  - *Are you using paper remittance or are you receiving remittance electronically?*
- EFT and ERA
  - *If you haven't been doing these electronically, do you know how operating rules will make it easier for providers to take advantage of these transactions?*

How Will Operating Rules Impact Providers?
Example: EFT & ERA Operating Rules

The ACA mandated EFT & ERA Operating Rules ensure more streamlined provider enrollment and processing of the EFT & ERA transactions

- ***Standardized electronic enrollment for EFT/ERA***:
  - Providers will be able to enroll in both EFT and ERA electronically with all health plans using a consistent set of data elements
- ***Reduction in manual claim rework***:
  - With health plans more consistently using denial and adjustments codes per the CORE-defined Business Scenarios, providers will have less rework
- ***Reduction in A/R days***:
  - Automated and timely re-association of EFT and ERA leading to efficiencies and reduced errors for payment posting

* Based on the CAQH CORE Phase I Measures of Success Study when working with Phase I CORE Certified health plans.

EFT Standard and EFT & ERA Operating Rules: *Required of All HIPAA Covered Entities*

- **Healthcare EFT Standard:** July 2012 CMS announces CMS-0024-IFC is in effect adopting the NACHA ACH CCD plus Addenda Record (CCD+) and the X12 835 TR3 TRN Segment as the HIPAA mandated healthcare EFT standard
- **EFT & ERA Operating Rules**: August 2012: CMS published an Interim Final Rule with Comment, CMS-0028-IFC; adopts Phase III CAQH CORE Operating Rules for the Electronic Funds Transfer (EFT) and Health Care Payment and Remittance Advice (ERA) transactions *except for rule requirements pertaining to Acknowledgements******

Compliance date for both the Healthcare EFT Standard and EFT & ERA Operating Rules is January 1, 2014

* CMS-0028-IFC excludes requirements pertaining to acknowledgements.

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CAQH CORE EFT & ERA Operating Rules in Action

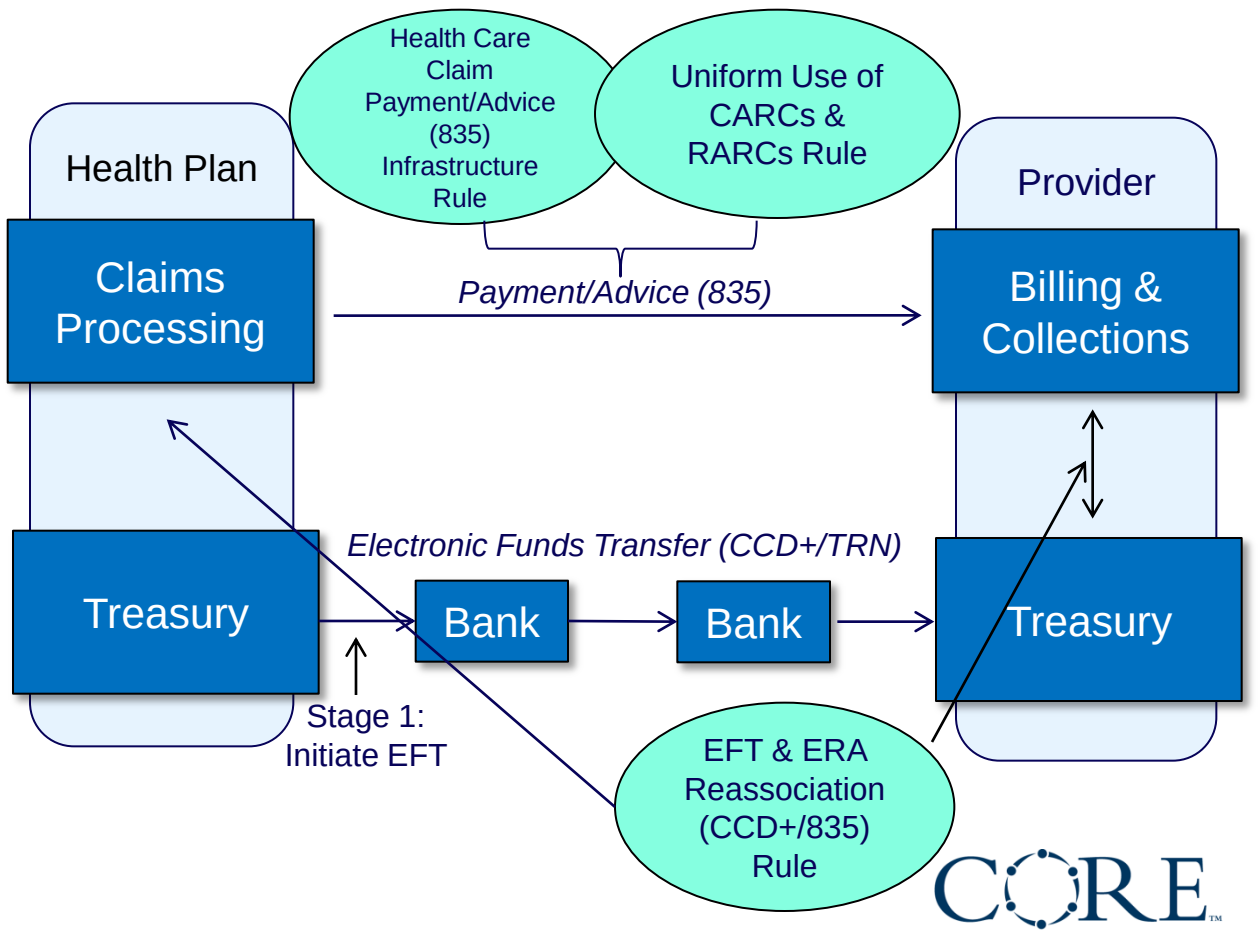
Pre- Payment: Provider Enrollment

EFT Enrollment Data Rule

ERA Enrollment Data Rule

Provider first enrolls in EFT and ERA with Health Plan(s) and works with bank to ensure receipt of the CORE-required Minimum ACH CCD+ Data Elements for reassociation

Claims Payment Process



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Example: *CAQH CORE Uniform Use of CARCs and RARCs Rule - Four Business Scenarios*

Pre CORE Rules

800+ CARCs × 300+ RARCs × 4 CAGCs = Inconsistent Use of Tens of Thousands of Potential Code Combinations

Post CORE Rules

Four Common Business Scenarios

CORE Business Scenario #1: Additional Information Required – Missing/Invalid/ Incomplete Documentation (≈470 code combos)

CORE Business Scenario #2: Additional Information Required – Missing/Invalid/ Incomplete Data from Submitted Claim (≈300 code combos)

CORE Business Scenario #3: Billed Service Not Covered by Health Plan (≈330 code combos)

CORE Business Scenario #4: Benefit for Billed Service Not Separately Payable (≈30 code combos)

Code Combinations not included in the CORE-defined Business Scenarios may be used with other non-CORE Business Scenarios

Polling Question #2:
Trading Partner Collaboration

Select the answer that best describes the degree to which your provider organization has engaged in conversations with trading partners about the status of their operating rule implementation efforts?

- High
- Medium
- Low
- No communication
- Does not apply to my organization

Introduction to Operating Rule Implementation Resources

Taking Action !

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Key Action Items for Providers

- ✓ Determine if your organization is conducting the applicable electronic transactions:
  - The ACA mandated operating rules only apply to providers if they are conducting the associated electronic transactions
  - *If you arent using these transactions electronically, have an internal dialog on why and if you want to begin to do so*
- ✓ If you conduct the transactions, assess your organization's readiness/compliance:
  - ❑ Use the CAQH CORE Analysis & Planning Guides (for Eligibility & Claim Status and EFT & ERA) to help you assess impacted systems/vendor
  - ❑ Speak with your PMS vendor* about their compliance/ability to support your practice
  - ❑ Ask your clearinghouse(s) if the product(s) your practice uses is compliant (clearinghouses are HIPAA covered, and thus should already be compliant)
  - ❑ If not already, encourage your vendors/clearinghouses to become voluntarily CORE-Certified to test conformance

* REMINDER: **PMSs <u>are not</u> HIPAA-covered entities**, and thus are not mandated to be compliant - so provider requests are critical!

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Voluntary CORE Certification

- Since its inception, CAQH CORE has offered a *voluntary* CORE Certification to health plans, vendors, clearinghouses, and providers
  - 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
- Recently completed CORE Certifications include:
  - DoradoSystems (clearinghouse)
  - HealthFusion for HealthFusion® Real-Time (vendor)
  - Humana (health plan)
  - Kaiser Permanente Colorado
  - Office Ally, Office Ally Clearinghouse
  - Loxogon, Loxogon Alloy™ (vendor)
  - RelayHealth, RelayExchange™
- Committed entities are
  - NextGen Healthcare, Real-Time Transaction Server (RTS) (Phase I & II: Q1 2013)
  - GE Healthcare, Centricity Business Version 5.0 Claim Status (Phase I & II: Q1 2013)

CERTIFIED CORE VENDOR PRODUCT Phase II
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CAQH CORE Free Resources

- Master the CAQH CORE Operating Rules
- If your implementation efforts/your vendor(s) are just getting started access CAQH CORE Analysis & Planning Guides for Eligibility & Claim Status Operating Rules and EFT & ERA Operating Rules
- If your implementation/your vendor(s) is fully underway or nearing completion:
  - Education Sessions: CAQH CORE holds frequent sessions with partners such as ASC X12, NACHA, Medicaid workgroups, etc.
  - 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
  - Request Process: Contact technical experts as needed at CORE@caqh.org
- If your implementation/your vendor(s) is complete or nearly complete, and/or you are testing readiness with trading partners:
  - Consider Voluntary CORE Certification: Phase I & Phase II
    - Voluntary CORE Certification provides verification that your IT systems or product operates in accordance with the federally mandated operating rules
  - If testing your implementation of operating rules with trading partners, then, **take 5 minutes** and tell others about your readiness at CORE Operating Rule Readiness:

Q&A

CAQH CORE
Operating Rule Requirements:

Please submit your question:

- By Phone: Press * followed by the number one (1) on your keypad
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Thank You!

See Appendix for more implementation resources and guidance

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Upcoming CAQH CORE Education Sessions

- Join us for these *free* CAQH CORE webinars held jointly with:
  - ASC X12: "Eligibility and Claims Status Transactions: ***A Deep Dive***"
    - Tuesday, March 26, 2013 from 2:00 pm to 3:30 pm ET
  - 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

GLOSSARY

Glossary: Informal Highlights

- ***ACH CCD+***: The CCD+ format is a NACHA ACH corporate payment format used in Electronic Funds Transfers (EFT) with a single 80 character addendum record capability. The addendum record is used by the originator to provide additional information to the payment recipient about to the payment.

- ***ACH Network***: A batch processing, store-and-forward system, governed by *The NACHA Operating Rules,* which provide for the interbank clearing of electronic payments for participating depository financial institutions.

- ***Accredited Standards Committee (ASC) X12***: Develops and maintains the X12 electronic data interchange (EDI) standards along with XML schemas which drive business processes globally. The membership of ASC X12 includes technologists and business process experts, encompassing health care, insurance, transportation, finance, government, supply chain and other industries.

- ***Business Associate***: A person or organization that performs a function or activity on behalf of, or provides services to, a Covered Entity that involves Individually Identifiable Health Information

- ***CMS Office of E-Health Standards and Services (OESS)***: 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.

- ***Electronic Data Interchange (EDI)***: The computer-to-computer exchange of business data in standard formats. In EDI, information is organized according to a specified format set by both parties, allowing a "hands-off" computer transaction that requires no human intervention or rekeying on either end. All information contained in an EDI transaction set is, for the most part, the same as on a conventionally printed document.

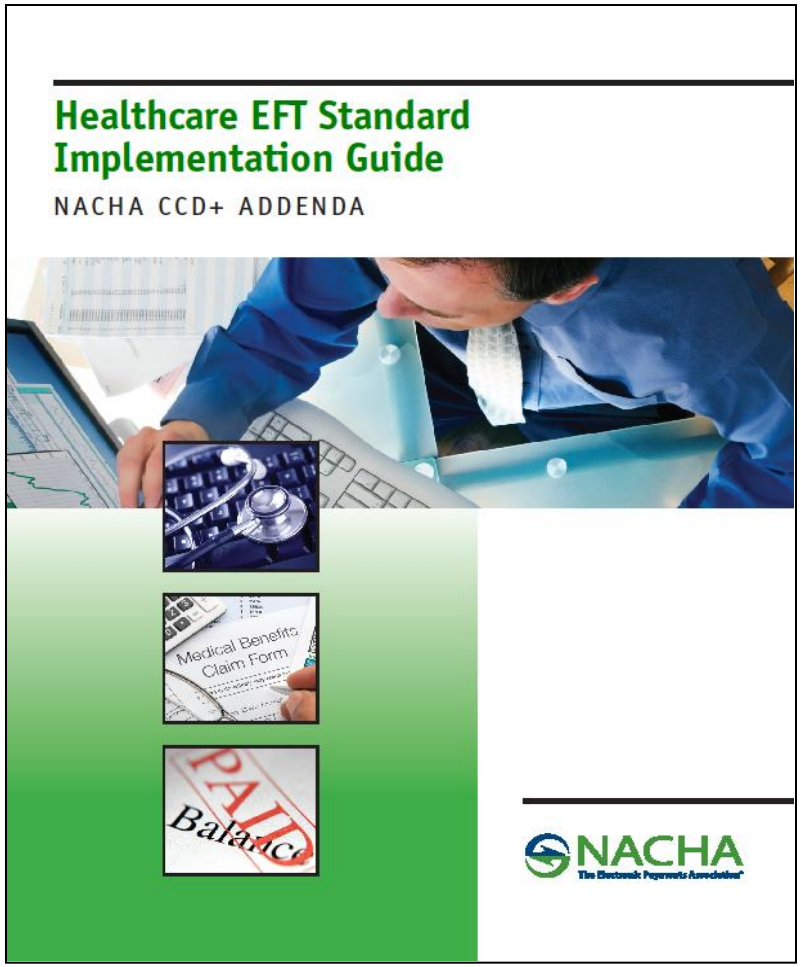
Glossary

- ***Healthcare Provider***: Any person or Organization who furnishes, bills, or is paid for healthcare in the normal course of business.
- ***Healthcare Transaction***: The transmission of information between two parties to carry out financial or administrative activities related to health care
- ***HIPAA-Covered Entities***: Health Plans, Healthcare Clearinghouses, and Healthcare Providers who transmit any health information in electronic form in connection with certain transactions
- ***NACHA (The Electronic Payments Association)***: A non-profit rule-making entity that manages the development, administration, and governance of the ACH Network, the backbone for the electronic movement of money and data.
- ***Operating Rules***: the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications
- ***Transmission Media***: Electronic form of transmitting information including, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

APPENDIX

Healthcare EFT Standard Implementation Guide

- Healthcare EFT Standard Implementation Guide
  - What is the EFT standard?
  - How does it work?
  - Includes the CCD format
  - How to populate the specific fields
  - What are *NACHA Operating Rules* and how do they impact the standard?
- Available from NACHA at https://www.nacha.org/eStore



NACHA The Electronic Payments Association®

NACHA Resources

- Healthcare Payments Resources Website
  - Provides a repository of information on a wide variety of topics for both financial institutions and the healthcare industry. Includes links to many other resources, as well as customized information to help “translate” concepts from one industry to the other (FAQs, reports, presentations).
  - http://healthcare.nacha.org/
- Healthcare EFT Standard Information
  - Located within the healthcare industry tab of the above website, specific information can be found on the healthcare EFT standard.
  - http://healthcare.nacha.org/
- Healthcare Payments Resource Guide
  - Publication designed to help financial institutions in implementing healthcare solutions. It give the reader a basic understanding of the complexities of the healthcare industry, identify key terms, review recent healthcare legislation, and discuss potential impacts on the financial services industry.
  - Order from the NACHA eStore “Healthcare Payments” section: www.nacha.org/estore.
- ACH Primer for Healthcare Payments
  - A guide to understanding EFT payment processing. Introduces the healthcare industry to the Automated Clearing House (ACH) Network, explains ACH transaction flow and applications, and includes two “next steps checklists,” one each for origination and receipt.
  - https://healthcare.nacha.org/ACHprimer
- Ongoing Education and Webinars
  - Check the Healthcare Payments Resource Website for “Events and Education”

Mandated Eligibility & Claim Status Operating Rules

CAQH CORE Eligibility & Claim Status Operating Rules were initially developed in two phases; for ease of use the rules are presented here by transaction addressed and rule type rather than by phase

- Rules Addressing the **ASC X12 270/271 Eligibility & Benefits Transactions**
  - Data Content Related Rules
    - CAQH CORE 154 & 260: Eligibility & Benefits Data Content Rules
    - CAQH CORE 258: Normalizing Patient Last Name Rule for Eligibility
    - CAQH CORE 259: AAA Error Code Rule for Eligibility
  - Infrastructure Related Rules
    - CAQH CORE 150: Batch Acknowledgements Rule for Eligibility (999)*
    - CAQH CORE 151: Real Time Acknowledgements Rule for Eligibility (999)*
    - CAQH CORE 152: Companion Guide Rule
    - CAQH CORE 155: Batch Response Time Rule for Eligibility
    - CAQH CORE 156: Real Time Response Rule for Eligibility
    - CAQH CORE 157: System Availability Rule
    - CAQH CORE 153 & CAQH CORE 270: Connectivity Rules
- Rules Addressing the **ASC X12 276/277 Claim Status Transactions**
    - CAQH CORE 250: 276/277 Claim Status Infrastructure Rule*

***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."

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Mandated EFT & ERA Operating Rules:
January 1, 2014 Requirements Scope

Rule		High-Level Requirements
Data Content	***Uniform Use of CARCs and RARCs (835) Rule*** Claim Adjustment Reason Code (CARC) Remittance Advice Remark Code (RARC) Rule 360	• Identifies a *minimum* set of four CAQH CORE-defined Business Scenarios with a *maximum* set of CAQH CORE-required code combinations that can be applied to convey details of the claim denial or payment to the provider
Infrastructure	***EFT Enrollment Data Rule*** Rule 380	• Identifies a maximum set of standard data elements for EFT enrollment • Outlines a flow and format for paper and electronic collection of the data elements • Requires health plan to offer electronic EFT enrollment
	ERA Enrollment Data Rule Rule 382	• Similar to EFT Enrollment Data Rule
	EFT & ERA Reassociation (CCD+/835) Rule Rule 370	• Addresses provider receipt of the CAQH CORE-required Minimum ACH CCD+ Data Elements required for re-association • 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
	Health Care Claim Payment/Advice (835) Infrastructure Rule Rule 350	• 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

* CMS-0028-IFC excludes requirements pertaining to acknowledgements.

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