CAQH Committee on Operating Rules for Information Exchange (CORE)
Results of Survey on Potential Enhancements to CORE Phase I and II Eligibility/Benefits and Claims Status Operating Rules for Recommendation to NCVHS

Executive Summary:

On 11/09/10, CAQH CORE distributed an on-line survey on potential enhancements to the CORE Phase I and II eligibility/benefits and claim status operating rules. The results of the survey were used to guide the direction of two identical Rules Work Group "Tiger Team" calls to address NCVHS' recommendation of the Phase I and II CORE Rules. On 09/30/10, NCVHS recommended the Phase I and II CORE operating rules to fulfill the federal mandate for non-retail pharmacy eligibility/benefits and claim status operating rules. CAQH CORE was encouraged by NCVHS to consider potential enhancements to the rules. CAQH staff collected suggestions for enhancements from CORE and non-CORE participants, including the states, and distributed an on-line survey outlining the detailed list of enhancements. Both CORE participants and non-participating organizations were asked to vote for, or against, inclusion of each enhancement. . Survey respondents also were provided the opportunity to write-in additional enhancements to be considered. On 11/11/10 and 11/12/10, CAQH CORE held CORE Rules Work Group "Tiger Team" calls to reach consensus on feasible enhancements for consideration. On the 11/12/10 call, participants agreed to keep the online survey open. The final results of the survey will be discussed by the Rules Work Group on 11/23/10 and 11/30/10.

Summary of Respondents:

Total Number of Entities:	**37**
Total % of CORE Participants:	85%
Total % of Non-CORE Participants	15%
Entities by Stakeholder Types	
Number of Provider/Provider Association Responses	5 (14%)
Number of Health Plan/Health Plan Association Responses	14 (38%)
Number of Clearinghouse and Provider Vendor Responses	7 (19%)
Number of Other Stakeholder Type Responses (SDO/Regional Entities, etc.)	11 (30%)

Percent Support for Potential Enhancements by Transaction Type:

Eligibility/Benefits Potential Enhancements:	**% Support**
From the Draft Phase III Rules:	
1. Additional service type codes (STC) and related patient financial reporting requirements	70%
2. STC grouping requirements for a 271 response to an explicit inquiry	65%
3. Requirements for reporting discretionary, carve-out, and sensitive benefits	52.5%
4. Replacing the X12N 997 Functional Acknowledgement with the 999	85%
Not Yet Drafted and/or Reviewed by CORE:	
5. Require a 271 response to include provider network identification information	52.5%
6. Require the 271 response to include the code indicating the type of health plan in the eligibility/benefits segment	60%
7. Limit the number of STCs that can be submitted in an explicit 270 inquiry/Limit the number of STCs that can be returned in a 271 response	35%
8. Draft WEDI/X12 Companion Guide[1]	62.5%
9. Establish uniform search/match logic (based upon requirements in Minnesota)	45%
Claims Status Potential Enhancements:	**% Support**
From the Draft Phase III Rules:	
1. Acknowledge v5010 837 claim submissions with a 277CA	78.9%
2. Uniform use of claim status category & claim status codes	71.1%
3. Maintain claim history for minimum 24 months	65.8%
4. Replacing the X12N 997 Functional Acknowledgement with the 999	89.5%
Not Yet Drafted and/or Reviewed by CORE:	
5.Draft WEDI/X12 Companion Guide[1]	63.2%

[1] Since the posting of the online survey, the WEDI/X12 Companion Guide has been approved for publication. While the Guide is currently available to the industry, it has not been through the CORE rules review process and CAQH CORE was not a sponsor of the Guide

CAQH Committee on Operating Rules for Information Exchange (CORE)
Results of Survey on Potential Enhancements to CORE Phase I and II Eligibility/Benefits and Claims Status Operating Rules for Recommendation to NCVHS

Additional Write-In Enhancements for Consideration by Transaction Type:

Eligibility/Benefits Write-In Enhancements:[2]
1. Within the EB segment there should be a flag that indicates whether the provider/service is for a specialist. We have a hard time with consistently knowing where to find the specialist info some payers return it in the comments with a message segment stating that it is a specialist others will use other terms and put in the message segment. It needs to be more consistent; having a flag to indicate specialist information may help with this.
2. When a health plan returns "Inactive" coverage on a 271 response with EB01value 6, 7, or 8, they must also return the date coverage ended if the policy was ever active with the health plan.
3. Requirements for communicating carve out source of the financial and other data if not available in the information source organization.
4. Limit use of MSG segments, and/or standardize the message segment.
5. Require Preauth/Precert indicator.
Claims Status Write-In Enhancements:
None

[2] Does not include comments about enhancements already detailed in the survey or recommendations for requirements to include in future phases of CORE.