CAQH CORE Participant Webinar

Phase V CAQH CORE Operating Rules

March 21, 2019

Logistics

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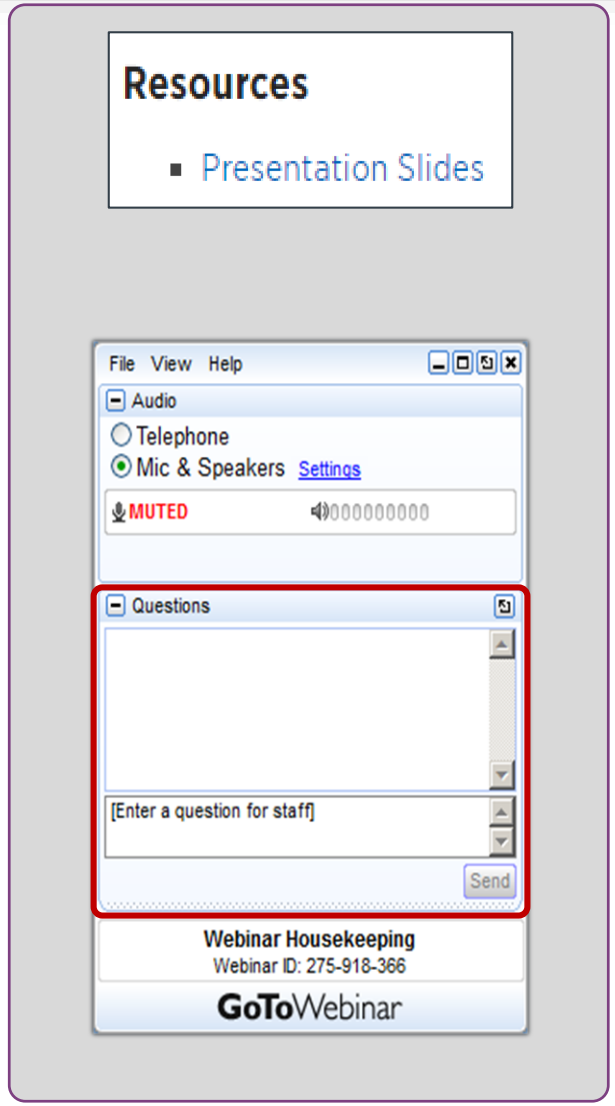

CAQH CORE

Session Outline

- CAQH CORE Approach to the Prior Authorization Challenge
- Phase V CAQH CORE Operating Rules Package Overview
  - *Phase V CAQH CORE Operating Rules Set*
    - *Draft Phase V CAQH CORE Prior Authorization (278) Request / Response Data Content Rule*
    - *Draft Phase V CAQH CORE Prior Authorization Web Portal Rule*
  - *Phase V CAQH CORE Certification Test Suite*
- Next Steps: Final CAQH CORE Vote
- Q&A

Thank You to Our Speakers

Noam Nahary

Senior Director, HSRs

Montefiore Medical Center

Rhonda Starkey

Director, eBusiness Services

Harvard Pilgrim Health Care

Robert Bowman

Director

CAQH CORE

CAQH CORE Approach to the Prior Authorization Challenge

The Prior Authorization Challenge

Prior authorization (PA) began as a means to manage the utilization of healthcare resources: people, time and dollars. It requires providers to request approval from a health plan before a specific procedure, laboratory test, service, device, supply or medication is provided to the patient. Referrals require a provider to obtain approval from a health plan before a patient can be referred to another provider (e.g., specialist). Each step of the prior authorization process is labor-intensive and generates time-consuming and costly administrative burden in the industry.

Fast Facts

PA within the Context of Other Administrative Transactions	The PA process is separate from the patient eligibility and claims processes. Siloed processes can jeopardize provider reimbursement and/or result in unintended patient out of pocket costs.	Example 1. Even if a PA is approved, the patient's eligibility may not be confirmed, or may have changed.	Example 2. Even if a PA is approved, edits may be applied to the claim, and the service may still be denied.
Volume*	Approximately 182 million prior authorization transactions per year (in the medical, commercial market alone).		
Transaction Mode*	51% manual (phone, fax, email); 36% partially electronic (web portal; interactive voice response system), 12% electronic (5010X217 278 Prior Authorization Request and Response).		
Wait Times**	Approx. 65% of physicians report waiting at least one business day for a PA response, and 26% report waiting at least 3 business days. 91% of Providers surveyed by the AMA reported that the PA process delays patient care.		
Potential Savings*	Full adoption of the standard prior authorization transaction (X12/v5010 278 Request and Response) by health plans and providers could result in a savings of $7.28 per transaction, for the portions of the prior authorization process included in the 5010X217 278 Request and Response.		

Sources: *CAQH Index (2018); commercial market figures only. | **AMA PA Physician Survey (2018).

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Continued Industry Engagement to Address Prior Authorization

- In response to the Phase IV CAQH CORE Operating Rules, the National Committee on Vital and Health Statistics (NCVHS) recommended research and development of additional operating rules to address barriers to improving the prior authorization process.*
- Significant public and private sector interest in addressing challenges throughout the prior authorization continuum.
  - July 31, 2018 Senate Health, Education, Labor and Pensions (HELP) Committee hearing on "Reducing Health Care Costs: Decreasing Administrative Spending" was the third in a series of hearings the committee has held on reducing health care costs – prior authorization was a key topic in multiple testimonies.
  - Multiple industry statements and guiding principles from multi-stakeholder and provider coalitions.
    - CAQH CORE Board responded with an open letter to the authors of the Consensus Statement on Improving the Prior Authorization Process.
  - ONC's work on drafting a strategy to reduce clinician burden, to which CAQH CORE responded.
  - CMS' Documentation Requirement Lookup Service Initiative.
  - Other complementary work efforts include AMA research, WEDI PA Council and Subworkgroup efforts, HL7, HATA, DaVinci Project use cases, etc.

In total, more than 100 organizations have substantively contributed to the CAQH CORE prior authorization rule development process through interviews, site visits, subgroup and work group participation and surveys demonstrating the strong industry commitment to this topic.

*Letter to the Secretary - Findings from Administrative Simplification Hearing, Letter to the Secretary - Recommendations for the Proposed Phase IV Operating Rules, Review Committee Findings and Recommendations on Adopted Standards and Operating Rules.

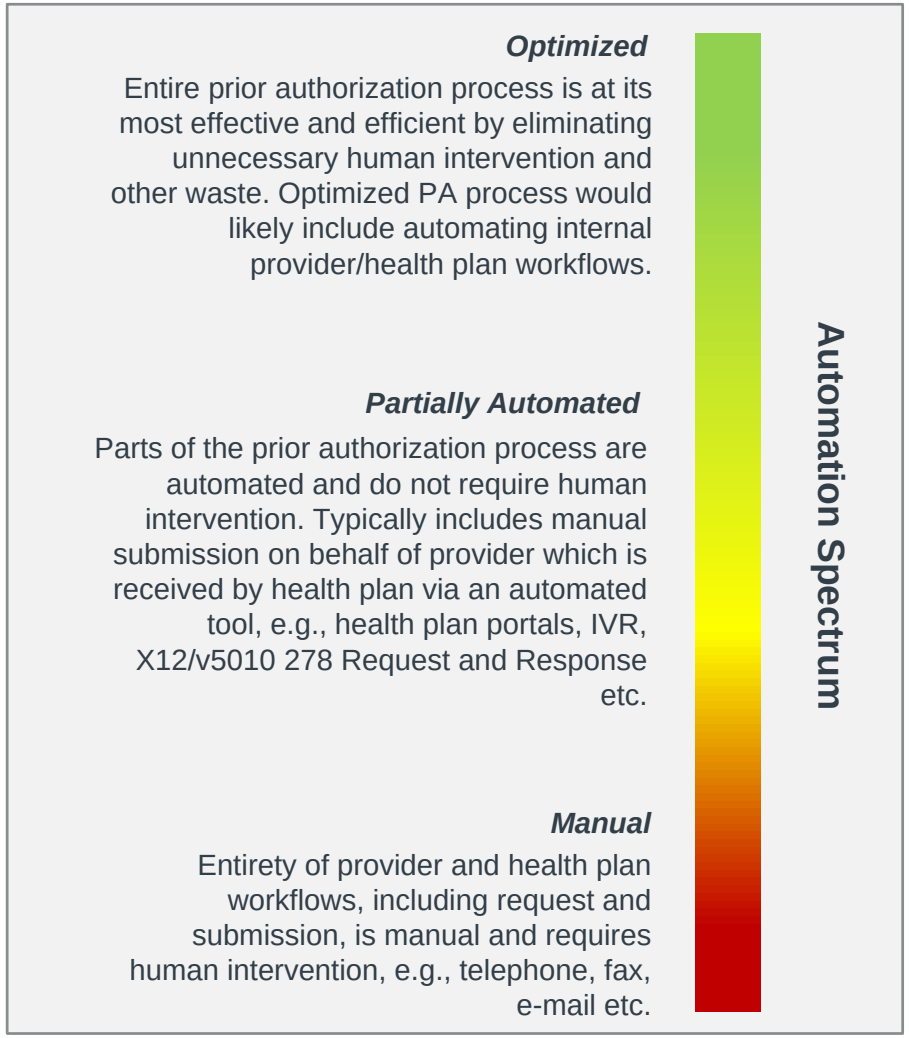
CAQH CORE Vision for Prior Authorization

Introduce targeted change to propel the industry collectively forward to a prior authorization process optimized by automation, thereby reducing administrative burden on providers and health plans and enhancing timely delivery of patient care.

The Phase IV Operating Rule established **foundational infrastructure requirements such as connectivity, response time**, etc. and builds consistency with other mandated operating rules required for all HIPAA transactions.

The Draft Phase V Operating Rules address **needed data content** in the prior authorization standard electronic transaction and **enable greater consistency across other modes of PA submissions.**

Ongoing efforts in 2019 to **pilot test requirements** for a provider to **determine whether an authorization is needed and** update the Phase IV Rule with a **timeframe for final determination.**



CAQH CORE Prior Authorization Initiative

Special Thanks to our Advisory Group Members & Group Co-chairs

CAQH CORE PRIOR AUTHORIZATION ADVISORY GROUP	
Anthem	Mary Jo Baughman, *Director, New Business Development, E-Solutions*
athenahealth	Joe Holtschlag, *Executive Director, Operations*
American Medical Association	Heather McComas, *Director, Administrative Simplification Initiatives*
Mayo Clinic	BJ Venhuizen, *Electronic Eligibility Coordinator DMC*
Humana	Kim Peters, *Process Owner, Provider Process Implementation*
Veterans Health Administration	Robert Huffman, *EDI Program Manager*

CAQH CORE CO-CHAIRS – PHASE V RULE DEVELOPMENT GROUPS		
athenahealth	Joe Holtschlag, *Executive Director, Operations*	Prior Authorization Subgroup, Certification & Testing Subgroup, Technical Work Group
Aetna	Amy Neves, *Director, EDI Transactions*	Technical Work Group
Cigna	Megan Soccorso, *Business Product Senior Specialist*	Certification & Testing Subgroup, Technical Work Group
Harvard Pilgrim Health Care	Rhonda Starkey, *Manager, Provider eBusiness Operations*	Prior Authorization Subgroup, Rules Work Group
Montefiore Medical Center	Noam Nahary, *Senior Director - HSR*	Rules Work Group
UnitedHealth Group/Optum	India Duncan, *Technical Product Manager*	Rules Work Group
Virginia Mason Medical Center	Lisa Ness, *Revenue Operations Manager*	Prior Authorization Subgroup

CAQH CORE Rule Research, Development & Voting Process

Identify Opportunities

Prior Authorization Advisory Group

The **Prior Authorization Advisory Group researched opportunities for potential rules** prior to the Prior Authorization Subgroup commencing rule writing.

Develop Phase V Rules & Test Suite

Rules Work Group

Prior Authorization Subgroup

Technical Work Group

Certification & Testing Subgroup

The **Prior Authorization Subgroup developed and straw polled draft rules** for review. The **Rules Work Group** reviewed and **voted on the draft rules.**

The **Certification & Testing Subgroup developed and straw polled a draft Certification Test Suite to accompany the draft rules.** The **Technical Work Group** voted on the draft test suite developed by the Certification & Testing Subgroup.

Approve Rules Package

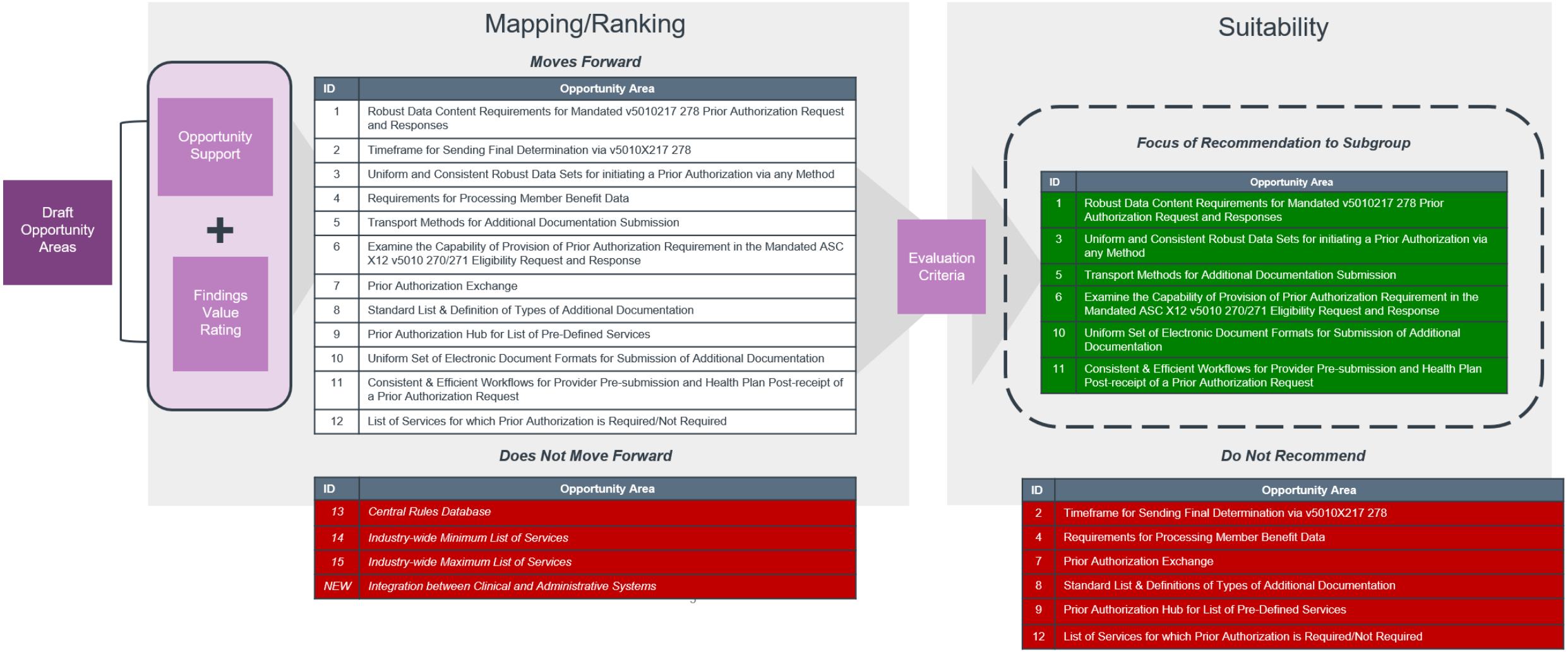
Full CORE Voting Participating Orgs

CAQH CORE Voting Participating Organizations (entities that create, transmit or use healthcare administrative data) vote on the Rules Package. The vote requires 60% quorum and a 66.67% approval.

CAQH CORE Board

The **Board** then **approves the package.**

Overview of Prior Authorization Advisory Group Prioritization Process



Moves Forward

ID	Opportunity Area
1	Robust Data Content Requirements for Mandated v5010217 278 Prior Authorization Request and Responses
2	Timeframe for Sending Final Determination via v5010X217 278
3	Uniform and Consistent Robust Data Sets for initiating a Prior Authorization via any Method
4	Requirements for Processing Member Benefit Data
5	Transport Methods for Additional Documentation Submission
6	Examine the Capability of Provision of Prior Authorization Requirement in the Mandated ASC X12 v5010 270/271 Eligibility Request and Response
7	Prior Authorization Exchange
8	Standard List & Definition of Types of Additional Documentation
9	Prior Authorization Hub for List of Pre-Defined Services
10	Uniform Set of Electronic Document Formats for Submission of Additional Documentation
11	Consistent & Efficient Workflows for Provider Pre-submission and Health Plan Post-receipt of a Prior Authorization Request
12	List of Services for which Prior Authorization is Required/Not Required

Does Not Move Forward

ID	Opportunity Area
13	*Central Rules Database*
14	*Industry-wide Minimum List of Services*
15	*Industry-wide Maximum List of Services*
NEW	*Integration between Clinical and Administrative Systems*

Focus of Recommendation to Subgroup

ID	Opportunity Area
1	Robust Data Content Requirements for Mandated v5010217 278 Prior Authorization Request and Responses
3	Uniform and Consistent Robust Data Sets for initiating a Prior Authorization via any Method
5	Transport Methods for Additional Documentation Submission
6	Examine the Capability of Provision of Prior Authorization Requirement in the Mandated ASC X12 v5010 270/271 Eligibility Request and Response
10	Uniform Set of Electronic Document Formats for Submission of Additional Documentation
11	Consistent & Efficient Workflows for Provider Pre-submission and Health Plan Post-receipt of a Prior Authorization Request

Do Not Recommend

ID	Opportunity Area
2	Timeframe for Sending Final Determination via v5010X217 278
4	Requirements for Processing Member Benefit Data
7	Prior Authorization Exchange
8	Standard List & Definitions of Types of Additional Documentation
9	Prior Authorization Hub for List of Pre-Defined Services
12	List of Services for which Prior Authorization is Required/Not Required

Examples of Prior Authorization Pain Points Addressed by CAQH CORE Phase V Operating Rules

Major Parts of the Prior Authorization Process*

Part A: Provider Determines if PA is Required & Info Needed

Provider identifies if PA is required and if additional documentation is required; Provider collects information for PA request

- Providers allocate substantial staffing resources to manage web portal submissions, as each portal is different. Lack of standardization increases time spent to prepare each request.

Part B: Provider & Health Plan Exchange Information

Provider submits PA Request; Health Plan receives and pends for additional documentation; Provider submits

- The availability of a system to receive a PA request is not always consistent, and it is difficult to determine such availability.
- Health plans often pend or deny PA requests due to incorrect, incomplete or inconsistent patient identification.
- Not enough detail included in the response to know why the request was pended and what additional information is needed to resolve the pend.
- With the lack of robust information in the response, providers telephone the plan to determine what is needed, or resubmit with incorrect/ incomplete information, resulting in additional pends or delays in care.

Part C: Health Plan Adjudicates & Approves / Denies PA Request

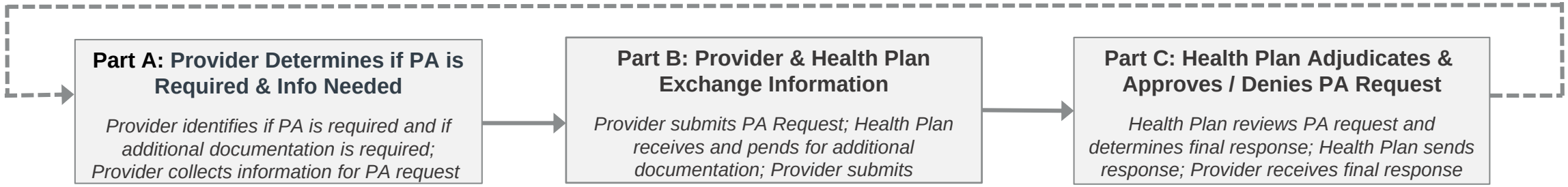
Health Plan reviews PA request and determines final response; Health Plan sends response; Provider receives final response

- When providers receive denied responses from the health plan/UMO, the codes supporting the Responses are not always consistent and are often ambiguous.

* Depicts the most common path for the PA process to follow.

CAQH CORE Operating Rules Address Key Pain Points in the Prior Authorization Process

Major Parts of the Prior Authorization Process*



- ★ **Consistent patient identification** to reduce common errors and associated denials.
- ★ **Application of standard X12 data field labels to web portals** to reduce variation in data elements to ease submission burden and encourage solutions that minimize the need for providers to submit information to multiple portals.
- ☆ **Standard Companion Guide format** to ensure trading partners are informed of the nuances required for successful transaction processing.

- ☆★ **System availability** requirements for a health plan to receive a PA request.
- ★ **Consistent review of diagnosis, procedure and revenue codes** to allow for full adjudication.
- ★ **Consistent use of codes** to indicate errors/next steps for the provider, including need for additional documentation.
- ★ **Detection and display of code descriptions** to reduce burden of interpretation.
- ☆★ **Confirmation of receipt of PA submission** to reduce manual follow-up for providers.
- ☆ **Consistent connectivity and security methods** between trading partners to improve timely flow of transactions and data.
- ☆ **Time requirement for initial response.**

- ☆ **Consistent connectivity and security methods** between trading partners to improve timely flow of transactions and data.
- ★ **Detection and display of code descriptions** to reduce burden of interpretation.

☆ *Requirement in CAQH CORE Phase IV Operating Rule – Available for Use.*

★ *Requirement in CAQH CORE Phase V Operating Rule – Nearing Implementation.*

* Depicts the most common path for the PA process to follow.

Phase V CAQH CORE Operating Rules Package Overview

Draft Phase V CAQH CORE Operating Rules Package Contents At a Glance

Phase V CAQH CORE Operating Rules Package Contents

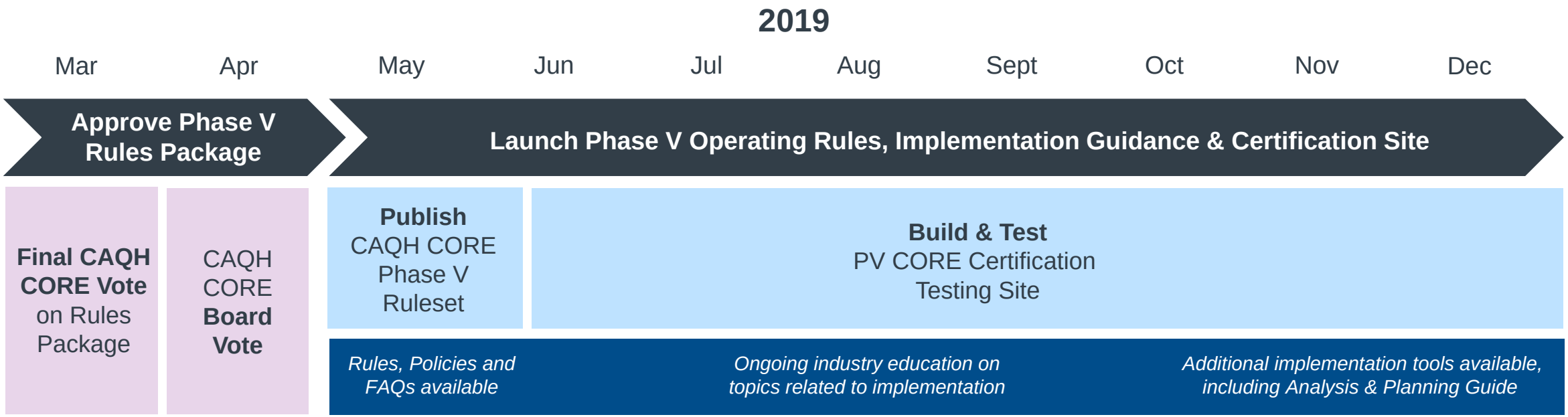
1. Draft Phase V CAQH CORE Operating Rules Set

- The **Draft Phase V CAQH CORE Prior Authorization (278) Request / Response Data Content Rule** targets one of the most significant problem areas in the prior authorization process: requests for medical services that are pended due to missing or incomplete information, primarily medical necessity information. These rule requirements reduce the unnecessary back and forth between providers and health plans and enable shorter adjudication timeframes and fewer staff resources spent on manual follow-up.
- The **Draft Phase V CAQH CORE Prior Authorization Web Portal Rule** builds a bridge toward overall consistency for referral and prior authorization requests and responses by addressing fundamental uniformity for data fields, ensuring confirmation of the receipt of a request and providing for system availability.

2. Draft Phase V CAQH CORE Certification Test Suite

- The **Draft Phase V CAQH CORE Certification Test Suite** contains the requirements that must be met by an entity seeking CORE Certification on the Phase V CAQH CORE Operating Rules to be awarded a CORE Certification Seal.

Phase V Operating Rules Package Voting and Launch Timeline



Final CAQH CORE Vote

- The Final CAQH CORE Vote is open from: **Tuesday, 03/12/19 until close of business Wednesday, 04/03/19.**
- For the Phase V Operating Rules Package to pass and be forwarded to the CAQH CORE Board Vote:
  - **Quorum of 60%** of Full CAQH CORE Voting Participating Organizations must be achieved.
  - **Approval of at least 66.67%** must be exceeded.

Phase V CAQH CORE Operating Rules Package Overview

1. *Phase V CAQH CORE Operating Rules Set*
   - *Draft Phase V CAQH CORE Prior Authorization (278) Request / Response Data Content Rule*
   - *Draft Phase V CAQH CORE Prior Authorization Web Portal Rule*
2. *Phase V QH CORE Certification Test Suite*

Prior Authorization (278) Request / Response Data Content Rule

Requirements & Scope

Key Rule Requirements
✓ Consistent patient identification and verification to reduce to reduce common errors and denials.
✓ Return of specific AAA error codes and action codes when certain errors are detected on the Request.
✓ Return of Health Care Service Decision Reason Codes to provide the clearest explanation to the submitter.
✓ Use of PWK01 Code (or Logical Identifiers Names and Codes & PWK01 Code) to provide clearer direction on status and what is needed for adjudication.
✓ Detection and display of all code descriptions to reduce burden of interpretation.

Scope	
In Scope	▪ Applies to the 5010X217 278 Request / Response transactions for prior authorizations for procedures, laboratory testing, medical services, devices, supplies or medications within the medical benefit. ▪ Applies when any HIPAA covered entity, conducts or processes the 5010X217 278 Request / Response transaction.
Out of Scope	× Prior authorizations covered by retail pharmacy benefit. × Prior authorization specific to emergency / urgent requests. × Referral requests.

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Prior Authorization (278) Request / Response Data Content Rule

Rule Requirements: Summary

DRAFT RULE
5010X217 278 Request / Response Data Content

Indicates that the Draft Rule Requirement is applicable to: *PA Submitter* *PA Responder* *Provider-facing Vendor*

DRAFT DATA CONTENT RULE REQUIREMENT FOCUS AREAS	PRIOR AUTHORIZATION PROCESS CHALLENGE	HIGH-LEVEL SOLUTION
Submitting Patient Identifying Information Normalizing Patient Last Name	▪ Health plans often pend or deny PA requests due to incorrect, incomplete or inconsistent patient identification.	**Information included on the Request and reviewed by the health plan that allows for successful adjudication.**
Logical Observation Identifiers Names and Codes (LOINCs) on Responses Pended for Additional Clinical Documentation[1] AAA Error Codes and Action Codes Health Care Service Decision Reason Codes	▪ When providers receive pended and denied Responses from the health plan / UMO, the codes supporting the Response are not always consistent and are often ambiguous.	**Consistent use of codes on the Response to indicate next steps.**
Detection and Display of 278 Response Data Elements	▪ Providers must contact the health plan (often via phone) to understand next steps.	**Detection and display of codes to enable consistent interpretation.**

[1]Using one or more appropriate Logical Observation Identifier Names and Codes (LOINC) Codes from the HL7 CDA® R2 Attachment Implementation Guide: Exchange of C-CDA Based Documents, Release 1.

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Prior Authorization (278) Request / Response Data Content Rule

Requirement Deep Dive: Consistent Patient Identification and Verification

DRAFT RULE
5010X217 278 Request / Response Data Content

Pain Point: Health plans often pend or deny PA requests due to incorrect, incomplete or inconsistent patient identification.

Draft Rule Requirement is applicable to PA Submitter and Provider-facing Vendor.

Submitting Patient Identifying Information

- Specifies data field (loop and segment) in which a provider must submit identifying information if patient is a ***subscriber.***
- Specifies data field (loop and segment) in which a provider must submit subscriber and dependent information if patient is the ***dependent.***

Draft Rule Requirement is applicable to PA Responder and Provider-facing Vendor.

Normalizing Patient Last Name

- Normalization applies to specific **characters in a patient's last name** including:
  - Punctuation values.
  - Upper case letters.
  - Special characters.
  - Name suffixes and prefixes.
- Requires character strings to be removed during name normalization.
- Recommends set of punctuation values to be used to delimit last name from suffix or prefix.

NOTE PERTAINING TO LAST NAME NORMALIZATION REQUIREMENT: *This Rule does NOT*

- Require CORE-certified entities to internally store data elements.
- Require conversion of letter case and/or special characters by any party for subsequent processing of the data through external systems.
- Specify whether the full last name or only a portion of the last name must be validated.
- Specify the search criteria used to identify a patient.

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Prior Authorization (278) Request / Response Data Content Rule

Requirement Deep Dive: Requesting Additional Documentation for a Pended Response

DRAFT RULE
5010X217 278 Request / Response Data Content

Pain Point: When providers receive pended and denied responses from the health plan/UMO, the codes supporting the responses are not always consistent and are often ambiguous.

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Draft Rule Requirement is applicable to PA Responder and Provider-facing Vendor.

Requesting Additional Documentation for a Pended Response

To indicate that review is pended for additional medical information at the patient event and service level requires the return of **HCR01 Action Code of A4 Pended** as well as the appropriate **HCR03 Industry Code** and *either*:

- The appropriate **PWK01** Attachment Report Type Code.

  OR

- One or more appropriate **LOINC**,

  AND

- The appropriate **PWK01** Attachment Report Type Code.

NOTE: The requirement applies when the 5010X217 278 Request transaction includes one or more Diagnosis Code(s) in Loop 2000E Patient Event Level HI Patient Diagnosis Health Care Information Codes and/or Procedure or Revenue Code(s) in Loop 2000F Service Level SV1, SV2, or SV3 segments that can be categorized by the health plan and its agent into one or more of the following types of service: General Outpatient, Inpatient, Surgery, Oncology, Cardiology, Imaging, Laboratory, Physical Therapy, Occupational Therapy, Speech-Language and Pathology.
The rule does NOT require providers to submit diagnosis or procedure code.

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Prior Authorization (278) Request / Response Data Content Rule

Consistent Use of Codes to Indicate Errors, Decisions and Next Steps

DRAFT RULE
5010X217 278 Request / Response Data Content

Pain Point: When providers receive pended and denied responses from the health plan/UMO, the codes supporting the responses are not always consistent and are often ambiguous.

Draft Rule Requirements are applicable to PA Responder and Provider-facing Vendor.

Consistent and Uniform Use of AAA Error and Action Codes

- Requires the return of specific AAA Error and Action Codes in Response when certain errors are detected in the request[1].

Using Health Care Service Decision Reason Codes (HCSDRC)

- Requires the use of a HCSDRC in the HCR segment be returned to the submitter in addition to the required code to provide the most comprehensive information.

[1]Specified in Sections 4.2.2, 4.2.3 & 4.2.3

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Prior Authorization (278) Request / Response Data Content Rule

Detection & Display of 278 Response Data Elements

DRAFT RULE
5010X217 278 Request / Response Data Content

Pain Point: Providers must contact health plans (often via phone) to understand next steps.

Draft Rule Requirement is applicable to PA Responder and Provider-facing Vendor.

Detection & Display of 278 Response Data Elements

- Requires the receiver of 5010X217 278 Response to detect and extract all data elements, data element codes and corresponding code definitions to which the rule applies in the 5010X217 278 Response.
- The receiver must display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the 5010X217 278 Response data content.

Phase V CAQH CORE Operating Rules Package Overview

1. *Phase V CAQH CORE Operating Rules Set*
   - *Draft Phase V CAQH CORE Prior Authorization (278) Request / Response Data Content Rule*
   - *Draft Phase V CAQH CORE Prior Authorization Web Portal Rule*
2. *Phase V CAQH CORE Certification Test Suite*

Prior Authorization Web Portals Rule

Requirements & Scope

Key Rule Requirements
✓ Use of the 5010X217 278 Request / Response TR3 Implementation Names or Alias Names for the web portal data field labels to reduce variation.
✓ System availability requirements for a health plan to receive requests, to enable predictability for providers.
✓ Confirmation of receipt of request to reduce manual follow up for providers.
✓ Adherence to the requirements outlined in the 278 Request / Response Data Content Rule when the portal operator maps the collected data from the web portal to the 5010X217 278 transaction.

Scope	
In Scope	▪ Applies to any web portal used to submit a referral as well as prior authorizations for procedures, laboratory testing, medical services, devices, supplies or medications within the medical benefit. ▪ Applies when any entity and its agent make available a web portal to a provider to submit a prior authorization request or referral.
Out of Scope	× Prior authorizations covered by retail pharmacy benefit. × Does not require any entity to conduct, use or process a prior authorization or referral via a web portal if it does not currently do so.

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Prior Authorization Web Portals Rule

Rule Requirements: Summary

DRAFT RULE
Prior Authorization Web Portals

Indicates that the Draft Rule Requirements are applicable to: PA Submitter, PA Responder, Provider-facing Vendor

DRAFT PA WEB PORTAL RULE REQUIREMENT FOCUS AREAS	PRIOR AUTHORIZATION PROCESS CHALLENGE	HIGH-LEVEL SOLUTION
Web Portal System Availability Percentage System Availability Reporting	▪ The availability of a system to receive a PA request is not always consistent, and it is difficult to determine such availability.	**System availability requirements for a health plan to receive a PA request, to enable predictability for providers.**
Standard Web Form Data Field Labels on Request & Response Conformance with the 278 Data Content Rule	▪ Providers allocate substantial staffing resources to manage web portal submissions, as each portal is different. Lack of standardization increases time spent to enter each request.	**Application of standard X12 data field labels to web portals to reduce variation in data elements to ease submission burden.**
Confirmation of Receipt of a PA Request	▪ Providers often must call to determine next steps after a PA is submitted.	**Confirmation of receipt of PA submission to reduce manual follow-up for providers.**

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Prior Authorization Web Portals Rule

System Availability & Reporting Requirements

DRAFT RULE
Prior Authorization Web Portals

Pain Point: The availability of a system to receive a PA request is not always consistent, and it is difficult to determine such availability.

Draft Rule Requirements are applicable to PA Responder and Provider-facing Vendor.

System Availability Requirements

- Web portal system availability must be **no less than 86%** per calendar week.
- This allows for 24 hours per calendar week for regularly scheduled web portal downtime.

System Availability Reporting Requirements

- Publish routinely scheduled **downtime,** including holidays**.**
- **No response required** during scheduled, non-routine or unscheduled downtime(s).
- Provide information **within one hour of emergency downtime.**
- Publish non-routine downtime at least **one week in advance.**

Not Required by Web Portal Rule: During downtime, web portals are **not** required to send a response to notify the provider that the web portal is down and where to submit a prior authorization request.

NOTE: When a web portal system is down, the web portal operator should provide an alternative mode of submission, if applicable.

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Prior Authorization Web Portals Rule

Confirmation of a Receipt of a Prior Authorization Request

DRAFT RULE
Prior Authorization Web Portals

Pain Point: Providers often must call to determine next steps after a prior authorization is submitted.

Draft Rule Requirement is applicable to PA Responder and Provider-facing Vendor.

Confirmation of a Receipt of a Prior Authorization Request

- Web portals must return a submission receipt to the provider indicating that the complete Prior Authorization form was **successfully received**.
- Web portals must return information about the **"next steps"** of the web portal operator.

Examples of next steps include:

- Notification that the web portal operator requires additional documentation to process the request.
- Option to print and save a PDF.
- View the prior authorization status.
- The status or an update of a previously submitted request.
- Assignment of a transaction or reference control number.
- A detailed timestamp, potentially including date, time and time zone of the submission.

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Prior Authorization Web Portals Rule

Web Form Data Field Labels and Conformance with the 278 Data Content Rule

DRAFT RULE
Prior Authorization Web Portals

Pain Point: Providers allocate substantial staffing resources to manage web portal submissions, as each portal is different. Lack of standardization increases time spent to enter each request.

Draft Rule Requirements are applicable to PA Responder and Provider-facing Vendor.

Web Form Data Field Labels

- Requires the use of 5010X217 278 Request / Response TR3 **Implementation Names** for the web portal data field labels, which supports the HIPAA-mandated standard transaction.
- Entities may also use the **TR3 "Alias" field** name.

A web portal operator may present supplemental information regarding the data fields via a "mouse hover" function or some similar functionality.

Conformance with the 278 Data Content Rule

- If a web portal operator **maps the data** collected from the web form to the X12/005010X217 Health Care Services Review – Request for Review and Response (278) transaction it must **conform** with the Phase V CAQH CORE Prior Authorization 278 Request / Response Data Content Rule.

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Phase V CAQH CORE Operating Rules Package Overview

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2. *Phase V CAQH CORE Certification Test Suite*

CORE Certification – Industry Gold Standard

Developed by Industry, for Industry to Promote Adoption

CORE Certification provides **assurance** to organizations that their IT systems/products conform to operating rules and deliver value afforded by the rules.

CORE Certification program was developed **by industry, for industry** by over 130 CORE Participating Organizations including health plans, providers, vendors, government agencies and associations.

CORE Certification involves a **phased approach**, building on previous phases; provides an end-to-end testing suite that is robust and comprehensive.

350+

certifications have been awarded.

aetna

Harvard Pilgrim HealthCare

MAYO CLINIC

CHANGE HEALTHCARE

DELTA DENTAL

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

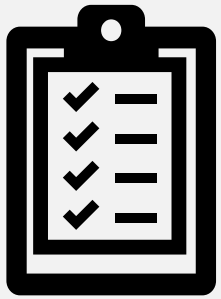
Department of Veterans Affairs

CVS caremark

athenahealth

CAQH CORE

Phase V CAQH CORE Certification Test Suite



The CAQH CORE Certification Test Suite defines testing and evaluation criteria for organizations seeking to demonstrate that they have successfully implemented operating rule requirements.

Goal:

- The Phase V CAQH CORE Certification Test Suite should meet industry needs for certifying organizations conducting the X12/v5010 278 transaction with specific data content and accommodate conformance testing for the Phase V CAQH CORE Prior Authorization Operating Rules.

Approach:

- CAQH CORE Certification Test Suites have been developed for CAQH CORE Phases I, II, III and IV.
- The Phase V CAQH CORE Certification Test Suite build retains the same organization and sections used in prior test suites.

Phase V CAQH CORE Certification Test Suite

Overview of Sections

Introduction:

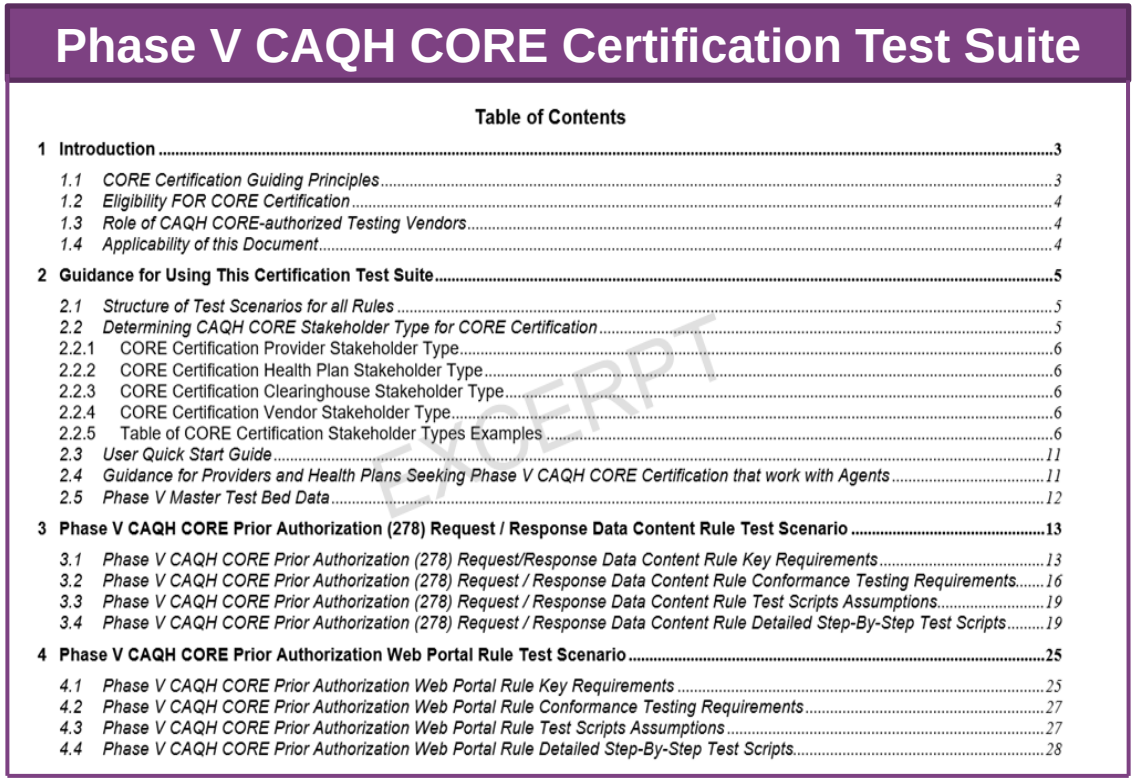
- Provides an overview and gives context on the CAQH CORE Certification Test Suites.

Guidance:

- Considerations regarding stakeholder categories, different business processes for applicable standard transactions and other guidance.

Two Test Scenarios - Data Content and Web Portal:

- Key Rule requirements.
- Conformance Testing requirements.
- Test Scripts assumptions by rule.
- Detailed step-by-step test scripts addressing each conformance requirement by rule for each stakeholder.



Phase V CAQH CORE Certification Test Suite

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EXCERPT

CAQH CORE

Next Steps:
CAQH CORE Participant Vote

Final Vote for Full CAQH CORE Voting Participating Organizations

Vote Overview:

- **Who:** Primary representatives and contacts engaged in Phase V Rule Development from Full CAQH CORE Voting Participating Organizations in good standing received the Official Final CORE Vote Ballot.

- **What:** For the Draft Phase V CAQH CORE Operating Rule Package being balloted organizations will be asked to select "Yes", "No", or "Abstain" to indicate whether or not your organization **supports the Rule Package**:
  - Draft Phase V CAQH CORE Operating Rules Set
    - Draft Phase V CAQH CORE Prior Authorization (278) Request / Response Data Content Rule
    - Draft Phase V CAQH CORE Prior Authorization Web Portal Rule
  - Draft Phase V CAQH CORE Certification Test Suite

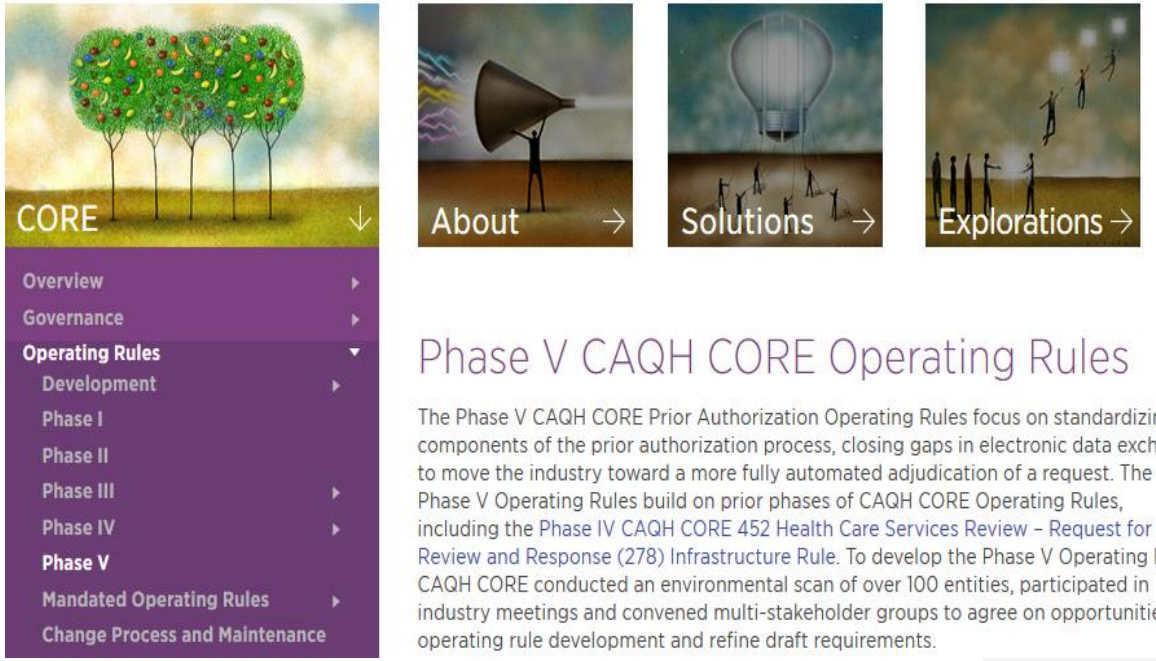
- **When:** Voting representatives from each voting participating organization in good standing received the Official Final CORE Vote Ballot **Tuesday 03/12/19.** The ballot will be open until **close of business Wednesday 04/03/19.**

How to Complete your Organization's Ballot:

- Submit your organization's Final CAQH CORE Vote via the online submission **link** **by close of business Wednesday 04/03/19.**
- The vote is to be submitted by CAQH CORE Participants only; please coordinate to submit one response for your organization.
- The results of the Final CAQH CORE Vote will be shared via email following the balloting period.
- NOTE: In accordance with CAQH CORE Policy, all responses will be kept strictly confidential and will be reported in aggregate.

If you have any questions please contact us at CORE@CAQH.org.

Resources



- One Page Overview of the Draft Phase V Operating Rules Package
- Draft Phase V CAQH CORE Operating Rule Set
- Draft Phase V Certification Test Suite
- Previous Webinars:
  - CAQH CORE Webinar: Prior Authorization Landscape
  - CAQH CORE Participant Forum

NOTE: The CORE Calendar available to Participants contains all materials developed from the Subgroup and Work Groups.

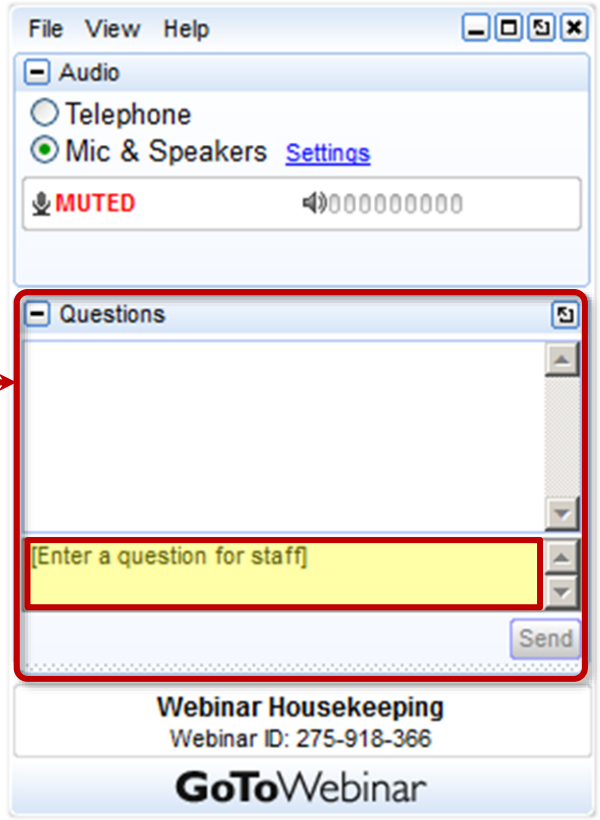
Please contact CAQH CORE Staff & Co-Chairs with any questions or concerns: CORE@CAQH.org

Audience Q&A

Please submit your questions

Enter your question into the “Questions” pane in the lower right hand corner of your screen.

You can also submit questions at any time to CORE@caqh.org



- The slides and webinar recording will be emailed to attendees and registrants in the next 1-2 business days.

CAQH CORE

Thank you for joining us!

@CAQH

Website: www.CAQH.org/CORE

Email: CORE@CAQH.org

The CAQH CORE Mission

Drive the creation and adoption of healthcare operating rules that support standards, accelerate interoperability and align administrative and clinical activities among providers, payers and consumers.

APPENDIX: List of Voting Participating Organizations*

Voting Participating Organizations are entities that create, transmit, or use healthcare administrative data.

- Aetna
- Allscripts
- Ameritas Life Insurance Corp.
- Anthem Inc.
- Arizona Health Care Cost Containment Sys
- athenahealth
- AultCare
- Availity, LLC
- Blue Cross Blue Shield of Michigan
- Blue Cross Blue Shield of North Carolina
- Blue Cross Blue Shield of Tennessee
- California Dept of Health Care Services
- CareFirst BlueCross BlueShield
- CareSource
- Centers for Medicare and Medicaid (CMS)
- Cerner/Healthcare Data Exchange
- Change Healthcare
- CHRISTUS Health
- CIGNA
- ClaimRemedi
- Community Health Plan of Washington
- Conduent
- CSRA Inc.
- DST Health Solutions
- DXC Technology
- Edifecs
- Emory Healthcare
- Epic
- eviCore Healthcare
- Excellus BlueCross BlueShield
- Experian
- Federal Reserve Bank of Atlanta
- Florida Agency for Health Care Administration
- Government Employees Health Association
- Harvard Pilgrim Healthcare
- Health Care Service Corporation
- Health Net Inc. / Centene
- Health Plan of San Joaquin
- HEALTHeNET
- Highmark, Inc.
- HMS
- Horizon BCBS of New Jersey
- Humana
- inMediata
- InstaMed
- ioHealth
- Kaiser Permanente
- Laboratory Corporation of America
- Louisiana Medicaid – Molina
- Marshfield Clinic / Security Health Plan
- Mayo Clinic
- MDxHealth
- Medical Mutual of Ohio, Inc.
- Michigan Department of Community Health
- Michigan Public Health Institute
- Minnesota Department of Health
- Missouri HealthNet Division
- Mobility Medical, Inc.
- Montefiore Medical Center
- New Mexico Cancer Center
- NextGen Healthcare Information Systems
- OhioHealth
- OODA Health
- Oregon Department of Human Services
- Ortho NorthEast (ONE)
- Palmetto GBA
- PaySpan
- Pennsylvania Department of Public Welfare
- PNC Bank
- PNT Data Corporation
- Premera Blue Cross Blue Shield
- Tampa General Hospital
- The SSI Group, Inc.
- TIBCO Software, Inc.
- TransUnion
- TrialCard
- TRICARE
- TriZetto Corporation, A Cognizant Company
- Tufts Health Plan
- United States Department of Veteran Affairs
- UnitedHealth Group / Optum / Unitedhealthcare
- Virginia Mason Medical Center
- Waystar
- Wipro

*Only voting participating organizations in good standing (current on 2018 CORE participant fees) are eligible to vote in the Final CORE Vote.