CAQH CORE Prior Authorization & Referrals (278) Infrastructure Rule vPA.2.0

Updates at a Glance

The updated requirements to the CAQH CORE Prior Authorization & Referrals (278) Infrastructure Rule passed in January 2020.

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The CAQH CORE Prior Authorization & Referrals (278) Infrastructure Rule establishes maximum timeframes at various steps in the prior authorization process using the 5010X217 278 Request and Response transaction, building upon existing infrastructure and connectivity requirements.

Prior Authorization & Referrals CAQH CORE Certification Test Suite Version PA.1.0

The CAQH CORE Certification Test Suite – Infrastructure Rule Test Scenario contains updated requirements that must be met by an entity seeking CORE Certification for Prior Authorization & Referrals to be awarded a CORE Certification Seal.

CAQH CORE Prior Authorization & Referrals (278) Infrastructure Rule: Updates at a Glance

Each HIPAA-covered entity or its agent must support the maximum response time requirements for at least **90 percent of all X12 278 Responses returned within a calendar month.*

	Batch Processing Mode	Real Time Processing Mode
In Scope	▪ Applies when any HIPAA covered entity, conducts or processes a 5010X217 278 Request/Response transaction.	
Out of Scope	▪ Prior authorization specific to emergent[1] or urgent[2] requests. ▪ Prior authorizations conducted retrospectively[3] (i.e. neither prospectively nor concurrently). ▪ Appeals Review Process (internal or external).	
Updated Requirement: **278 Initial Response Time Requirement**	▪ Maximum response time for availability of a 5010X217 278 Response is **two business days** following submission of the 5010X217 278 Request. (Note: The previous requirement was 3 business days).	▪ Maximum response time for the receipt of a 5010X217 278 Response is **20 seconds** following submission of the 5010X217 278 Request.
New Requirement #1: **Time Requirement for Requesting Additional Information/ Documentation**	▪ Health plans must make a 5010X217 278 Response available specifying the additional information needed to make a final determination within **two business days** following submission of a 5010X217 278 Request.	▪ *When the additional information is immediately known* to a health plan, it must return the pended 5010X217 278 specifying the additional information needed within **20 seconds** from receipt of the 5010X217 278 Request. ▪ *When the additional information is initially unknown* to a health plan, it must return an unsolicited pended 5010X217 278 Response specifying the additional information needed within **two business days** from receipt of the 5010X217 278 Request.
New Requirement #2: **Time Requirement for Final Determination: Approval or Denial**	▪ Health plan or its agent must return a solicited or unsolicited 5010X217 278 containing a final determination within **two business days** following receipt of a *complete* 5010X217 278 Request with all information/documentation necessary to reach a final determination.	▪ Health plan or its agent must return a 5010X217 278 containing a final determination within **two business days** following receipt of a *complete* 5010X217 278 Request with all information/ documentation necessary to reach a final determination.
New Requirement #3: **Close Out Time Requirement**	▪ A health plan or its agent *may choose* to close out a pended 5010X217 278 Request if a provider or its agent does not respond to a request for additional information/documentation from the health plan or its agent after a minimum of 15 business days following the return of a pended 5010X217 278 Response requesting additional information/documentation necessary to adjudicate the pended 5010X217 278 Request.	

[1] The ACA prohibits requirements for prior authorization to access emergency services under section 29 CFR 2590.715-2719A, patient protections. In line with federal law, a growing number of state laws set additional limits around prior authorizations for emergency and urgent care.
[2] In the context of this CAQH CORE rule "prospective review" is defined as a utilization review conducted before an admission or a course of treatment including any required preauthorization or precertification, including extensions of outpatient treatment.
[3] In the context of this CAQH CORE rule "concurrent review" is defined as a utilization review conducted during a patient's hospital stay or course of inpatient treatment.

Table 1. CAQH CORE Prior Authorization & Referrals (278) Infrastructure Rule – Response Time Requirements Workflow Diagram

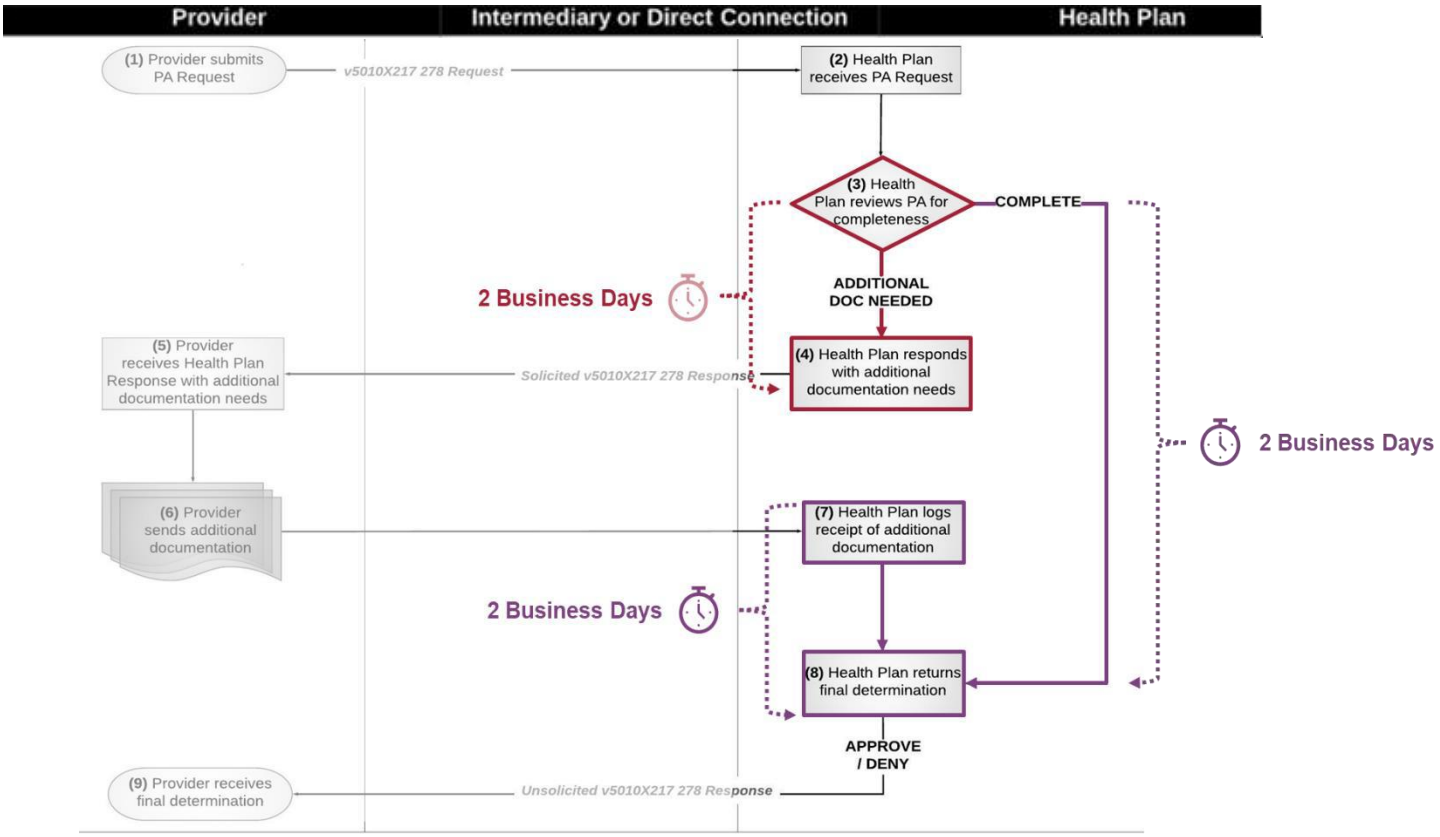

Table 2. CAQH CORE Prior Authorization & Referrals (278) Infrastructure Rule – Close Out Requirement Workflow Diagram