CAQH CORE and X12 Webinar Series: Diving Into to the 270/271 Transaction, Standard, & Operating Rules

December 1, 2022

3:30-4:30pm ET

Logistics

Presentation Slides

- Accessing webinar materials:
  - You can download the presentation slides now from the “Handouts” section of the GoToWebinar menu.
  - You can download the presentation slides and recording at www.caqh.org/core/events after the webinar.
  - A copy of the slides and the webinar recording will also be emailed to all attendees and registrants in the next 1-2 business days.

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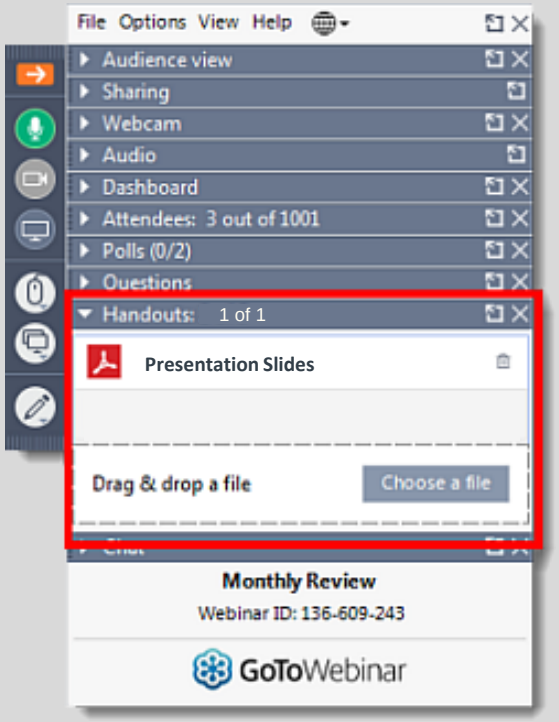


Part II of a Three-Part Series

Watch our Introduction to the 270/271 Here!

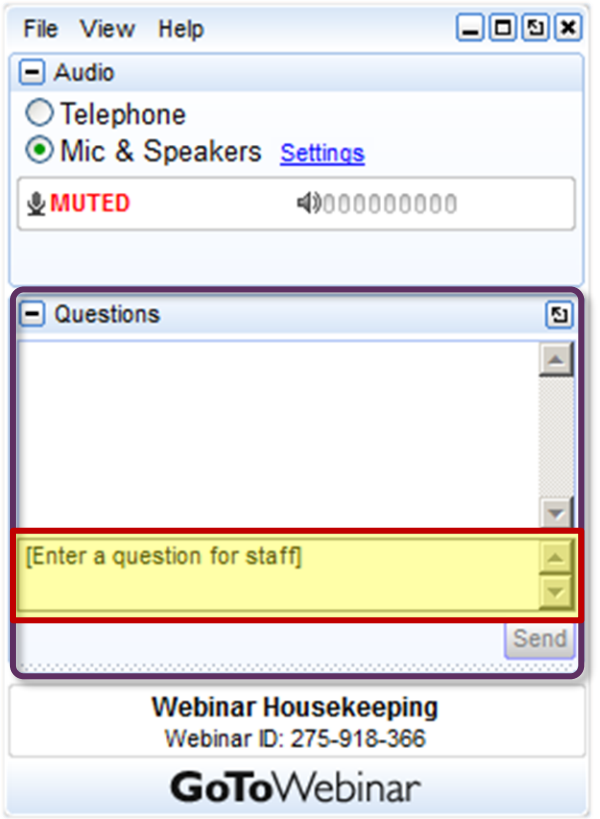
(July 11, 2022)

Audience Participation

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



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Presentation Resources

- Webinar Recording
- Presentation Slides

Thank You to Our Speakers

Donna Campbell

Provider Portal and Provider Connectivity Manager

BCBS Illinois

Evert Ford

Product Manager

Optum

Bob Bowman

Principal

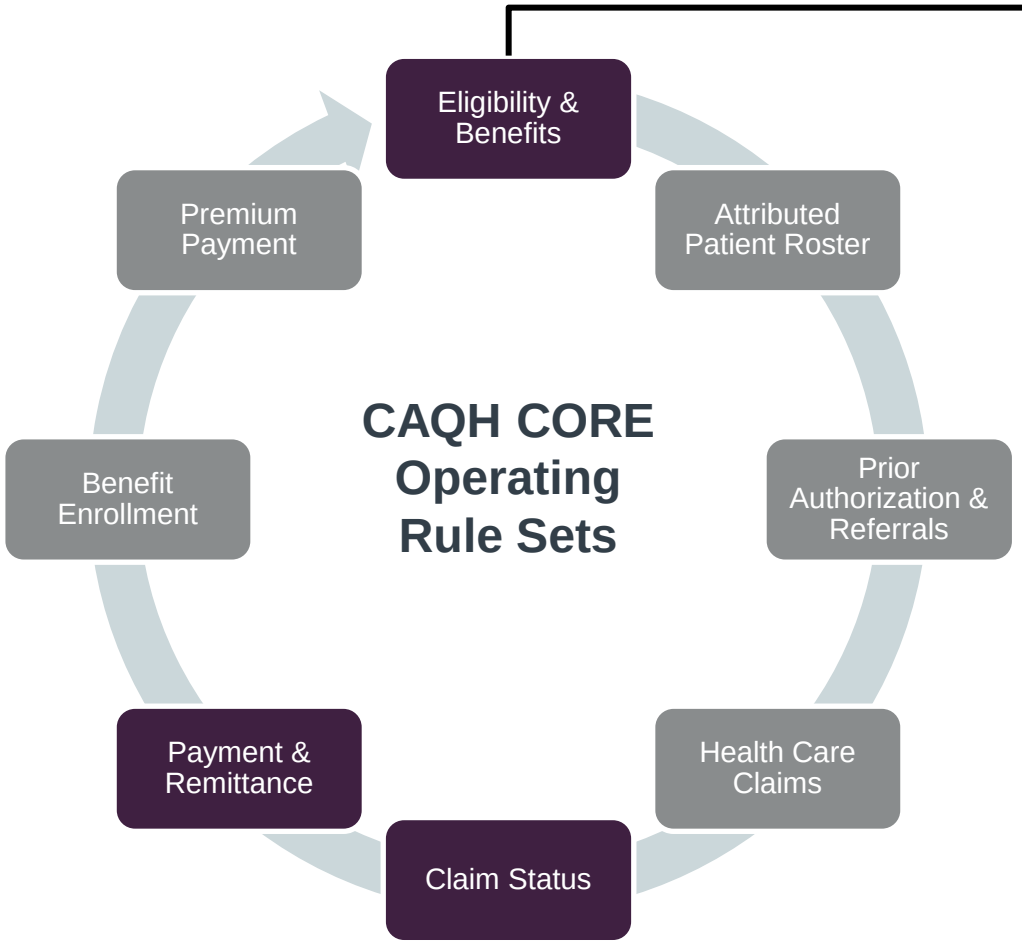
CAQH CORE

Session Outline

- Coding:
  - Understanding generic and explicit inquiries
  - Support for procedure codes in the 270/271 transactions
- AAA Error Codes
- Q & A
- Connect with X12 and CAQH CORE

CAQH CORE Operating Rules Support Key Revenue Cycle Functions

Three Rule Sets Adopted Under HIPAA



Eligibility & Benefits Rule Set Components:

- Eligibility & Benefits (270/271) **Infrastructure** Rule
- Eligibility & Benefits (270/271) **Data Content** Rule
- **Connectivity** Rules

- Eligibility & Benefits (270/271) Single Patient Attribution **Data Content** Rule*

*Developed in 2020 by the CAQH CORE Participants, the Single Patient Attribution Data Content Rule is not federally mandated.

■ *Certain requirements within these rule sets are federally mandated.*

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E&B: Coding

Understanding generic and explicit inquiries

Support for procedure codes

CAQH CORE Eligibility & Benefits (270/271) Data Content Rule vEB.2.0

Understanding Generic vs Explicit Inquiries

- To electronically determine a patient's eligibility and benefits, providers need to have a robust Eligibility Benefit Request and Response (270/271).
- There are two different types of inquiries that can be sent through the 270/271:

Generic

A 270 Health Care Eligibility Benefit Inquiry that contains **only STC '30' (Health Benefit Plan Coverage)** in the EQ01 segment of the transaction.

Explicit

A 270 Health Care Eligibility Benefit Inquiry that contains **a STC other than and not including '30' (Health Benefit Plan Coverage)** in the EQ01 segment of the transaction.

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CAQH CORE Eligibility & Benefits (270/271) Data Content Rule vEB.2.0

Service Type Codes: Mandatory vs. Discretionary

Expanded Subset of Service Type Codes (v5010 X12 270/271 Code)	Expanded Subset of Service Type Code Definitions (v5010 X12 270/271 Definition)	Service Type Codes Required for a Generic Inquiry	Service Type Codes Required for an Explicit Inquiry	Service Type Codes Required for Remaining Coverage Benefits	Return Patient Financial Responsibility information and Benefit Information
1	Medical Care	Y	Y		Discretionary
2	Surgical		Y		Mandatory
3	Consultation		Y		Discretionary
4	Diagnostic X-Ray		Y		Mandatory
5	Diagnostic Lab		Y		Mandatory
6	Radiation Therapy		Y		Mandatory
7	Anesthesia		Y		Mandatory
8	Surgical Assistance		Y		Mandatory
9	Other Medical		Y		Discretionary

- **When are Service Type Codes Discretionary?**
  - A code is too general for a response to be meaningful (e.g., 1 – Medical);
  - A code is typically a “carve-out” benefit (e.g., AL – Vision) where the specific benefit information is not available to the health plan or information source; Or
  - A code is related to behavioral health or substance abuse (e.g., AI - Substance Abuse) where privacy issues may impact a health plan or information source’s ability to return information.

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CAQH CORE Eligibility & Benefits (270/271) Data Content Rule vEB.2.0

Support for Procedure Codes in the 270/271 Transaction

- To electronically determine a patient's eligibility and benefits, providers need to have a robust ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271).

- This robust response includes the **health plans** providing financial information for base and remaining deductible, co-insurance, co-payment and coverage and benefit information pertaining to telemedicine, authorization or certification indication, and tiered benefits for CORE-required service types codes and **procedure codes**.

Basic Requirements

Health Plans	Providers
A health plan and its agent must comply with all requirements specified in this rule when returning the 271 when the individual is located in the health plan's system.	The receiver of a 271 is required to detect and extract all data elements to which this rule applies as returned by the health plan and its agent in the 271. The receiver must display or otherwise make the data available to the end user without altering the semantic meaning of the 271 data content.

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E&B:
AAA Error Codes

Improving the use of AAA Error Codes

CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule vEB.2.0

Improving the Use of AAA Error Codes

Rule Requirements	
Real Time *2.2.1. Use of the 999 and X12 v5010 271 Acknowledgements for Real Time*	**Batch** *3.2.1. Use of the X12 v5010 999 and X12 v5010 271 Acknowledgements for Batch*
• Conformance: Submitter of a 270 in Real Time will receive one acknowledgement/response from the receiver: a rejection (X12 v5010 999) or a 271 Response. • When a submitters provides insufficient or invalid information within the 270, they are **sent a 271 Response with AAA segments identifying the error**. The AAA segments will be used to report business level error situations**.**	• Submitters will receive a 999 and a 271 Response transaction. • The 999 will indicate acceptance, rejection or errors. • The 271 Response will **use AAA Validation Request segments** to indicate business level errors.

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CAQH CORE Eligibility & Benefits (270/271) Data Content Rule vEB.2.0

Improving the Use of AAA Error Codes

Rule Requirements

Health Plans and Information Sources

Basic Requirements:

- To return a AAA segment for each error condition as defined in the "Error Condition Description" column of the Error Reporting Codes & Requirements Table *and*
- To return code N in the AAA01 Valid Request Indicator data element *and*
- To return the specific Reject Reason Code in AAA03 *and*
- To return code C in the AAA04 *and*
- To return data elements submitted and used as specified in the Error Reporting Codes & Requirements Table

Pre-Query Error Conditions and Reporting Requirements

- When a health plan (or information source) performs a pre-query evaluation, it must return a AAA segment for each error condition detected along with the data elements submitted and used for:
  - Missing & Required Data Element
  - Invalid MID or DOB
  - Pre-Query Error Reporting

Post-Query Error Conditions and Reporting Requirements

- Post-query errors may occur when a health plan (or information source) attempts a database look-up in its eligibility system and is not able to locate a unique record.
- When a health plan (or information source) detects any of the specified error conditions, it must:
  - Return a AAA segment for each error detected using the appropriate Reject Reason Code for each Post-Query Error Condition *and* Return the data elements as specified in the Error Reporting Codes & Requirements Table

Receivers of the v5010 271

Basic Requirements:

- To detect all combinations of error conditions in the segments in the 271 as defined in the "Error Condition Description" column of the Error Reporting Codes & Requirements Table *and*
- To detect all data elements to which this rule applies as returned by the health plan in the 271 *and*
- To display to the end user text that uniquely describes the specific error conditions and data elements returned by the HP in the 271 *and*
- Ensure that the actual wording of the text displayed accurately represents the error code and the error code description

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Audience Q&A

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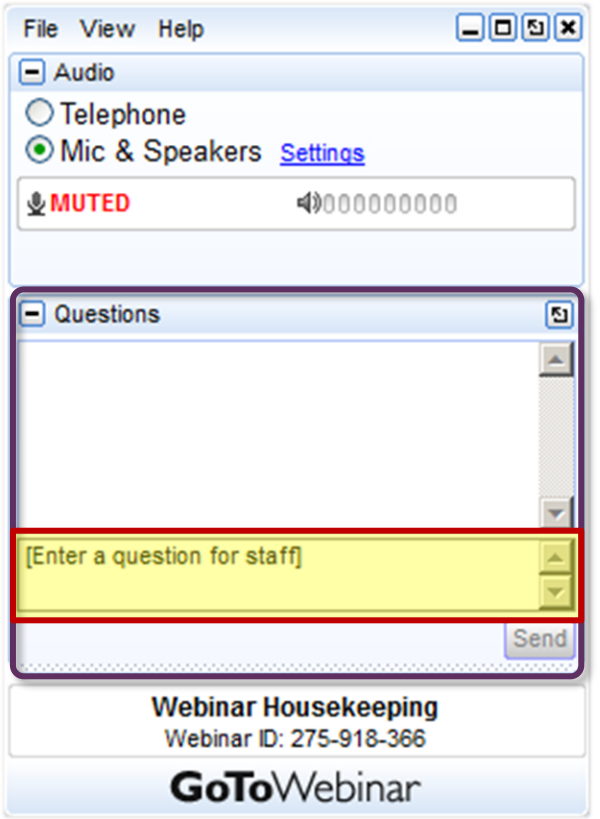

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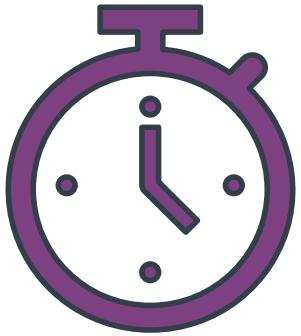
Call to Action

Become Involved in Streamlining Healthcare Data Exchange



Participate in Ongoing Pilot/ROI Assessment:

CAQH CORE continues to work With industry partners to measure the impact of current and potential future operating rules and corresponding standards on organizations' efficiency metrics.

Become CORE Certified:

Demonstrate conformance and commitment to streamlining administrative data exchange.

Engage with us as a CAQH CORE Participant:

Collaborate with decision makers that comprise 75% of the industry to drive creation of operating rules and accelerate interoperability.

Email CORE@caqh.org for more information.

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Thank you for joining us!

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Website: www.CAQH.org/CORE

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