CAQH CORE and X12 Webinar Series

Introduction to the 275 Transaction, Standard, & Operating Rules

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Agenda

- X12 Overview
- Electronic Attachments:
  - Purpose and Scope
  - Benefits
  - Users
  - Workflow
- CORE Overview
- CORE Health Care Claims Attachments Operating Rules
- Questions
- Call to Action

Webinar Logistics

- Accessing webinar materials:
  - Download the presentation slides from the “Handouts” section of the GoToWebinar menu.
  - An e-mail will be sent to all attendees and registrants in the next 1-2 business days with information on how to access slides and today’s recording.
- Have a question?
  - Submit your question **at any time** using the Questions panel on your GoToWebinar menu.

Thank You to Our Speakers

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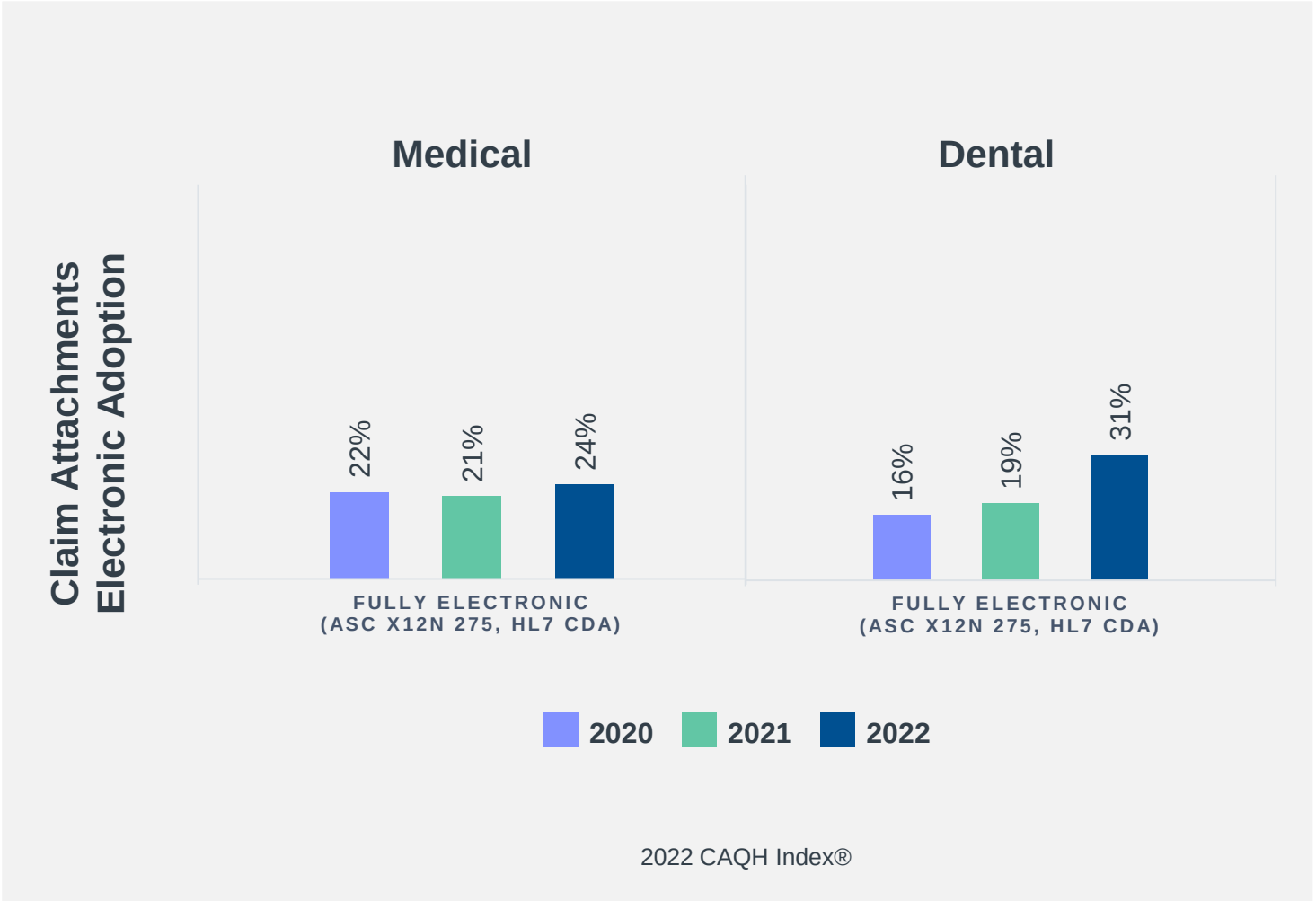
Health Care Claims
Definition and Industry Adoption

Claim Attachment:

Attachments refer to the exchange of patient-specific medical information or supplemental documentation to support an a health care claim submission.



ELECTRONIC ATTACHMENTS
WHAT'S HAPPENING AT X12?

DISCLAIMER

- This presentation is for informational purposes only
- This presentation does not represent legal advice
- This presentation contains point-in-time content and is subject to revision

TOPICS

1. About X12
2. Electronic Attachments:
   - *Purpose and Scope*
   - *Benefits*
   - *Users*
   - *Workflow*
3. Wrap-Up

Background

THE X12 ORGANIZATION

- X12 is a consensus-based ANSI-accredited National Standards Developer (ASD) focusing on the development and ongoing use of cross-industry interoperable data interchange standards
- X12's standards have proven reliable, efficient, & effective in supporting organizations and industries for 40+ years
- X12 maintains electronic messaging that supports finance, government, health care, insurance, supply chain, transportation, and other industries

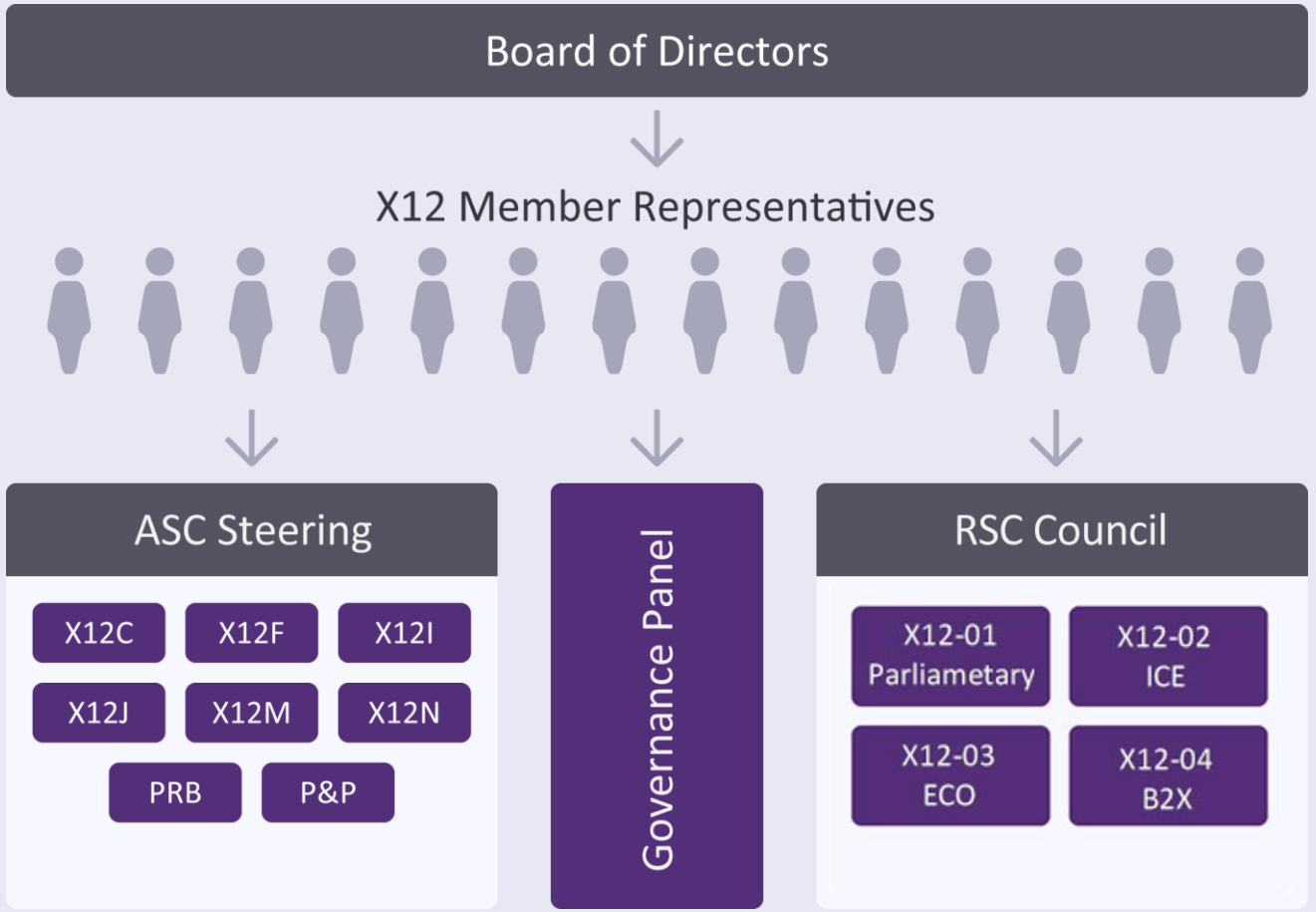
THE X12 ORGANIZATION

- X12 is comprised of a handful of staff, hundreds of members, and more than a thousand member representatives
- Members include corporations, associations, organizations, government entities, and individuals
- X12 standards are the workhorse standards for business to business exchanges
- Many partner-to-partner “standards” are developed based on X12’s intellectual property

X12 IMPLEMENTATION BASE

- Billions of transactions based on X12 standards are utilized daily across various industries including finance, government, health care, insurance, supply chain, transportation, and others
- Millions of entities around the world have an established infrastructure that supports X12 transactions, representing a significant investment in a stable and effective infrastructure
- The data exchanged in X12 transactions is well-defined and has been use-tested in production systems for over 40 years

X12 ORGANIZATIONAL STRUCTURE



THE X12 ORGANIZATION

- Most in health care are familiar with X12's Accredited Standards Committee (ASC)
  - *The ASC develops and maintains the EDI Standard and related implementation guides, including those mandated under HIPAA*
- Some are not as familiar with another X12 committee, the Registered Standards Committee (RSC)
  - *The RSC's External Code List Oversite (ECO) subcommittee develops and maintains X12's terminology, aka vocabulary, resources, excepting those defined within the EDI Standard*

X12 PRODUCTS

X12's product library includes

- *The EDI Standard which is comprised of hundreds of transactions and internal code lists*
- *Technical reports, including implementation guides, describing the business rules and data content for various uses of the EDI Standard*
- *External code lists, aka terminology or vocabulary resources*
- *Schema based on the EDI Standard and implementation guides*
- *Other offerings designed to assist implementers*

X12'S APPROACH

- Open-minded, with vision and insight related to data exchange in both current and developing technologies
- Responsive to business requirements presented by other organizations
- Collaborating enthusiastically with other SDOs, industry groups, government, and business-focused entities

Electronic Attachments

About X12

Purpose and Scope

Benefits

Users

Workflow

Wrap-Up

PURPOSE AND SCOPE

- The purpose of the 275 transaction is to provide standardized data requirements and content that focuses on sending additional information about a claim, encounter or prior authorization request.
- There are two version of the 275-implementation guide used in the industry
  - *Additional Information to Support a Healthcare Claim or Encounter*
  - *Additional Information to Support a Healthcare Services Review*

BENEFITS

- Provides a vehicle for providers to submit additional information to support a claim/encounter or prior authorization request
- Saves providers and payers on printing, mailing and postage costs
- Saves providers and payers mailroom costs
- Streamlines the process of sending the information to payers in a consistent manner
- Saves provider and payers on Appeal costs as information flows more efficiently
- Faster turn around time, as information is received electronically

USERS

- Healthcare Providers, such as:
  - *Physicians*
  - *Practioners*
  - *Suppliers*
  - *Hospitals*
- Health Plans
- Third Party Administrators (TPA's) such as Clearinghouses
- Healthcare Property and Casualty
- Vendors

UNSOLICITED WORKFLOW

- Provider knows that the services being submitted on the claim, or the prior authorization request require additional supporting documentation
- Provider submits the claim or the prior authorization request
- Provider submits the supporting documentation using the appropriate X12 275 transaction
- Payer matches the 275 documentation to the claim or prior authorization request using the Attachment Control Number
- Payer process the claim for payment or completes the prior authorization request

SOLICITED WORKFLOW

- Provider submits a claim or a prior authorization request
- Payer/Utilization Management Organization (UMO) receives the claim or prior authorization request and determines additional information is needed for processing
- Payer/UMO requests the additional information by X12 277RFAI, X12 278 or paper process
- Provider gathers the requested information and returns the documentation in the appropriate X12 275 transaction
- Payer/UMO processes the claim or prior authorization request

Wrap Up

REMINDER

- X12N maintains a library of informational PowerPoints, position papers, checklists, etc.
- Visit X12's Info Center at x12.org to review other relevant information, including:
  - *ASCN023 – Overview of the X12N Subcommittee*
  - *ASCN024 – Overview of X12N's Task Groups*
  - *ASCN025 – Overview of X12N's Work Groups*
  - *ASCN026 through ASCN038 provide more details about each of X12's individual work groups **

* indicates planned materials

STAY CONNECTED

- Learn more about X12 and become a member at X12.org
- Stay informed by following X12
  - *@x12standards on Twitter*
  - *#X12 on LinkedIn*

FEEDBACK
IDEAS
QUESTIONS

TELL US AT

X12.ORG/FEEDBACK

CORE Overview

Taha Anjarwalla
Associate Director, CAQH CORE

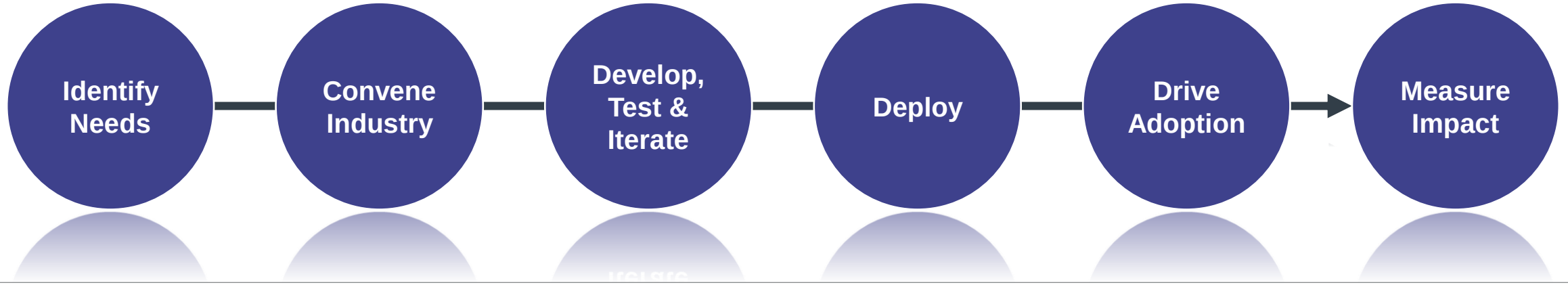
CAQH CORE Mission & Vision

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.

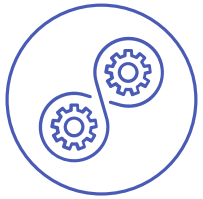
Vision

An **industry-wide facilitator** of a trusted, simple and sustainable healthcare data exchange that evolves and aligns with market needs.



Committee on **O**perating **R**ules for Information **E**xchange

Federally designated by the Department of Health and Human Services (HHS) as the National Operating Rule Authoring Entity for all HIPAA mandated administrative transactions.



Develop business rules to help industry effectively and efficiently use electronic standards while remaining technology- and standard-agnostic.

Multi-stakeholder Board Members include health plans, providers, vendors, and government entities. Advisors to the Board include SDOs.

More than 100 CAQH CORE Participating Organizations

Government

- Arizona Health Care Cost Containment System
- California Department of Health Care Services
- Centers for Medicare and Medicaid Services (CMS)
- Federal Reserve Bank of Atlanta
- Florida Agency for Health Care Administration
- Health Plan of San Joaquin
- Michigan Department of Community Health
- Minnesota Department of Health
- Minnesota Department of Human Services
- Missouri HealthNet Division
- North Dakota Medicaid
- Oregon Department of Human Services
- Oregon Health Authority
- Pennsylvania Department of Public Welfare
- TRICARE
- United States Department of Treasury Financial Management
- United States Department of Veterans Affairs

Health Plans

- Aetna
- Ameritas Life Insurance Corp.
- AultCare
- Blue Cross and Blue Shield Association (BCBSA)
- Blue Cross Blue Shield of Michigan
- Blue Cross Blue Shield of North Carolina
- Blue Cross Blue Shield of Tennessee
- CareFirst BlueCross BlueShield
- Centene Corporation
- CIGNA
- Elevance Health
- Health Care Service Corp
- Horizon Blue Cross Blue Shield of New Jersey
- Humana
- Medical Mutual of Ohio, Inc.
- Point32Health
- UnitedHealthGroup

Integrated Plan/Provider

- Highmark Health (Highmark, Inc.)
- Kaiser Permanente
- Marshfield Clinic/Security Health Plan of Wisconsin, Inc.

Vendors & Clearinghouses

- AIM Specialty Health
- athenahealth
- Availity, LLC
- Averhealth
- Cedar Inc
- Cerner/Healthcare Data Exchange
- Change Healthcare
- ClaimMD
- Cloud Software Group
- Cognizant
- Conduent
- CSRA
- DXC Technology
- Edifecs
- Epic
- Experian
- Healthedge Software Inc
- HEALTHeNET
- HMS
- Infocrossing LLC
- JP Morgan Healthcare Payments
- NantHealth NaviNet
- NextGen Healthcare Information Systems, Inc.
- OptumInsight
- PaySpan
- PNC Bank
- PriorAuthNow
- SS&C Health
- Surescripts
- The SSI Group, Inc.
- TriZetto Corporation, A Cognizant Company
- Utah Health Information Network (UHIN)
- Wells Fargo
- Zelis

Providers

- American Hospital Association (AHA)
- American Medical Association (AMA)
- Aspen Dental Management, Inc.
- Children's Healthcare of Atlanta Inc
- Cleveland Clinic
- Greater New York Hospital Association (GNYHA)
- Healthcare Financial Management Association (HFMA)
- Laboratory Corporation of America
- Mayo Clinic
- Medical Group Management Association (MGMA)
- Montefiore Medical Center
- New Mexico Cancer Center
- OhioHealth
- Ortho NorthEast (ONE)
- OSF HealthCare
- Peace Health
- St. Joseph's Health
- Virginia Mason Medical Center

Other

- Accenture
- ASC X12
- Cognosante
- Healthcare Business Management Association
- Healthcare Business Association of New York (HCBA)
- HL7
- NACHA The Electronic Payments Association
- National Association of Health Data Organizations (NAHDO)
- National Committee for Quality Assurance (NCQA)
- National Council for Prescription Drug Programs (NCPDP)
- New England HealthCare Exchange Network (NEHEN)
- Preferra Insurance Company Risk Retention Group
- Private Sector Technology Group
- Tata Consultancy Services Ltd
- Utilization Review Accreditation Commission (URAC)
- Work Group for Electronic Data Interchange (WEDI)

Account for 75% of total American covered lives.

Operating Rules Defined

ACA Definition

- The “necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications.”
- Federally mandated for the HIPAA adopted electronic standards.

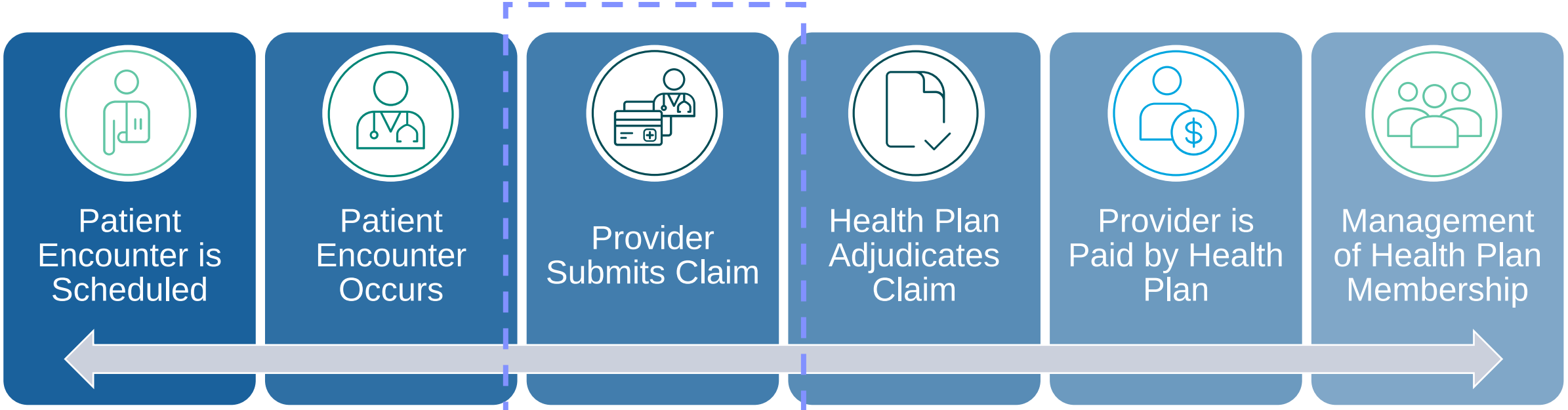
Common in Other Industries

- Many industries rely on operating rules including:
  - Financial services
  - Transportation
  - Retail

Support Revenue Cycle Automation

- Operating rules create common expectations for electronic data exchange.
- Allow provider and payer systems to automate communications across trading partners.

CAQH CORE Operating Rules Support Key Revenue Cycle Functions



*Rule Set Contains Federally Mandated Operating Rules

CORE Health Care Claims Operating Rule Overview

CAQH CORE Attachments Health Care Claims Infrastructure Rule

CAQH CORE Attachments Health Care Claims Data Content Rule

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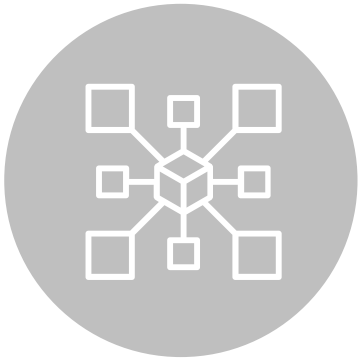
Associate Director, CAQH CORE

Infrastructure and Data Content Operating Rules
Definitions



Infrastructure Operating Rules

Infrastructure rules apply across transactions – establishing basic expectations on how the US data exchange “system” works; e.g., ability to track response times across all trading partners.

Note: Infrastructure rules can be used with any version of a standard.

Data Content Operating Rules

Support the exchange of valuable data that allow stakeholders to access information needed to manage an identified process; rules can address ongoing maintenance, setting expectation of evolution.

Note: Content rules support further use of base standards whenever possible.

CORE Health Care Claim Attachments Infrastructure Rule

The CORE Attachments Health Care Claims Infrastructure Rule vHC.1.0	Non-X12 Method	X12 Method
System Availability Weekly system availability must be no less than **90% per calendar week**. Includes the option for **24 additional downtime hours per calendar quarter** for larger system upgrades.	✓	✓
Connectivity Support most **current CAQH CORE Connectivity** standard, presently vC4.0.0.	✓	✓
File Size Systems must have the capability to **accept 64MB of data** to ensure attachments can be processed across varying systems. Please note for **healthcare claims only** there was a minimum file size support when sending multiple attachments in a singular 275.	✓	✓
Electronic Policy Access of Required Information For **healthcare claims only**, health plans must offer readily accessible information identifying data needed to support a claim adjudication request.	✓	✓
Processing Mode and Response Time Health plans must implement the server requirements for **Batch or Real Time Processing Modes** and support 2nd business day response or 20 second response, respectively, 90% of the time		✓
Acknowledgements and Addressing Errors System must return errors and acceptance for batch processing and errors for real-time processing. Requires providers and their agents to address errors within 1 business day of notification from health plans.		✓
Companion Guide If a Companion Guide covering X12 transaction (v6020) is published, it must follow the format/flow defined in the CORE Master Companion Guide Template		✓

CORE Health Care Claim Attachments Data Content Rule

CORE Attachments Health Care Claims Data Content Rule vHC.1.0

Reassociation of additional information sent to support prior authorization or claims adjudication is time-consuming, error-prone, and ultimately can delay or jeopardize patient care. This issue is compounded when attachments are sent without solicitation. New operating rule requirements ease this burden **through the following reassociation requirements:**

Non-X12 Method	X12 Method
Provider requirement: ✓ Indicate that additional documentation was **sent electronically, specifying attachment type.** ✓ Utilize SOAP or REST **Headers consistent with CORE Connectivity vC4.0.0.** ✓ Providers are encouraged include the **data elements** to assist with reassociation.	**Provider requirement:** ✓ Must use **code 'EL'** to notify health plans that additional information is being transmitted electronically. ✓ Encouraged to send **recommended metadata and/or reference data** to assist with reassociation.
	Health plans: ✓ Must use **code 'EL'** to request the electronic submission of additional information in a pended response. ✓ Should use appropriate **LOINC** code to make requests as specific as possible for the claims use case.

Questions

Call to Action

Call to Action

E-mail CORE@CAQH.ORG to Get Involved!

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

Become CORE Certified

Demonstrate conformance and commitment to streamlining administrative data exchange.

Be an Advocate
Work with CORE to measure the impact of operating rules and corresponding standards on organizations' efficiency metrics.

Thank you for joining us!

E-mail CORE@CAQH.ORG to Get Involved!