# X12 and CAQH CORE Webinar Series: Introduction to the 278 Transaction, Standard & Operating Rules

April 30, 2020

2:00-3:00pm ET

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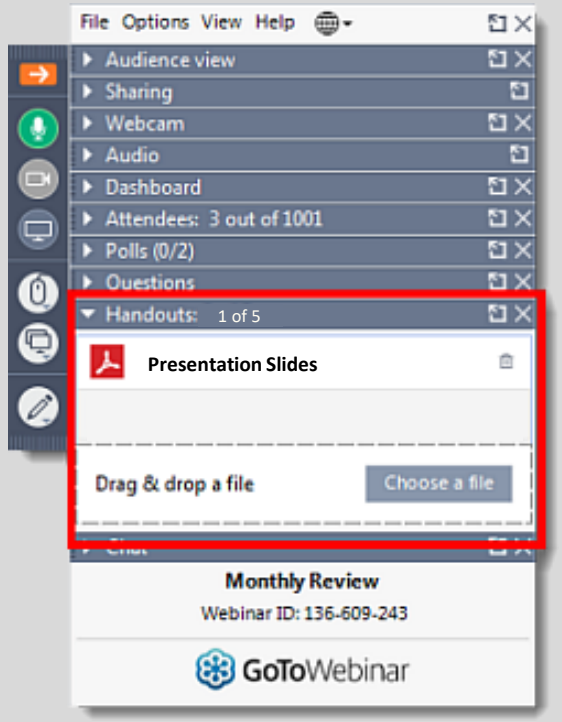

# Session Outline

- Introduction to the 278 Transaction Standard
- CAQH CORE Prior Authorization Operating Rules
- At a Glance: Return on Investment
- Q&A

# Thank You to Our Speakers

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# Introduction to the 278 Transaction Standard

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# DISCLAIMER

## This presentation is for informational purposes only

- This presentation is not intended to represent legal advice
- The content is point-in-time information, which is subject to revision
- If you have questions regarding specific information shared during this presentation, please send them to info@x12.org
- Visit www.x12.org for additional details about X12

# ABOUT X12

- Established by the American National Standards Institute (ANSI) more than 35 years ago
- Develops, establishes and maintains Electronic Data Interchange (EDI) standards, technical reports as well as Extensible Markup Language (XML) schemas which drive business processes globally
- X12 membership includes providers, technologists, and business process experts across all industries which range from health care insurance, transportation, finance, logistics, supply chain management and other industries
- For more information about what we do and how you can become a member, visit us at www.x12.org

# HEALTH CARE SERVICES REVIEW (278)

- Agenda
  - Purpose and Scope
  - 278 Benefits
  - Uses of the 278
  - Who uses the 278
  - Different 278 TR3 implementation guides and business processes
  - A life cycle of the 278 Authorization work flow process
  - Other unique data supported to assist with the UM review

# PURPOSE AND SCOPE

The purpose of the 278 TR3 implementation guides are to provide standardized data requirements and content for all users of the ASC X12 Health Care Service Review (278). These 278 TR3 implementation guides each has its own business purpose that contains information about reporting the details of whom is making the request, for which member, details of the entities performing the services, where and when the services are to be performed, the approval status and why the services are needed by inclusion of the diagnosis and other unique data to support the reason for the request.

These implementation guides are designed to assist those who send and/or receive Authorization requests, notifications, or inquiries on these statuses by using the 278 format.

# 278 Benefits

- EDI exchanges can automate the function of entering Authorization data directly into the Utilization Management (UM) database and/or systems used to assist the health care workflows.
- May eliminate/reduce telephonic requests and manual entry
- Opportunity to reduce FTEs required to support Authorizations, or allow staff to concentrate more on patient care versus administrative efforts
- Improves the accuracy of requests as data is codified
- Opportunity to facilitate faster UM review turn-around time as some responses can be returned in seconds
- Electronic option could be available for all provider entities involved with the patient care

# USES OF THE 278 TR3 Implementation Guides

- Request an Authorization for any services that would require UM review and approval before the services are to take place.
- To inquire upon the patients UM event history for purposes of authorization status, scheduling, verification of the services to be performed and the time frame in which they will need to be completed.
- Notification between health care entities of events that have or haven't occurred to include the approval status from both UM delegated and non-delegated arrangements.

# WHO USES THE 278 ?

- Organizations sending and receiving the 278 include:
- Vendors or Clearinghouses
- Payers
- Utilization Management Organizations
- Laboratories
- Physicians practices
- Facilities
- Home Health Care
- Ambulance Transport
- Behavioral Health

# 278 TR3 implementation guides and business processes

- Request for Review and Response (X217)
  - Request for Authorization and Referrals
  - Elective inpatient/outpatient surgeries, drug, dental, ambulance transport, home health, or any service that can be reported using a procedure code or service type.
  - This 278 technical report is adopted under HIPAA
- Inquiry and Response (X215)
  - Provides ability to view the approval status of a request
- Notification and Acknowledgment (X216)
  - Allows exchange of patient care event data between any entities that have a reason to use this information to support patient care.

# The life cycle of the 278 Authorization work flow process

- Provider submits a request to the Payer/UMO for services
- The Payer returns a Pended response that includes a request for additional information using LOINC to express the type of data needed to complete the UM review that includes an attachment control # that will need to be included when returning supporting documentation (or has 2 business days to request this same data)
- Provider returns the required data to the Payer/UMO using the 275 that supports a Health Care Service Review that will include the attachment control #
- Once the Payer/UMO has all of the data needed to complete the review they will have 2 business days to send a final response

# Other unique data supported to assist with the UM review

- Tracking Numbers that are unique to the entire event or for a specific service
- Authorization/Administrative/Attachment Control #'s
- Dates to support Admissions, Discharge, Accident, Events and/or Services
- Ability to report if it is an initial request or an update
- Delivery patterns that require a frequency of care
- The specialty of the health care entity
- Address data for providers, or when needed for ambulance pickup and drop off locations
- Dental and Tooth segments
- Drug requests
- Place holders to provide LOINC at event or service levels
- Free form text if needed to describe data that is not codified

# WHAT CAN YOU DO

- Become an X12 member
- Participate in X12 standing meetings
- Review draft implementation guides prior to publication
- Submit requests for functionality your organization needs

# THANK YOU

- If you have feedback or questions regarding the information presented, post them at www.x12.org/forms/feedback
- More information about X12 is at www.x12.org
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# CAQH CORE Prior Authorization Operating Rules

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# CAQH CORE Mission/Vision & Industry Role

Industry-led, CAQH CORE Participants include healthcare providers, health plans, vendors, government entities, associations and standard-setting organizations. Health plans participating in CAQH CORE represent **75 percent of the insured US population.**

**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.

**DESIGNATION** CAQH CORE is the **national operating rule author to improve the efficiency, accuracy and effectiveness of industry-driven business transactions.** The Department of Health and Human Services (HHS) designated CAQH CORE as the author of national operating rules for the HIPAA-covered administrative transactions.


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

**CAQH CORE BOARD** **Multi-stakeholder.** Members include health plans, providers (some of which are appointed by associations such as the AHA, AMA, MGMA), vendors, and government entities. Advisors to the Board include SDOs (X12, HL7, NACHA, NCPDP) and WEDI.





CAQH CORE

# What are Operating Rules?

**Operating Rules** are the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted. **CAQH CORE is the HHS-designated Operating Rule Author for all HIPAA-covered transactions, including Claims Attachments.**

| Industry Use Case | Standard | Operating Rule |
|---|---|---|
| **Healthcare** | Providers and health plans must use the ASC X12 v5010 270/271 Eligibility Request and Response transaction to exchange patient eligibility information. | When using the eligibility transaction, health plans must return patient financial information including copay and deductible in real-time. |
| **Finance** | Financial organizations must use ASC X9 standards in all ATM transactions with their clientele, standardizing layout, data content and messaging. | Financial organizations must use NACHA, the Electronic Payments Association, and the Federal Reserve operating rules for every automated clearinghouse (ACH) Transaction which allows consumers to use any debit card in any ATM around the world regardless of bank affiliation. |

Operating Rules **do not** specify whether or how a payer/provider structures a business process supported by an electronic transaction. For example, operating rules do not specify when or how prior authorization is used by a health plan; if prior authorization is used, operating rules specify how information regarding that transaction is electronically exchanged.

# CAQH CORE Operating Rules: Rule Set Crosswalk

## Phase-based Operating Rules Sets (sunsetting in Q2 2020)

**Phase IV**

- Health Care Claim (837) Infrastructure Rule
- Prior Authorization (278) Infrastructure Rule
- Benefit Enrollment (834) Infrastructure Rule
- Premium Payment (820) Infrastructure Rule
- Connectivity Rule

**Phase V**

- Prior Authorization (278) Data Content Rule
- Prior Authorization Web Portal Rule

## New Business Transaction-based Operating Rule Sets

**Prior Authorization & Referrals**

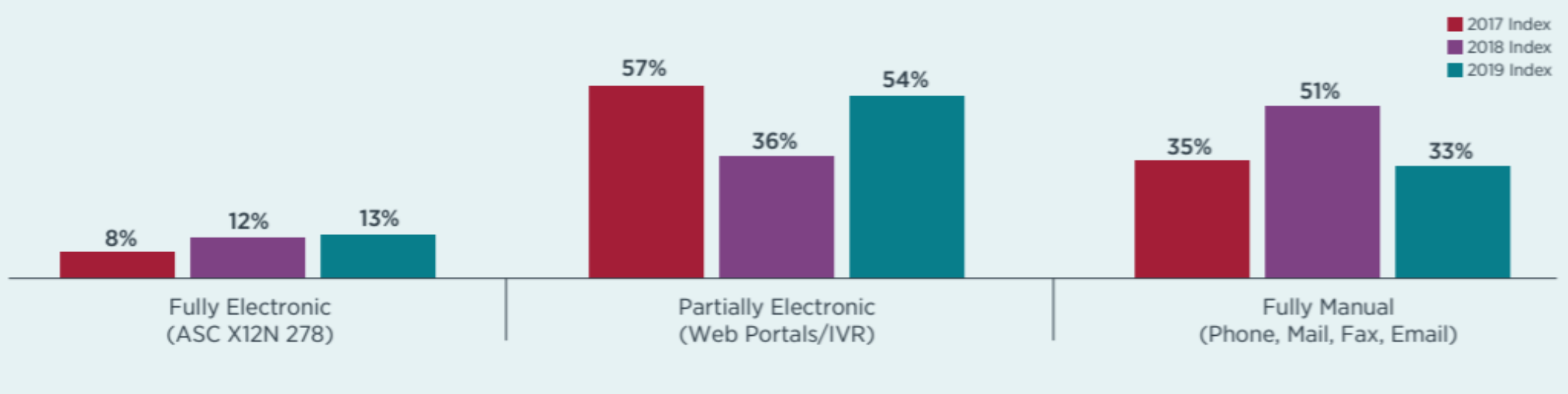
- Prior Authorization (278) Infrastructure Rule
- Prior Authorization (278) Data Content Rule
- Prior Authorization Web Portal Rule
- Connectivity Rule vC.3.0 (PIV)*

** End Goal: Single Connectivity Rule across rule sets*

# 2019 CAQH Index Report

*Medical Industry Electronic Transaction Adoption*

## Medical Plan Adoption of Prior Authorization, 2017-2019 CAQH Index




Source: 2019 CAQH Index





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# Barriers to Industry Adoption of Electronic Prior Authorization

## Key barriers preventing full automation and auto-adjudication of Prior Authorization

- There is **a lack of consistency** in use of data content across industry and electronic discovery of what information is required for an authorization request to be fully adjudicated.
- **No federally mandated attachment standard** to communicate clinical documentation.
- **Lack of integration** between clinical and administrative systems.
- **Limited availability** of vendor products that readily support the standard transaction.
- **State requirements** for manual intervention.
- **Lack of understanding** of the breadth of the information available in the 5010X217 278 Request and Response, and a lack of awareness that this standard prior authorization transaction is federally-mandated – particularly among providers.
- **Varying levels of maturity** along the standards and technology adoption curve, making interoperability a challenge.

## CAQH CORE Key Findings

Engaged 100+ industry organizations to identify how they communicate status, errors, next steps, and additional information needs. Due to wide variety, creates **confusion and delays** additional steps in the PA process.

**Low vendor support**: a supplement to the 2017 CAQH Index found that only 12% of vendors supported electronic prior authorization. For all other electronic transactions, vendor support was between 74% and 91%.

CAQH CORE environmental scans and industry polling reveal provider organizations are unaware of the **federal prior authorization standard** and health plans are required to accept it.





CAQH CORE

# Status of CAQH CORE Operating Rules Related to Prior Authorization

**Prior Authorization Operating Rules reduce administrative burden, close automation gaps and allow for patients to receive more timely care.**

## Provider Determines if PA is Required & Information Needed

*Provider identifies if PA is required and what documentation is required; collects info*

### Existing

- Standard Companion Guide
- Accurate patient identification
- Application of standard data field labels to proprietary web portals

### Under Consideration

- Use of codes to communicate if a PA is required and what documentation is needed

## Provider & Health Plan Exchange Information

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

### Existing

- System availability for standard transaction
- PA receipt confirmation
- Consistent connectivity and security methods
- Time requirement for initial response
- Consistent system availability for web portals
- Consistent review of diagnosis/procedure/revenue codes for adjudication
- Consistent communication of specific errors
- Display of code descriptions
- Use of codes to communicate reason for pend and additional documentation needed
- Response time requirement for requesting additional clinical information

### Under Consideration

- Updated, consistent connectivity modes for data exchange (APIs, REST)
- Consistent electronic exchange of additional clinical information

## Health Plan Adjudicates & Approves / Denies PA Request

*Health Plan reviews request and determines response; sends response to Provider*

### Existing

- Consistent connectivity and security methods
- Detection and display of code descriptions
- Response time requirement for final determination
- *Optional* – close out a prior authorization request if requested information is not received (Note: this is not an approval or denial).

### Under Consideration

- Updated, consistent connectivity modes for data exchange (APIs, REST)
- Reassociation of additional clinical documentation with prior authorization request

# Prior Authorization (278) Infrastructure Rule


The **CAQH CORE Prior Authorization Infrastructure Rule** specifies requirements for response times, system availability, acknowledgements, and companion guides. This rule establishes time frames for health plans to request supporting information from providers and to make final determinations.

## Key Rule Requirements

- ✓ Batch Processing Mode Response Time – If Batch Offered
- ✓ Batch Acknowledgements – If Batch Offered
- ✓ Real Time Processing Mode Response Time – If Real Time Offered
- ✓ Real Time Acknowledgements – If Real Time Offered
- ✓ Safe Harbor Connectivity and Security – Required
- ✓ System Availability – Required
- ✓ Companion Guide Template – Required
- ✓ Time Requirement for Health Plan to Request Additional Information/Documentation
- ✓ Time Requirement for Final Determination (Approval/Denial)
- ✓ Time Requirement for a 278 Close Out

# Prior Authorization (278) Infrastructure Rule Update

*Summary of New Updated Rule Requirements*

**The update enables timelier sending and receiving of batch and real time prior authorizations that are not emergent or urgent.**

1. **Time Requirement for Health Plan to Request Additional Information/Documentation:**
   - **Batch:** The health plan or its agent has **two business days** to review the 5010X217 278 Request and respond with a final determination or with additional documentation needed to complete the Request.
   - **Real Time:**
     - The health plan or its agent has **20 seconds** to review the 5010X217 278 Request and respond with a final determination or additional documentation needed to complete the Request **if additional documentation needs are immediately known**.
     - **The health plan or its agent has 20 seconds** to review and pend the 5010X217 278 Request when **additional documentation needs are unknown** at the time of request and then **two business days** to respond with additional documentation needed to complete the Request.
2. **Time Requirement for Final Determination (Approval/Denial):** The health plan or its agent has **two business days** to review the additional documentation (if additional documentation is required), once it has received all information from the provider, and send a 5010X217 278 Response containing a final determination.
3. **Time Requirement for a 278 Close Out:** The health plan or its agent **may choose** to close out a pended 5010x217 278 Request if the additional information needed to make a final determination is not received from the provider within **15 business days** of communicating what additional information is needed.

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

# Prior Authorization (278) Connectivity Rule


The **CAQH CORE Connectivity Rule** drives industry alignment by converging on common transport, message envelope, security and authentication standards to reduce implementation variations, improve interoperability and advance the automation of administrative data exchange.

## Key Rule Requirements

- ✓ Adds implementer feedback to improve the clarity of the rule wording.
- ✓ Increases network transport security.
- ✓ Separates the payload and processing mode documentation into separate documents for easier change maintenance.
- ✓ Simplifies interoperability:
  - Convergence to single message envelope
  - Single authentication standard
- ✓ Contains additional message interactions for conducting additional transactions.
- ✓ CORE Safe Harbor allows entities to implement the CAQH CORE Connectivity Rule across all transactions, or other connectivity methods.

# Prior Authorization (278) Request / Response Data Content Rule


The **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.

## 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.

# Prior Authorization Web Portals Rule


The **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. This rule supports an interim strategy to bring greater consistency to web portals given current widespread industry use, with a long-term goal of driving adoption of standard transactions.

## 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.

# CAQH CORE Prior Authorization Pilot Initiative

*Vision, Goals, Participation Options*

## Initiative Vision

**Partner with industry organizations to measure the impact of existing and new CAQH CORE prior authorization operating rules and corresponding standards on organizations' efficiency metrics.**

## Goals for Initiative

- **Apply existing and test new operating rules** that support greater automation of the end-to-end PA workflow.
- **Ensure that operating rules support industry organizations** in varying stages of maturity along the standards (existing and emerging: X12, HL7 FHIR, etc.) and technology adoption curve.
- Identify opportunities to **refine existing rules and prioritize new rules** to continue to close critical automation gaps.
- Quantify impact to support potential rule recommendations for **national implementation** to NCVHS and HHS.

## Participation Options

Work with CAQH CORE subject matter and measurement experts to:

**Option 1.** Track and articulate the impact of an *existing* prior authorization automation project within your organization.

**Option 2.** Track and articulate the impact of a *new* implementation of operating rules and standards.

# CAQH CORE Rule Package for NCVHS/HHS Consideration

*Prior Authorization & Connectivity Operating Rules Increase Value & Use of Electronic Transactions*

- In February 2020, the CAQH CORE Board sent a letter to NCVHS proposing a CAQH CORE Prior Authorization and Connectivity Operating Rules package for recommendation to the HHS Secretary for national adoption under HIPAA that includes:
  - **CAQH CORE Prior Authorization (278) Data Content Rule v5.0.0**
  - **CAQH CORE Prior Authorization (278) Infrastructure Rule v4.1.0**
  - **CAQH CORE Connectivity Rule v4.0.0**

- The Board proposed this rule package for federal mandate for three reasons:

1. The prior authorization operating rules address a pressing need to improve automation and timeliness of the prior authorization process.
2. The connectivity operating rule enhances security and promotes uniform interoperability requirements across administrative transactions.
3. These operating rules set the stage for future operating rules to further enable the critical convergence of administrative and clinical data and support the use of new technologies with existing standards.

**A NCVHS hearing on the proposed rule package is scheduled for later this year in Washington, D.C.**

# Polling Question #1

**How do you currently transmit an authorization request? (Select all that apply).**

- 278 transaction
- Web portal
- Phone, mail, fax, email
- Other (DIRECT messaging, APIs)

# At a Glance: Return on Investment


## Average Cost per Transaction

| Transaction | Method | Plan Cost | Provider Cost | Industry Cost | Plan Savings Opportunity | Provider Savings Opportunity | Industry Savings Opportunity |
|---|---|---|---|---|---|---|---|
| Prior Authorization | Manual | $3.32 | $10.92 | $14.24 | $3.27 | $9.04 | $12.31 |
| | Partial | $0.05 | $3.99 | $4.04 | $0.00 | $2.11 | $2.11 |
| | Electronic | $0.05 | $1.88 | $1.93 | | | |

**Source:** [2019 CAQH Index]

# Audience Q&A

**Please submit your questions**

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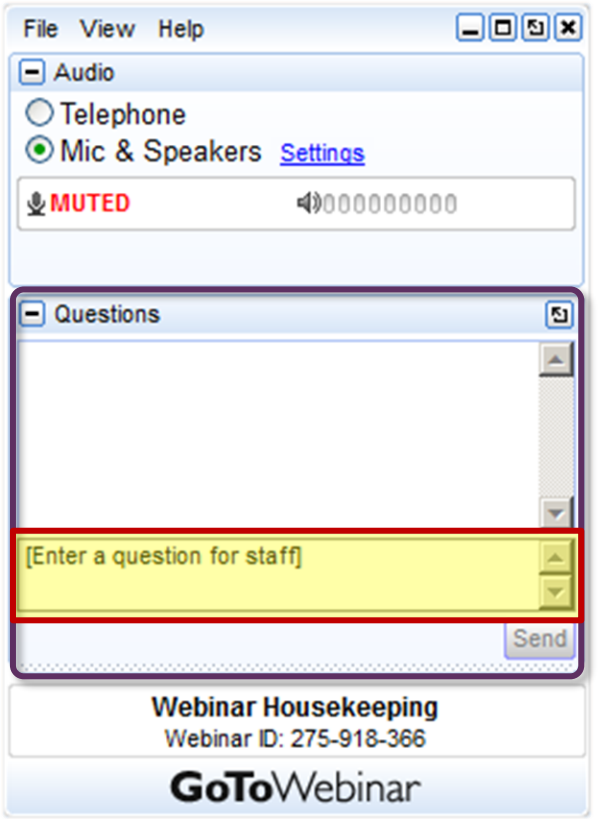


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