CAQH Committee on Operating Rules for Information Exchange (CORE)
CAQH CORE Eligibility and Benefits Task Group (EBTG)
ASG-CL Straw Poll #1: Non-Substantive Comments and Dropped Opportunity Area Comments

Non-Substantive Comments and Comments Received on Dropped Opportunity Areas on CAQH CORE EBTG Straw Poll 1

Table 1. Non-Substantive Comments

Table 1 summarizes non-substantive comments received by EBTG Straw Poll #1 respondents along with CAQH CORE EBTG Co-chair and staff response, when applicable.

Table 1.

#	Summary of Comment	EBTG Co-Chair and CAQH Core Staff Response
	Telemedicine	
1.	One entity expressed that telemedicine is the future and the new normal, so it must be addressed.	N/A
2.	One entity indicated support the use of external codes for communication of telemedicine services, but not making it a requirement.	Based on high levels of support, CAQH CORE will draft rule requirements related to the use of codifiable methods to communicate and return telemedicine services using the X12 v5010 27/271.
3.	One entity noted that as telemedicine becomes more prevalent, being able to communicate telemedicine services in codifiable ways would be valuable.	N/A
4.	One entity stated that the level of effort for implementing a telemedicine rule requirement would be low for clearinghouse and medium for hosted data services.	N/A
5.	One entity expressed support for codifiable methods to communicate telemedicine benefits. However, the entity expressed concern that the informative value of this operating rule will be limited unless CAQH CORE also pursues a rule requiring implementers to communicate benefit information at the procedure level (for example, to address situations where telemedicine coverage is available for certain types of visits within a codified service type, but not others).	
	STC Codes	
6.	On entity expressed support for Option A over Option B, given that X12 v8020 270/271 is expected to require industry support for all STCs.	Based on high levels of support, CAQH CORE will move forward with the Option B to require that a selected group of STCs (to be determined through consensus-based process by the EBTG) listed within the X12 v5010 270/271 TR3 become CORE-required for an explicit inquiry. Further, CAQH CORE will also draft rule requirements related to the use of procedure codes for coverage and benefit determination using the X12 v5010 27/271.
7.	One entity commented that they only support STC 30 in the X12 270 inquiry. Further, the entity expressed it would find it valuable to expand and support the use of additional Service Type Codes.	N/A

8.	One entity stated that level of effort for implementing additional STCs would be low for clearinghouses and high for hosted data services. The entity expressed preference for Option B as the impact will be difficult for smaller payers to adopt.	Based on high levels of support, CAQH CORE will move forward with the Option B to require that a selected group of STCs (to be determined through consensus-based process by the EBTG) listed within the X12 v5010 270/271 TR3 become CORE-required for an explicit inquiry.
9.	One entity noted that both options will require business analysis and system updates to support the mapping of additional service type codes to applicable benefit packages.	N/A
10.	One entity commented that adding few more STCs as needed from time to time may be less burdensome for trading partners to implement compared to adding all 135 remaining STCs at once for an explicit inquiry.	Based on high levels of support, CAQH CORE will move forward with the Option B to require that a selected group of STCs (to be determined through consensus-based process by the EBTG) listed within the X12 v5010 270/271 TR3 become CORE-required for an explicit inquiry.
Remaining Coverage Benefits		
11.	One entity indicated remaining coverage benefits is the top opportunity areas for their organization.	N/A
Tiered Benefits		
12.	One entity stated that level of effort for implementing tiered benefits is low for clearinghouses and high for hosted data services.	N/A
Procedure Codes		
13.	One entity stated that implementation complexity would normally be high, but their organization has already done mapping for their web portal to handle these inquiries.	N/A
14.	One entity expressed strong support for support pursuing procedure codes as an opportunity and indicated that it should be priority for the EBTG.	Based on high levels of support CAQH CORE will draft rule requirements related to the use of procedure codes for coverage and benefit determination using the X12 v5010 270/271. EBTG Participants will have the opportunity on future calls and straw polls to give feedback on draft rule requirements.
15.	One entity commented that being able to verify coverage and benefit information for procedures, specifically those that are high dollar values, would be of industry value.	Based on high levels of support CAQH CORE will draft rule requirements related to the use of procedure codes for coverage and benefit determination using the X12 v5010 270/271. EBTG Participants will have the opportunity on future calls and straw polls to give feedback on draft rule requirements.
16.	One entity stated that their eligibility and benefit system would need to be updated to support procedure code reporting affiliated with benefit packages.	Based off high levels of support, CAQH CORE will engage the EBTG in consensus-building via future calls and straw polls to identify procedure codes and/or categories of codes to require as part of the draft rule update.
17.	One entity commented that for processors support procedure level benefits, then specific procedure codes should be defined by operating rules, otherwise processors shouldn't be required to support the capability.	Based off high levels of support, CAQH CORE will engage the EBTG in consensus-building via future calls and straw polls to identify procedure

		codes and/or categories of codes to require as part of the draft rule update.
18.	One entity expressed that supporting all procedure codes today, also takes care of tomorrow, as new codes are added.	Based off high levels of support, CAQH CORE will engage the EBTG in consensus-building via future calls and straw polls to identify procedure codes and/or categories of codes to require as part of the draft rule update.
19.	One entity expressed support for pursuing procedure code based operating rules but indicated that rule requirements should apply to all procedure codes.	Based off high levels of support, CAQH CORE will engage the EBTG in consensus-building via future calls and straw polls to identify procedure codes and/or categories of codes to require as part of the draft rule update.
20.	One entity noted that that an operating rule should require procedure code based inquires and responses only if such a request is supported by the processor.	Based on high levels of support CAQH CORE will draft rule requirements requiring health plans to return coverage and benefit information on an X12 v5010 271 response when a CORE-required procedure code is received on v5010 270 inquiry.
Authorization		
21.	One entity commented that the X12 278 transaction is used for authorization. Further, the entity noted that rarely the specific procedure code is known at the time of eligibility is checked. As such, the entity expressed that excessive amount of time required to implement when the appropriate use will be so low	CAQH CORE Participants identified authorization determination as a priority topic for CAQH CORE to address via the CAQH CORE Eligibility & Benefit Rule Update.
22.	*Authorization – Requirement A* One entity indicated that they are currently supporting this requirement. However, the entity noted that the way health plans are changing, the authorization indicator can vary within the STC, which makes it difficult to communicate it accurately at the STC level.	Draft rule requirement would apply to CORE-required Service Type Codes, to be determined by the Task Group through a consensus-based process.
23.	*Authorization – Requirement B* One entity commented that to implement this requirement it would require them to completely change the logic of identifying if authorization is needed or not.	N/A
24.	*Authorization – Requirement B* One entity stated that their eligibility and benefit system would need to be updated to support procedure code reporting affiliated with benefit packages.	Draft rule requirement would apply to CORE-required Procedure Codes, to be determined by the Task Group through a consensus-based process.
25.	*Authorization – Requirement B*	Based on high levels of support CAQH CORE will draft rule requirements related to authorization and certification requirements at the Procedure Code level. EBTG Participants will have the opportunity

	One entity expressed support for supporting authorization determination (Y/N) at the procedure code (CPT) level. Further, the entity noted that providers will also want a way (reference #, etc.) to provide proof that payer provided a No Authorization Required response in the event of a post-service claim denial or appeal.	on future calls and straw polls to give feedback on draft rule requirements.
26.	*Authorization – Requirement C* On entity stated they would prefer support for all diagnosis codes, not just CORE-specified.	This potential rule requirement to use diagnosis codes for certification determination received less than 70% support. As such, CAQH CORE EBTG Co-chairs and staff recommended to not pursue this potential rule requirement for the CAQH CORE Eligibility & Benefit Rule Update. This topic will be revisited and considered for evaluation in a future rule update.
27.	*Authorization – Requirement C* One entity stated their eligibility and benefit system does not currently support diagnosis linkage to benefit packages.	This potential rule requirement to use diagnosis codes for certification determination received less than 70% support. As such, CAQH CORE EBTG Co-chairs and staff recommended to not pursue this potential rule requirement for the CAQH CORE Eligibility & Benefit Rule Update. This topic will be revisited and considered for evaluation in a future rule update.
	Certification	
28.	*Certification - Rule Requirement B* One entity expressed support for certification determination at the procedure code (CPT) level. However, the entity indicated that procedure codes on their own may not be enough to ascertain medical necessity.	Based on high levels of support CAQH CORE will draft rule requirements related to authorization and certification requirements at the Procedure Code level. EBTG Participants will have the opportunity on future calls and straw polls to give feedback on draft rule requirements.
29.	*Certification - Rule Requirement C* One entity noted that diagnosis codes are good indicators of medical necessity. However, they indicated that Certification Y/N determination using a combination of diagnosis code(s) and procedure code(s) would be highly effective.	Based on high levels of support CAQH CORE will draft rule requirements related to authorization and certification requirements at the Procedure Code level. EBTG Participants will have the opportunity on future calls and straw polls to give feedback on draft rule requirements. However, the potential rule requirement to use diagnosis codes for certification determination received less than 70% support. As such, CAQH CORE EBTG Co-chairs and staff recommended to not pursue this potential rule requirement for the CAQH CORE Eligibility & Benefit Rule Update. This topic will be revisited and considered for evaluation in a future rule update.
30.	*Certification - Rule Requirement C*	This potential rule requirement to use diagnosis codes for certification determination received less than 70% support. As such, CAQH CORE EBTG Co-chairs and staff recommended to not pursue this potential

	On entity stated they would prefer support for all diagnosis codes, not just CORE-specified.	rule requirement for the CAQH CORE Eligibility & Benefit Rule Update. This topic will be revisited and considered for evaluation in a future rule update.

Table 2. Comments Received on Dropped Opportunity Areas

Table 2 summarizes comments received by EBTG Straw Poll #1 respondents on dropped opportunity areas along with CAQH CORE EBTG Co-chair and staff response, when applicable.

Table 2.

#	Summary of Comment	EBTG Co-Chair and CAQH CORE Staff Response
	Diagnosis Codes	
1.	One entity noted that diagnosis codes alone do not always map to coverage limitations. Further, the entity indicated that in some instances diagnosis and procedure codes determine benefit coverage, such services related to ESRD.	This potential rule requirement received less than 70% support. As such, CAQH CORE EBTG Co-chairs and staff recommended to not pursue this potential rule requirement for the CAQH CORE Eligibility & Benefit Rule Update. This topic will be revisited and considered for evaluation in a future rule update.
2.	One entity stated that CPT and Diagnosis codes should go hand in hand.	
3.	One entity commented that if defined and implemented appropriately, this could be of value in situations when a procedure code or service type would vary based upon diagnosis.	
4.	One entity explained that level of complexity would be determined based on the number of diagnosis codes selected.	
5.	One entity stated that this would be a complex requirement to implement.	
	Provider Network Status	
6.	One entity offered support for communication of provider network status but noted any tiering should be communicated as well.	This potential rule requirement received less than 70% support. As such, CAQH CORE EBTG Co-chairs and staff recommended to not pursue this potential rule requirement for the CAQH CORE Eligibility & Benefit Rule Update. This topic will be revisited and considered for evaluation in a future rule update.
7.	One entity indicated that the NPI the provider uses is not always what is used on the claim for adjudication.	
8.	One entity explained that network status is only as good as the provider data that is received on the X12 270.	
9.	One entity commented that additional factors beyond NPI may be needed such as location or taxonomy to determine provider network status.	
10.	One entity expressed support for requiring health plans to return a provider's network status in the X12 271. The entity further noted that network status should be calculated from the most specific NPI sent in the X12 270.	
11.	One entity stated that they unsure of how provider network status would be handled in the X12 v5010 270/271.	

CAQH Committee on Operating Rules for Information Exchange (CORE)
CAQH CORE Eligibility and Benefits Task Group (EBTG)
ASG-CL Straw Poll #1: Non-Substantive Comments and Dropped Opportunity Area Comments

AAA Error Code Reporting		
12.	One entity expressed that they do not support returning anything other than the X12 999 transaction.	This potential rule requirement received less than 70% support. As such, CAQH CORE EBTG Co-chairs and staff recommended to not pursue this potential rule requirement for the CAQH CORE Eligibility & Benefit Rule Update. This topic will be revisited and considered for evaluation in a future rule update.
13.	One entity indicated that that there is a need for work around error reporting but would like EBTG feedback on industry approaches to this issue, including potential structural changes within the X12 v8020 270.	
14.	One entity noted that this potential rule option would cause more confusion rather than clarity.	
15.	One entity asked how a health plan is to know if a submitter does not accept a X12 999.	
16.	One entity commented that development of operating rules specifying when to use each of the error codes could help with data quality and ensuring the claim reflects an accurate picture.	
17.	One entity stated that existing CAQH CORE Operating Rules require submitters to support X12 999 acknowledgments in response to a X12 inquiry. Further, the entity indicated that, if the receiver cannot process the 270/271 due to system outage a AAA03 value of 42 in the 271 could convey this in Loop 2000A.	
18.	One entity commented that health plans apply error codes in different ways which leaves providers guessing about the patient's coverage.	
Coordination of Benefits (COB)		
19.	One entity expressed more clarity is needed around this rule option and that rule development for COB would be potentially complex.	This potential rule requirement received less than 70% support. As such, CAQH CORE EBTG Co-chairs and staff recommended to not pursue this potential rule requirement for the CAQH CORE Eligibility & Benefit Rule Update. This topic will be revisited and considered for evaluation in a future rule update.
20.	One entity noted that this rule option would help to resolve challenges around knowing if a patient has additional coverages.	
21.	One entity indicated that COB needs its own workgroup and should be out of scope for the EBTG.	
22.	One entity indicated that COB may be out of scope for the EBTG.	
Patient Data Sharing		
23.	One entity stated that it is unclear how this rule would work with the following two moving pieces: 1) payers sharing membership data with other payers, and 2) including this information in the existing X2 271 structures.	This potential rule requirement received less than 70% support. As such, CAQH CORE EBTG Co-chairs and staff recommended to not pursue this potential rule requirement for the CAQH CORE Eligibility & Benefit Rule Update. This topic will be revisited and considered for evaluation as part of a separate work group.
24.	One entity noted that cost sharing data is so patient-specific and relies heavily on individual benefits, particularly deductibles.	
25.	One entity expressed that the X12 270/271 should not be used for patient data sharing as there are other transactions that would be more appropriate.	
26.	One entity noted that patient data sharing is out of scope for CAQH CORE.	
27.	One entity stated that patient data sharing is a huge undertaking and is too much for the EBTG to address.	

28.	One entity commented that patient data sharing is a topic of discussion in the industry now and should be considered for review.	
29.	One entity expressed that helping a patient understand the level of benefits they will use for a given provider is very challenging for providers. They noted that this is the single biggest challenge with patient facing estimator tools. Further stating that if payors want downward pressure on healthcare costs, they should fix this today, in that it needs to be uniformity across payors, so it can be reliably displayed to patients.	
30.	One entity stated that it might not be known to the payer that the data being returned will be on a consumer facing application. The entity further explained that if done via FHIR, a request is a request and does not depend upon who the requestor is.	