CAQH Committee on Operating Rules for Information Exchange (CORE)
Review Work Group (RWG)
Doc 3: RWG Straw Poll #2 Results

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1. Overview

1.1 Background on CAQH CORE Eligibility & Benefits Data Content Rule Update

In Fall 2020, CAQH CORE Participants identified the eligibility and benefits business process as an area for CAQH CORE to prioritize for operating rule enhancement in 2021.

In Spring 2021, CAQH CORE launched a Task Group to evaluate opportunity areas for operating rule enhancement for the existing CAQH CORE Eligibility & Benefits Data Content Rule. The Task Group evaluated numerous opportunities and after discussion and feedback among Task Group participants, drafted updated operating rule requirements for the following areas:

1. **Telemedicine**: Addressed the emergent need to communicate telemedicine-specific eligibility and benefit information
2. **Service Type Codes**: Added additional SCT Codes beyond the current 52 CORE-required STC codes
3. **Remaining Coverage Benefits**: Supported the communication of the number of remaining visits/services left on a benefit
4. **Procedure Codes**: Added the ability to respond to eligibility and benefit requests at the procedure level (e.g., CPT, HCPCS)
5. **Prior Authorization/Certification**: Added the ability to communicate if a prior authorization/certification is required for a specific procedure or service
6. **Tiered Benefits**: Specified more granular level data for members of tiered benefit plans

On its 09/23/21 call, the RWG reviewed the updates to the Draft CAQH CORE Eligibility & Benefit Rule in preparation for this straw poll.

1.2 Background on Potential Updates to Existing CAQH CORE Infrastructure Operating Rules

Each set of CAQH CORE Operating Rules includes an infrastructure rule with requirements for processing mode, response time, system availability, connectivity, acknowledgements, and companion guides, by transaction. Many of these requirements were developed more than ten years ago during the early phases of CAQH CORE operating rule development.

In response to feedback from CAQH CORE Participants and the CAQH CORE Board, a survey was sent to all CAQH CORE Participants to identify areas where there may be consensus to update the infrastructure requirements across the CAQH CORE Infrastructure Rules with a focus on system availability and processing mode response times:

1. CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule vEB.1.0
2. CAQH CORE Claim Status (276/277) Infrastructure Rule vCS.1.0
3. CAQH CORE Payment & Remittance (835) Infrastructure Rule vPR.1.0
4. CAQH CORE Prior Authorization & Referrals (278) Infrastructure Rule vPA.2.0
5. CAQH CORE Health Care Claim (837) Infrastructure Rule vHC.1.0
6. CAQH CORE Benefit Enrollment (834) Infrastructure Rule vBE.1.0
7. CAQH CORE Premium Payment (820) Infrastructure Rule vPP.1.0
8. CAQH CORE Attributed Patient Roster (X12 005010X318 834) Infrastructure Rule vAPR.1.0

The Infrastructure Operating Rules Update Survey was distributed in September. On its 10/21/21 call, the RWG reviewed the results and discussed comments received in preparation for this straw poll.

1.3 Format of Straw Poll

RWG participants reviewed each rule, by section. Items reviewed are listed below in the order that they appeared on the straw poll.

Part A: CAQH CORE Eligibility & Benefits Data Content Rule Update

1. §1.1 Issue to be Addressed and Business Requirement Justification
2. §1.2 Scope
3. §1.3 Service Type Codes: Electronic Delivery of Patient Financial Information and Benefit Information Rule Requirements
4. §1.4 Procedure Codes: Electronic Delivery of Patient Financial and Benefit Information Rule Requirements
5. §1.5 Tiered Benefits
6. §5 Appendix

Part B: CAQH CORE Infrastructure Operating Rules Update

7. System Availability Requirements (two questions)
8. Real Time Processing Mode Requirement
9. Batch Processing Mode Response Time Requirement for Benefit Enrollment
10. Batch Processing Mode Response Time Requirement for Premium Payment

2. Summary of Straw Poll Respondents

Responses were received from **34** respondents representing **74%** of RWG participating organizations.

Total Number of Individual Responses	34 (74% of the RWG)
Number of Provider/Provider Associations Responses	6 (18% of responses)
Number of Health Plan/Health Plan Associations Responses	13 (38% of responses)
Number of Vendor/Clearinghouse Responses	8 (24% of responses)
Number of Government Responses	2 (6% of responses)
Number of 'Other' (includes standards organizations) Responses	5 (15% of responses)

3. Percent Support for *Draft CAQH CORE Eligibility & Benefits Data Content Rule*

When the straw poll closed on Monday, 11/08/21, each updated *Draft CAQH CORE Eligibility & Benefits Data Content Rule* section received at least **83%** support, as shown in Table 1 below.

Table 1. Percent Support for the *Draft CAQH CORE Eligibility & Benefits Data Content Rule*

PART A: Draft CAQH CORE Eligibility & Benefits Data Content Rule Update			
	Support (%)	**Do Not Support (%)**	**Abstain**
§ 1.1 Issue to be Addressed	29 (94%)	2 (6%)	3
§ 1.2 Scope	29 (91%)	3 (9%)	2
§ 1.3 Service Type Codes: Electronic Delivery of Patient Financial and Benefit Information Rule Requirements	26 (84%)	5 (16%)	3
§ 1.4 Procedure Codes: Electronic Delivery of Patient Financial and Benefit Information Rule Requirements	25 (83%)	5 (17%)	4
§ 1.5 Tiered Benefits	23 (88%)	3 (12%)	8
§ 5 Appendix	28 (93%)	3 (7%)	3

4. Summary of RWG Straw Poll Comments Received

Respondents were given the opportunity to provide comments on each of the questions asked on the straw poll. As always, comments were categorized into one of three categories.

1. **Points of Clarification** – Pertain to areas where more explanation for the work group is required*; may* require adjustments to the draftrules, which do not change rule requirements.
2. **Substantive Comments** – May impact rule requirements; some comments require work group discussion on suggested adjustments tothe draft requirements.
3. **Non-substantive Comments** – Pertain to typographical/grammatical errors, wordsmithing, clarifying language, addition of references; donot impact rule requirements.

The tables in Sections 5 and 7 summarize substantive comments and points of clarification submitted by RWG Straw Poll #2 respondents along with the summary of adjustments, as applicable.

5. Comments Received on *Draft CAQH CORE Eligibility & Benefits Data Content Rule*

5.1 Points of Clarification Received on *Draft CAQH CORE Eligibility & Benefits Data Content Rule*

Table 2 summarizes points of clarification comments by RWG respondents pertaining to *Draft CAQH CORE Eligibility & Benefits Data Content Rule* and RWG co-chair and staff response, when applicable.

Note: No Substantive comments were received on *Draft CAQH CORE Eligibility & Benefits Data Content Rule.* Non-substantive comments are summarized in the Appendix of this document.

Table 2. Points of Clarification Received on *Draft CAQH CORE Eligibility & Benefits Data Content Rule*

#	Section	Summary of Comment(s)	RWG Co-chair and CAQH Core Staff Response
1.	§ 1.3 Service Type Codes	One entity noted there are more values other than IND or FAM that can be returned in the EB02 segment and that they are not required to return an element in the EB02 segment.	**Do not adjust.** CAQH CORE Operating Rules require the use of the EB02 segment for individual and family deductibles, when applicable.
2.	§ 1.3 Service Type Codes - Telemedicine	One entity suggested that Place of Service Code 10 = Telehealth Provided in Patient's Home should also be included as part of the rule requirement, in addition to Place of Service Code 02 = Telehealth Provided Other than in Patient's Home.	**Agree to adjust.** CAQH CORE Co-chairs and staff recommend including Place of Service Code 10 to the rule, as it was recently added to Centers for Medicare and Medicaid Place of Service (POS) Codes for Telehealth in October 2021. **See: New/Modifications to the Place of Service (POS) Codes for Telehealth
3.	§ 1.3 Service Type Codes - Telemedicine	One entity noted Telehealth can be used for PCP office visits and/or mental health office visits and asked for clarification on which STC Codes are allowable per rule requirements to identify Telemedicine coverage.	**Do not adjust.** CAQH CORE Operating Rules for Telehealth allow health plans to use any applicable STC Code available for Telemedicine.

#	Section	Summary of Comment(s)	RWG Co-chair and CAQH Core Staff Response
4.	§ 1.3 Service Type Codes – Telemedicine	One entity noted the language used in the draft telemedicine rule requirement is still under review by X12 in the Draft RFI #2486.	**Do not adjust.** X12 has drafted an RFI, Draft RFI #2486, which addresses the codification of Telemedicine to replace RFIs #1957 and #2136. While the RFI is still under review within the X12 RFI process, CAQH CORE can provide guidance to the industry by aligning operating rules to the draft RFI for addressing telemedicine in the X12 v5010 270/271. Further, on EBTG Straw Poll #1, 90% of organizations supported the approach of using a codifiable method to communicate telemedicine benefit information via the X12 v5010 271 Response for a specific Service Type Code.
5.	§ 1.3 Service Type Codes – Remaining Coverage Benefits	One entity expressed concerns over the Remaining Benefit with Date ranges and suggests extending the date range for the future.	**Do not adjust.** CAQH CORE Operating Rules aim to establish a floor and not a ceiling. At a minimum, health plans are required to support coverage information for 12 months into the past or in the future to end of the current month. Rule requirements do not preclude health plans from returning eligibility and benefit information outside of these date ranges.
6.	§ 1.4 Procedure Codes	One entity noted Surgery is too generic for a category and suggested it should be specific to a surgery procedure code.	**Do not adjust.** Categories of Service refer to the business grouping of healthcare services or benefits. Service type codes, procedure codes, revenue codes, and diagnosis codes can all be grouped into categories of service. The approach of classifying procedure codes via categories of service was used when drafting the CAQH CORE Prior Authorization Data Content Rule. The categories of service requirements are placed on health plans to process a limited set of use cases for when a particular CPT or HCPCS code falls into a set of categories identified in the rule. When those CPT or HCPCS codes fall outside these categories of service the rule requirements do not apply. The rule requirements would be analogous to how the existing CAQH CORE Eligibility & Benefits (270/271) Data Content Rule addresses requirements for STCs. For example, if a health plan receives an explicit procedure code inquiry, and the procedure code falls into a CORE-required Category of Service, the health plan must return a response for the procedure code received.

#	Section	Summary of Comment(s)	RWG Co-chair and CAQH Core Staff Response
7.	§ 1.4 Procedure Codes	Two entities commented on the inclusion of Service Categories and Procedure Codes. − One entity asked why PT, OT, Imaging, and Surgery were only included as Service Categories. − One entity noted that they do not support procedure codes on inquires and responses and suggested that the rule should not be mandatory.	**Do not adjust**. Given 83% of RWG Participants supported Section 1.4 Procedure Codes, as written, RWG Co-chairs and CORE Staff do not recommend adjusting the Service Categories or Procedure Codes. Additionally, EBTG Participants engaged in consensus-building via calls, feedback forms, and straw polls and received high levels of support to include this limited set of categories of service that health plans should be required to return coverage and benefit information on an X12 v5010 271 Response when a procedure code is received on v5010 270 Inquiry. These requirements are not mandated under HIPAA.
8.	§ 1.5 Tiered Benefits	One entity noted providing tiered benefit information should only be enforced with a codified system and that allowing varying values to be used in the MSG segment to indicate the type of tier could create confusion. They further noted that they only way network status can be identified in an X12 v5010 271 response is if a provider is included in an X12 v5010 270 inquiry.	**Do not adjust.** In reference to how required tiered benefit information should communicated, it is recommended that operating rule implementers follow guidance from X12 RFI #1767. As the X12 v5010 270/271 does not currently address tiered benefits, implementers may have to use a combination of codifiable approaches and the MSG segment.
9.	§ 1.5 Tiered Benefits	One entity asked for clarification on the differences between 1.5.1. *Member Tiered Benefit Coverage* and 1.5.2. *Provider Tiered Benefit Reimbursement*.	**Do not adjust.** Member Tiered Benefit refers to the communication of coverage information (deductible, co-payment, co-insurance, coverage level, etc.) specific to the member in relationship to a corresponding benefit tier. Provider Network Reimbursement refers to the communication of a provider's tier status (in-network, out-of-network, exclusive/preferred, etc.) and return of coverage information specific to a patient's benefit
10.	§ 1.5 Tiered Benefits	One entity suggested to add specificity to what the MSG segment content must begin with for the following rule requirement; they requested boilerplate language for clarity.	**Agree to adjust.** RWG Co-chairs and CORE staff recommend updating the rule requirement for the MSG segment when a tiered benefit cannot be determined to include: **"MSG*Benefit Tier cannot be determined."**
11.	§ 5 Appendix	Two entities noted that they do not support the inclusion of Transplant as a mandatory STC.	**Do not adjust.** Given 93% of RWG Participants supported the Appendix, as written, RWG Co-chairs and CORE Staff do not recommend removing Transplant as a mandatory STC. Additionally, EBTG Participants engaged in consensus-building via calls, feedback forms, straw polls and had high levels of support in identifying which Service Type Codes should be added to the CORE-Required STC List for mandatory and discretionary reporting.

6. Percent Support for Potential Updates to Existing *CAQH CORE Infrastructure Operating Rules*

Table 3 below summarizes the results of the potential updates to the existing *CAQH CORE Infrastructure Operating Rules* when RWG Straw Poll #2 closed on Monday, 11/08/21.

Table 3. Percent Support for the *Draft CAQH CORE Infrastructure Operating Rules*

Part B: CAQH CORE Infrastructure Operating Rule						
Requirements	**86%**	**90%**	**93%**	**95%**	**Abstain**	
Weekly System Availability	13 (42%)	6 (19%)	4 (13%)	8 (26%)	3	
	8 hours	**12 hours**	**18 hours**	**24 hours**	**Abstain**	**Do Not Support**
Quarterly System Downtime Requirements*	4 (14%)	5 (17%)	2 (7%)	14 (48%)	5	4 (14%)
	15 seconds	**20 seconds**			**Abstain**	
Real Time Processing Mode Response Time	9 (27%)	24 (73%)			1	
	2nd Business Day	**3rd Business Day**			**Abstain**	
Batch Processing Mode Response Time - Benefit Enrollment	12 (41%)	17 (59%)			5	
Batch Processing Mode Response Time - Premium Payment	13 (43%)	17 (57%)			4	

*On its 10/21/21 call, the RWG discussed various options to update system availability downtime. RWG Participants recommended adding an option for additional quarterly system downtime *if the weekly system availability requirement was increased*, to accommodate system migrations, mitigation, and more integrated system needs.

7. Comments Received on Potential Updates to Existing *CAQH CORE Infrastructure Operating Rules*

7.1 Substantive Comments Received on Potential Updates to Existing *CAQH CORE Infrastructure Operating Rules*

Table 4 below summarizes substantive comments received by RWG respondents pertaining to potential updates to existing *CAQH CORE Infrastructure Operating Rules* and RWG co-chair and staff response, when applicable.

Note: No Point of Clarification comments were received on the potential updates to existing *CAQH CORE Infrastructure Operating Rules.* Non-substantive comments are summarized in the Appendix of this document.

Table 4. Substantive Comments Received on Potential Updates to Existing *CAQH CORE Infrastructure Operating Rules*

#	Section	Summary of Comment(s)	RWG Co-Chair and CAQH Core Staff Response
1.	General Comments	One entity recommended waiting to update the infrastructure requirements until the new HIPAA standards are released and implemented, given the new standards may increase the need for system downtime. **NOTE**: This comment was made throughout the Infrastructure Update questions.	The intent of the CAQH CORE Infrastructure Rule Update is to align requirements to evolving business needs and technology that may have matured in the years since initial development of the requirements. As such, RWG Co-chairs and staff recommend moving forward with the infrastructure updates that CORE Participants and RWG Straw Poll Respondents voted to pursue, including weekly and quarterly system availability adjustments. CAQH CORE has a detailed maintenance process to update CAQH CORE Operating Rules when new versions and standards are made available and when HHS designates them for mandate. Additionally, CAQH CORE plans to consider updates to the CAQH CORE Infrastructure Rules on a regular basis to continue to ensure alignment with technological advancements in the industry.
2.	Weekly System Availability	Two entities commented that vendor systems are interdependent, making it difficult for the industry to meet more stringent system availability requirements.	Given 58% of RWG Straw Poll respondents selected a system availability percentage above 86%, RWG Co-chairs and CORE staff recommend increasing system availability to 90% across all transactions. 90% system availability represents a step towards increasing total system availability, while understanding that the industry may not be ready for the higher system availability percentages under consideration.
3.	Weekly System Availability	One entity suggested that system availability requirements could be different for Batch and Real Time Processing Modes, as an alternative to increasing system availability for Batch Processing while keeping Real Time at 86% system availability.	RWG Co-chairs and CORE staff recommend that this be considered during the next infrastructure review. CAQH CORE will conduct environmental scans to obtain additional data to share and for work group review. Separate requirements may make better business sense as we move to a more API driven interaction between providers and health plans.
4.	Real Time Processing Mode Response Time	Two entities noted that file size should be taken into consideration when deciding Real Time Processing Mode Response Times, as large file sizes would present a barrier to the adoption of Real Time Processing for certain transactions.	Given 73% of RWG straw poll respondents voted to maintain the existing requirement, RWG Co-chairs and CORE staff recommend not adjusting the existing Real Time Processing requirement of 20-seconds or less but suggest file size should be considered for future updates to the requirement.

5.	Batch Processing Mode Response Time – Premium Payment	One entity recommended the group consider adoption of the current CMS eight day required response time for Batch Processing of Premium Payments.	The current requirement specifies a response by the third business day when using Batch Processing for premium payments. The intent of the CAQH CORE Infrastructure Update is to move the industry forward to align with evolving technology and business needs. As such, adjusting the response time requirement to allow for an eight-business day response time does not support the goal of increasing efficiency and reducing time to payment and patient care within the healthcare industry.

8. Appendix

The tables in Section 8 summarize non-substantive comments submitted by RWG Straw Poll #2 respondents along with the summary of adjustments, as applicable.

8.1 Non-Substantive Comments Received on *Draft CAQH CORE Eligibility & Benefits Data Content Rule*

Table 6 summarizes non-substantive comments received by RWG straw poll respondents pertaining to *Draft CAQH CORE Eligibility & Benefits Data Content Rule* and RWG co-chair and CORE staff response, when applicable.

Table 6. Non-Substantive Comments Received on *Draft CAQH CORE Eligibility & Benefits Data Content Rule*

#	Section	Summary of Comment(s)	RWG Co-chair and CAQH CORE Staff Response
1.	§ 1.1 Issues to be Addressed	One entity suggested rewording line 17 to the following: "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 service types and procedure codes."	**Agree to adjust.** RWG Co-chairs and CORE staff recommend updating the draft rule language to add further clarification, per suggested recommendation.
2.	§ 1.1 Issues to be Addressed	One entity noted they support categories of service in general, however they do not support surgery as a required category due to the broad types of procedures that fall into this category.	**Do not adjust**. Given 83% of RWG Participants supported Section 1.4 Procedure Codes, as written, RWG Co-chairs and CORE Staff do not recommend adjusting the Service Categories or Procedure Codes. Additionally, EBTG Participants engaged in consensus-building via calls, feedback forms, and straw polls and received high levels of support to include this limited set of categories of service that health plans should be required to return coverage and benefit information on an X12 v5010 271 Response when a procedure code is received on v5010 270 Inquiry. These requirements are not mandated under HIPAA.

#	Section	Summary of Comment(s)	RWG Co-chair and CAQH CORE Staff Response
3.	§ 1.2 Scope	One entity suggested rewording line 123 to: "Telemedicine/Telehealth is when a provider delivers care for a patient without an in-person office visit, for example, online with internet access on a computer, tablet, or smartphone or via telephone".	**Agree to adjust.** RWG Co-chairs and CORE staff recommend updating rule language to add further clarification per suggested recommendation.
4.	§ 1.2 Scope	One entity suggested revising the definition of Authorization/Certification on lines 93-95 which states that providing this information "enables the provider to deliver more accurate patient financial responsibility..." to "...to enable the provider to be aware when they need to obtain payer approval prior to performing a service, procedure, or testing on the patient."	**Agree to adjust.** RWG Co-chairs and CORE staff recommend updating rule language to add further clarification per suggested recommendation.
5.	§ 1.2 Scope	One entity noted their support with Telemedicine, Tier Benefits and Authorization rule but do not support procedure level inquires.	**Do not adjust**. Given 83% of RWG Participants supported Section 1.4 Procedure Codes, as written, RWG Co-chairs and CORE Staff do not recommend adjusting the Service Categories or Procedure Codes. Additionally, EBTG Participants engaged in consensus-building via calls, feedback forms, and straw polls and received high levels of support to include this limited set of categories of service that health plans should be required to return coverage and benefit information on an X12 v5010 271 Response when a procedure code is received on v5010 270 Inquiry. These requirements are not mandated under HIPAA.
6.	§ 1.2 Scope	One entity commented the use of procedure code inquires would require extensive systems modifications. Adding that the procedure code alone is insufficient for the payer to return information in a X12 271 and would require modifiers and DX codes as well.	**Do not adjust**. Given 83% of RWG Participants supported Section 1.4 Procedure Codes, as written, RWG Co-chairs and CORE Staff do not recommend adjusting the Service Categories or Procedure Codes. Additionally, EBTG Participants engaged in consensus-building via calls, feedback forms, and straw polls and received high levels of support for the include this limited set of categories of service that health plans should be required to return coverage and benefit information on an X12 v5010 271 Response when a procedure code is received on v5010 270 Inquiry. These requirements are not mandated under HIPAA.

#	Section	Summary of Comment(s)	RWG Co-chair and CAQH CORE Staff Response
7.	§ 1.2 Scope	One entity indicated support for procedure codes inquires, as these will allow for detailed requests and benefit responses.	**N/A**
8.	§ 1.3 Service Type Codes – Telemedicine	One entity commented support for the Telemedicine rule requirements.	**N/A**
9.	§ 1.3 Service Type Codes – Remaining Coverage Benefits	One entity commented that they currently provide the last service date and benefit limitation. The entity noted that providers can easily determine the next coverage date, thus producing future date could create confusion and hinder provider workflow. Adding future date would be redundant.	**Do not adjust**. Given 84% of RWG Participants supported Section 1.3 Service Type Codes, as written, RWG Co-chairs and CORE Staff do not recommend adjusting date requirements for Remaining Coverage Benefits. Additionally, EBTG Participants engaged in consensus-building via calls, feedback forms, and straw polls and received high levels of support for health plans to return the next eligible date when a service type has a date limitation using EB and DTP segments.
10.	§ 1.3 Service Type Codes – Remaining Coverage Benefits	One entity had four suggestions on rewording: − Line 340 (§1.3.2.12) to A health plan and its agent must return maximum benefit limitations and return remaining benefits for each maximum benefit limitation for the 10 CORE-required remaining coverage benefit service types specified in §5.1 using two EB segment occurrences. − Line 344 (§1.3.2.12.1) to A health plan and its agent must return the maximum benefit limitation in an EB segment as follows: − Line 355 (§1.3.2.12.2) to A health plan and its agent must return the related remaining benefit limitation in an EB segment as follows: − Line 366 (§1.3.2.12.3) to A health plan and its agent must return the next eligible date for a benefit when a service type has a date limitation, when applicable, using the EB and DTP segments as follows:	**Agree to adjust.** RWG Co-chairs and CORE staff recommend updating rule language to add further clarification per suggested recommendations.
11.	§ 1.3 Service Type Codes – Remaining Coverage Benefits	One entity suggested rewording 'status' to 'coverage status' in line 158.	**Agree to adjust.** RWG Co-chairs and CORE staff recommend updating rule language to add further clarification per suggested recommendation.

#	Section	Summary of Comment(s)	RWG Co-chair and CAQH CORE Staff Response
12.	§ 1.3 Service Type Codes – Remaining Coverage Benefits	One entity commented their system currently requires use of procedure codes, DX codes, and modifiers to identify services, eligibility, and authorization requirements. Use of STC codes would require major systems re-design and re-development to align coverages, utilization, next available and remaining benefits.	**Do not adjust**. Given 84% of RWG Participants supported Section 1.3 Service Type Codes, as written, RWG Co-chairs and CORE Staff do not recommend adjusting requirements for specifying maximum and remaining coverage benefits for the 10 CORE-required remaining coverage benefit service types. Additionally, EBTG Participants engaged in consensus-building via calls, feedback forms, and straw polls and received high levels of support to align this rule requirement at the Service Type Code level.
13.	§ 1.4 Procedure Codes	One entity provided two comments on procedure code inquires: − The entity agreed that these categories of service are appropriate and represent high volume requests. − Further, the entity indicated support for authorization/certification requirements at the procedure code level, as this will allow for a more specific response to providers.	**N/A**
14.	§ 1.4 Procedure Codes	One entity commented they do not support surgery category as a required category due to the broad types of procedures that fall into the category. They noted there are several codes that fall into that category that would be considered cosmetic and be subject to further medical review.	**Do not adjust**. Given 83% of RWG Participants supported Section 1.4 Procedure Codes, as written, RWG Co-chairs and CORE Staff do not recommend adjusting the Service Categories or Procedure Codes. Additionally, EBTG Participants engaged in consensus-building via calls, feedback forms, and straw polls and received high levels of support for the include this limited set of categories of service that health plans should be required to return coverage and benefit information on an X12 v5010 271 Response when a procedure code is received on v5010 270 Inquiry. These requirements are not mandated under HIPAA.
15.	§ 1.4 Procedure Codes	One entity provided two suggestions: − Line 411: Consider adding the loop number for AAA03-901 Reject Reason Code − Line 516: Change 'service type' to 'procedure code.'	**Do Not Adjust.** RWG Co-chairs and CORE staff note that AAA Loop numbers are specified in the AAA Error Code Reporting Rule. **Agree to adjust.** RWG Co-chairs and CORE staff recommend updating rule language to add further clarification per suggested recommendation.

#	Section	Summary of Comment(s)	RWG Co-chair and CAQH CORE Staff Response
16.	§ 1.5 Tiered Benefits	One entity commented that eligibility may be done for one provider in a practice, then used for another provider visit. This would be a problem for practices with multiple specialties when the eligibility response only includes the tier information for one provider.	**N/A**
17.	§ 1.5 Tiered Benefits	One entity provided two suggestions: − The entity recommended that the message segment starting with 'BenefitTier' should begin with either 'Tier 1' or 'Tier 2' Instead − Further, entity noted that §1.5.2, should be optional for plans and should be updated to read 'When Health Plan and its agents can be able to identify they provider…'	**Do not adjust.** Given 88% of RWG Participants supported the Tiered Benefits, as written, RWG Co-chairs and CORE Staff do not recommend adjusting MSG Segment requirements for Tiered Benefits. Additionally, EBTG Participants engaged in consensus-building via calls, feedback forms, and straw polls and had high levels of support to require health plans to return provider tier network information when they can appropriate identify the provider.
20.	§ 1.5 Tiered Benefits	One entity provided three comments: − The entity indicated that they currently support member tiering for STCs and noted that procedure code tiering will be more specific. − Further, the entity stated that they are currently returning if provider is identified, planning enhancements. − Additionally, the entity shared that some submitters do want all tiers returned, not just tier for provider submitted.	**N/A**
21.	§ 5 Appendix	One entity noted that §1.6 does not exist.	This was an error with the straw poll question. This question was referring to §5 Appendix.
22.	§ 5 Appendix	One entity commented they use the service codes listed based on benefits they offer.	**N/A**
23.	§ 5 Appendix	One entity noted they do not currently support human readable messages.	**N/A**
24.	§ 5 Appendix	One entity had two comments: − The entity sated that the list of STC codes appears appropriate per the TR3. − Additionally, the entity indicated that they are currently supporting time period qualifiers.	**N/A**

#	Section	Summary of Comment(s)	RWG Co-chair and CAQH CORE Staff Response
25.	§ 5 Appendix	One entity noted their support for most items in the Appendix, but have concerns about Alternative Method Dialysis, Cabulance, Donor Procedures, and Transplants being mandatory. The entity suggested to make these items discretionary rather than mandatory.	**Do not adjust.** Given 93% of RWG Participants supported the Appendix, as written, RWG Co-chairs and CORE Staff do not recommend adjusting STCs. Additionally, EBTG Participants engaged in consensus-building via calls, feedback forms, and straw polls and had high levels of support in identifying which Service Type Codes should be added to the CORE-Required STC List for mandatory and discretionary reporting.

8.2 Non-Substantive Comments Received on Potential Updates to Existing *CAQH CORE Infrastructure Operating Rules*

Table 7 summarizes non-substantive comments received by RWG straw poll respondents pertaining to potential updates to existing *CAQH CORE Infrastructure Operating Rules* and RWG Co-chair and staff response, when applicable.

Table 7. Non-Substantive Comments Received on *Draft CAQH CORE Infrastructure Operating Rules*

#	Section	Summary of Comment(s)	RWG Co-chair and CAQH CORE Staff Respone
1.	System Availability	Four entities explained their support for maintaining 86% system availability per calendar week: − One of these stated it allows for larger system upgrades that may be necessary. − Another noted it allows all entities to adhere to the requirement. − Another noted that the current system availability allows them to work with more complex transactions. − Another suggested that leaving it as-is may allow for entities to make necessary changes as new HIPAA standards are released. Two entities explained their support to increase system availability to 95% per calendar week: − One entity commented that they support the highest possible system availability. − Another noted that higher system availability is important, but alternate solutions should be available during downtime.	**RWG Co-chair & CORE Staff Recommendation:** Update weekly system availability requirement to specify 90% system availability per calendar week.

#	Section	Summary of Comment(s)	RWG Co-chair and CAQH CORE Staff Respone
2.	Real Time Processing Mode	Three entities provided explanation for their Real Time Response Processing Mode selection: − One of these noted that **20 seconds** works for 90% of their responses. They also commented that entities can typically process Real Time in far shorter timeframes. − Another said their organization supports maintaining the current requirement of **20 seconds**. − Another explained their support for **15 second** response time for Real Time Processing, stating that the requirement should be for the lowest-possible time is available for greater than 90% of all responses.	**RWG Co-chair & CORE Staff Recommendation:** Maintain 20 second Real Time Processing Mode requirement.
3.	Quarterly System Downtime	Eight entities explained their quarterly downtime selection: − One entity noted that while having larger windows would be best, having a quarterly exception would be a good start. − Another commented that communication of downtime is most important for providers. − Another clarified that they only supported **24 hours** of quarterly downtime if the weekly downtime was increased to 93% or higher. − Another commented that they support **24 hours** based on their system integrations that require downtime for installation, validation, and regression testing. − Another commented that if weekly system availability increased, they would support a **24 hour** scheduled downtime to accommodate major releases. − Another explained they support **8 hours**, as it is the highest possible system availability. − Another stated they do not support of any form of quarterly downtime. − Another recommended maintaining the system availability requirements, as written, to account for ensuing HIPAA standards updates.	**RWG Co-chair & CORE Staff Recommendation:** New Quarterly System Downtime Requirement of 24 additional hours system downtime per quarter with an increased weekly system availability of 90% per calendar week.
4.	Batch Processing Mode - Premium Payment	Three entities explained their Batch response time selection for premium payments: − One of these entities stated that there may be a need for additional time to process X12 820 transactions. − Another noted that an increased quantity in files, as well as larger documents, may impact needed processing time. − Another commented that Batch Processing for Premium Payment is not applicable to their business model.	**RWG Co-chair & CORE Staff Recommendation:** Maintain three business day Batch Processing Mode requirement for Premium Payments.

#	Section	Summary of Comment(s)	RWG Co-chair and CAQH CORE Staff Respone
5.	Batch Processing Mode - Benefit Enrollment	Six entities provided further explanation for their Batch Processing Mode Response Time selection for Benefit Enrollments. − Two entities noted that their ideal response time would be the **next business day**. − Another explained **two business days** should be enough time to process batch for most benefit enrollments. − Two additional entities explained that they want to maintain the existing **three business day requirement**, with one of the entities noting that files are getting larger as technology improves. − One entity commented that this question was not applicable to their business model.	**RWG Co-chair & CORE Staff Recommendation:** Maintain three business day Batch Processing Mode requirement for Benefit Enrollments.