

CAQH CORE Eligibility & Benefits Data Content Rule Updates at a Glance

CAQH CORE Eligibility & Benefits (270/271) Data Content Rule Updates to Review

The <u>CAQH CORE Eligibility & Benefits Data Content Rule</u> enhances the exchange of eligibility and benefit information between health plans and providers through requirements including providing financial information, especially co-insurance, copayment, deductible, remaining deductible amounts, and coverage information for a set of service type and procedure codes.

This rule builds upon the X12N v5010 270/271 Technical Report Type 3 and defines specific business information requirements that health plans must return and vendors, clearinghouses and providers must support.

The updates to the rule aim to support industry's evolving needs for comprehensive coverage information by addressing priority topics.

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Electronic Delivery of Patient Financial and Benefit Information Rule **Requirements**: Support the delivery of robust eligibility, coverage, and benefit information for a set of service type and procedure codes.

The updates to these rule requirements:

Address the emergent need to communicate **telemedicine** specific eligibility

- and benefit information. Include additional Service Type Codes beyond the current 52 CORE-
- required STC codes. 71 discretionary and 55 mandatory STC codes added. Support the communication of the number of remaining visits/services left
- on a benefit for a set of specific service types.
- Include the ability to respond to eligibility and benefit requests at the procedure level (CPT and HCPCS) for a set of categories of service.
- Enable the ability to determine if **prior authorization or certification** is required for a specific service type or procedure.
- Provide more granular level data for members of tiered benefit plans and provider tier network status.

Note: Normalizing Patient Last Name Rule Requirements and AAA Error Code Reporting Rule Requirements are out of scope.

Key Rule Updates