Contents

Introduction

This document contains draft language for updates to the following CORE Operating Rules:

1. CORE Benefit Enrollment and Maintenance Infrastructure Rule
2. CORE Attributed Patent Roster Data Content Rule
3. CORE Attributed Patient Roster Infrastructure Rule
4. CORE Health Care Claim Submission Data Content Rule (excerpt)

Updates are highlighted in gray to delineate where existing operating rule requirements overlap with proposed new requirements and substantive adjustments based on Subgroup agreement. Links to the current published versions of the operating rules have been provided, where applicable, to aid your review.

If you have questions, please reach out directly to Mike Phillips, Sr. Manager, CORE at mphillips@caqh.org.

Supporting Information for Section II of Straw Poll #6: CORE Benefit Enrollment and Maintenance Infrastructure Rule – X12 v5010X220 834

Draft requirements would be included as updates to the existing CORE Benefit Enrollment and Maintenance Infrastructure Rule. Published version available here.

4.9.1. Requirements to Follow the Format and Flow of the CAQH CORE Companion Guide Template for HIPAA Transactions

If a HIPAA-covered entity or its agent publishes a Companion Guide covering the X12 v5010 834 transaction, the Companion Guide must follow the format/flow as defined in the CAQH CORE Companion Guide Template for HIPAA Transactions (CAQH CORE Companion Guide Template available HERE).

NOTE: This rule does not require any entity to modify any other existing Companion Guides that cover other HIPAA-mandated transaction implementation guides.

4.9.2. Requirements to Include Language Disclosing Collection, Exchange, Processing, and Use of Socio-Demographic Information Collected at Enrollment or Renewal.

Per requirements in the CORE Benefit Enrollment and Maintenance Data Content Operating Rule, a health plan or its agent must create language disclosing the purpose and use associated with the collection, exchange, and processing of socio-demographic information at member enrollment or renewal. This information must be presented to a member at enrollment or renewal to inform their decision to disclose potentially sensitive demographic information.

To support the purposes of transparency and consent to disclosure, if a health plan or its agent publishes a Companion Guide covering the X12 v5010X220 834 transaction, the generated disclosure language must be included in the Companion Guide Appendix and appropriately hyperlinked in the table of contents to allow for ease of access.

Supporting Information for Section III of Straw Poll #6: CORE Attributed Patient Roster Data Content Rule – X12 v5010X318 834

Draft requirements would be included as updates to the existing CORE Attributed Patient Roster Data Content Rule. Published version available here.

3.5 Applicable Loops & Data Elements

This rule addresses the use of the following specified loops, segments and data elements in the X12 v5010X318 834 transaction.

Table 1: Applicable Loops and Segments - Patient (Subscriber/Dependent) Identifying Data Elements

#	X12 Data Element Name	Applicable Loop and Segment in the X12 v5010X318 834	Use of Applicable Loop and Segment in the X12 v5010X318 834	CAQH CORE Operating Rule Supplemental Descriptions
1.	Enrollee Level Detail	Loop 2000 – INS01_1073 Yes/No	*Required Use*	Identify if member is subscriber or dependent
2.	Individual Relationship Code	Loop 2000 – INS02_1069	*Required Use*	Identify relationship of dependent to subscriber
3.	Maintenance Type Code	Loop 2000 – INS03_875	*Required Use*	Identifies Enrollment Status of Subscriber or Dependent
4.	Entity Identifier Code	Loop 2100A – NM101_98	*Required Use*	Identifies the attributed subscriber/dependent.
5.	Entity Type Qualifier	Loop 2100A – NM102_1065	*Required Use*	
6.	Last Name	Loop 2100A – NM103_1035	*Required Use*	
7.	First Name	Loop 2100A – NM104_1036	*Situational Use*	
8.	Middle Name	Loop 2100A – NM105_1037	*Situational Use*	
9.	Name Prefix	Loop 2100A – NM106_1038	*Situational Use*	
10.	Identification Code Qualifier	Loop 2100A – NM108_66	*Required Use*	
11.	Identification Code	Loop 2100A – NM109_67	*Required Use*	
12.	Address Line 1	Loop 2100A – N301_166	*Required Use*	Identifies the primary address of the attributed subscriber/ dependent.
13.	Address Line 2	Loop 2100A – N302_166	*Situational Use*	

14.	City Name	Loop 2100A – N401_19	*Required Use*	
15.	State/Province	Loop 2100A – N402_156	*Situational Use*	
16.	ZIP Code/ Postal Code	Loop 2100A – N403_116	*Situational Use*	
17.	Country Code	Loop 2100A – N404_26	*Situational Use*	
18.	DMG Member Demographics	Loop 2100A – DMG01_02	*Required Use*	Enrollee Birth Date
19.		Loop 2100A – DMG03	*Required Use*	Gender Code
20.		Loop 2100A – DMG05_01_03	*Situational Use*	Composite Race and Ethnicity Code and Industry Code
21.	LUI Member Language	Loop 2100A – LUI02_04	*Situational Use*	Identification Code and Use of Language Indicator Code
22.	Reporting Category	Loop 2750 – N102	*Situational Use*	When N102 = 'Gender'
23.		Loop 2750 – REF02	*Situational Use*	Alphanumeric Gender Identity Code

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Supporting Information for Section IV of Straw Poll #6: CORE Attributed Patient Roster Infrastructure Rule - X12 v5010X318 834

Draft requirements would be included as updates to the existing CORE Attributed Patient Roster Infrastructure Rule. Published version available here.

4.3 Plan Member Reporting for Attributed Patient Roster Real Time Processing Mode Response Time Requirements

Maximum response time for the receipt of an X12 v5010 999 transaction from the time of submission or receipt of an X12 v5010X318 834 must be 20 seconds when processing in Real Time Processing Mode.

Each HIPAA-covered entity or its agent must support this *maximum* response time requirement to ensure that at least 90 percent of all required responses are returned within the specified maximum response time as measured within a calendar month.

Each HIPAA-covered entity or its agent must capture, log, audit, match, and report the date (YYYYMMDD), time (HHMMSS) and control numbers from its own internal systems and the corresponding data received from its trading partners.

The recommended maximum response time between each participant in the transaction routing path is 4 seconds or less per hop as long as the 20-second total roundtrip *maximum* requirement is met.

Each HIPAA-covered entity or its agent must support these response time requirements in this section and other CAQH CORE Operating Rules regardless of the connectivity mode and methods used between trading partners.

The goal of this requirement is to adhere to the principles of EDI in assuring that transactions sent are accurately received and to facilitate correction of errors in Functional Groups of X12 v5010X318 834 transactions.

This requirement assumes a successful communication connection has been established.

4.4. Plan Member Reporting for Attributed Patient Roster Real Time Processing Mode Acknowledge Requirements

These requirements for use of acknowledgements for Real Time Processing mode places parallel responsibilities on both receivers of the X12 v5010X318 834 and senders of the X12 v5010X318 834 for sending and accepting X12 v5010 999 acknowledgements. The goal of this approach is to adhere to the principles of EDI in assuring that transactions sent are accurately received and to facilitate health plan correction of errors in their outbound transactions.

The rule assumes a successful communication connection has been established.

4.5 Plan Member Reporting for Attributed Patient Roster Batch Processing Mode Response Time Requirements

Maximum response time for availability of X12 v5010 999 transaction when processing an X12 v5010X318 834 transaction submitted in Batch Processing Mode by 9:00 pm Eastern Time of a business day by a health plan sponsor or its agent must be no later than 7:00 am Eastern Time the third business day following submission.

A business day consists of the 24 hours commencing with 12:00 am (Midnight or 0000 hours) of each designated day through 11:59 pm (2359 hours) of that same designated day. The actual calendar day(s) constituting business days are defined by and at the discretion of each HIPAA-covered health plan or its agent.

Each HIPAA-covered entity or its agent must support this *maximum* response time requirement to ensure that at least 90 percent of all required responses are returned within the specified maximum

response time as measured within a calendar month.

Each HIPAA-covered entity or its agent must capture, log, audit, match, and report the date (YYYYMMDD), time (HHMMSS) and control numbers from its own internal systems and the corresponding data received from its trading partners.

Each HIPAA-covered entity or its agent must support these response time requirements in this section and other CAQH CORE Operating Rules regardless of the connectivity mode and methods used between trading partners.

The goal of this requirement is to adhere to the principles of EDI in assuring that transactions sent are accurately received and to facilitate correction of errors in Functional Groups of X12 v5010 834 transactions.

This requirement assumes a successful communication connection has been established.

4.7.1. Requirements to Follow the Format and Flow of the CAQH CORE Companion Guide Template for HIPAA Transactions

If a HIPAA-covered entity and its agent publishes a companion guide covering the X12 v5010X318 834 transaction for the use of exchanging attributed patient rosters, the companion guide must follow the format/flow as defined in the CAQH CORE Master Companion Guide Template for HIPAA transactions.

NOTE: This rule does not require any entity to modify any other existing companion guides that cover other HIPAA-mandated transaction implementation guides.

4.7.2. Requirements to Include Language Disclosing Collection, Exchange, Processing, and Use of Socio-Demographic Information Collected at Enrollment or Renewal

Per requirements in the CORE Benefit Enrollment and Maintenance Data Content Operating Rule, a health plan or its agent must create language disclosing the purpose and use associated with the collection, exchange, and processing of socio-demographic information at member enrollment or renewal. This information must be presented to a member at enrollment or renewal to inform their decision to disclose potentially sensitive demographic information.

Though the information exchanged as part of the X12 v5010X318 834 transaction has already been recorded and processed into the system of a health plan or its agent, greater transparency can be achieved by making the language available to implementers of this transaction.

Therefore, to support transparency and consent to disclosure, if a health plan or its agent publishes a Companion Guide covering the X12 v5010X318 834 transaction, the generated disclosure language must be included in the Companion Guide Appendix and appropriately hyperlinked in the table of contents to allow for ease of access.

Supporting Information for Section V of Straw Poll #6: Health Care Claims Submission – X12 v5010 837 (Professional and Institutional)

Draft requirements to be included in the new CORE Health Care Claims Submission Data Content Rule. Section numbers are pending.

4.x Data Content Requirements Supporting the Submissions of Additional Claims for a Single Encounter

Professional claim submissions using the X12 v5010 837 are limited to 12 diagnosis fields, necessitating prioritization by providers of what diagnoses to include on a claim. Providers can submit supplementary claims for a single encounter to add diagnoses, but data content requirements for this process differ between health plans. Though typically encountered for professional claims, this issue can uncommonly affect institutional claims and requirements are applied to both professional and institutional transactions.

4.x.x Health Plan Requirements for Matching Information Between an Initial and Supplementary Claim to Submit Additional Diagnoses for a Single Encounter

When a health plan or its agent accepts the submission of supplementary claims, they must require the following information to match between the initial claim and supplementary claims:

- Rendering Provider NPI
- Billing Provider NPI
- Member Identification Number
- Dates of Service

Health plans and their agents must make this data requirement easily accessible to submitters of an X12 v5010 837, either on the plan website or in the transaction-specific companion guide.

4.x.x Submitter Requirements for the Matching Information Between an Initial and Supplementary Claim to Submit Additional Diagnoses for a Single Encounter

Submitters must match the information included in an initial claim and the information included in a supplementary claim consistent with the data elements indicated in **Section 4.x.x.** using the following loops, segments, and data elements from the X12 v5010 837.

- **Rendering Provider NPI**
  - Loop 2300 – Claim Information
  - Loop 2310B – Rendering Provider Name
    - NM1 – Rendering Provider Name
      - NM108 = XX (CMS NPI)
      - NM109 = Rendering Provider NPI
- **Billing Provider NPI**
  - Loop 2000A – Billing Provider Hierarchical Level
  - Loop 2010AA – Billing Provider Name
    - NM1 – Billing Provider Name
      - NM108 = XX (CMS NPI)
      - NM109 = Billing Provider NPI
- **Member ID**
  - Loop 2000C – Patient Hierarchical Level
  - Loop 2010CA – Patient Name
    - REF – Property and Casualty Patient Identifier
      - REF01 = 1W (Member Identification Number)
      - REF02 = Member Identification Number

- **Dates of Service**
  - Loop 2000C – Patient Hierarchical Level
  - Loop 2400 – Service Line Number
    - DTP – Date – Service Date
      - DTP01 = 472 (Service)
      - DTP02 = D8 (Date Expressed in Format CCYYMMDD)
      - DTP03 = Service date