CAQH CORE® Phase I and II Operating Rules Frequently Asked Questions

Introduction

CAQH CORE® Phase I and II Operating Rules support electronic eligibility and claim status inquiries. The Rules streamline and bring uniformity to essential administrative transactions between healthcare providers and health plans. In addition, the rules simplify interoperability for all trading partners.

1. What is CAQH CORE?

CAQH: Council for Affordable Quality Healthcare

CORE: Committee on Operating Rules for Information Exchange

The CAQH CORE is a multi-stakeholder industry collaboration developing operating rules that streamline administrative transactions. Over the past eight years, CAQH CORE participation has grown to more than 140 organizations. CAQH CORE has a proven track record of delivering a strong return on investment that is driven by widespread adoption and voluntary certification of operating rules. CAQH CORE was designated by the Department of Health and Human Services to author three sets of federally mandated operating rules under ACA. To learn more about CAQH CORE, visit www.caqh.org/benefits.php.

2. What are operating rules?

Section 1104(1) of the Patient Protection and Affordable Care Act (ACA) defines operating rules as "the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications."

The CORE operating rules build on existing standards to make electronic transactions more predictable and consistent, regardless of the technology. They address gaps in standards, help refine the infrastructure that supports electronic data exchange, and recognize interdependencies among transactions.

3. How do the Phase I and Phase II CAQH CORE Eligibility and Claim Status Operating Rules affect providers?

The CAQH CORE Eligibility and Claim Status Operating Rules will allow providers to do the following:

- Receive eligibility responses that include the required CAQH CORE service type codes covered by the recipient's Medicaid plan. These service type codes will be returned on the EDI 5010 270/271 transaction and the Provider Web Portal eligibility responses.
- Inquire on eligibility using a generic or explicit inquiry request. A generic inquiry response will include all 12 CAQH CORE service type codes. An explicit inquiry response will only include the CAQH CORE service type codes that were used on the explicit eligibility request.

4. What is a generic 5010 270 eligibility inquiry?

A generic 5010 270 eligibility inquiry is a request that only contains service type code "30" for Health Benefit Plan coverage in the EQ01 segment of the transaction.

5. What service type codes are returned on a generic 5010 271 eligibility response?

A generic 5010 271 eligibility response will contain the following 12 service type codes:

- 1 Medical Care
- 33 Chiropractic
- 35 Dental Care
- 47 Hospital
- 48 Hospital - Inpatient
- 50 Hospital - Outpatient
- 86 Emergency Services
- 88 Pharmacy
- 98 Professional (Physician) Visit - Office
- AL Vision (Optometry)
- MH Mental Health
- UC Urgent Care

6. What is an explicit eligibility inquiry?

An explicit 5010 270 inquiry is a request that contains a service type code other than and not including "30" for Health Benefit Plan coverage in the EQ01 segment of the transaction. An Explicit Inquiry asks about coverage of a specific type of benefit, for example, "48" (Hospital - Inpatient).

7. Is there a limit on the number of service type codes that can be used on an explicit eligibility inquiry?

An explicit 5010 270/271 eligibility inquiry can contain up to 10 service type codes. If an explicit 5010 270/271 eligibility inquiry contains more than 10 service type codes, the 271 response will return the equivalent of a Generic Inquiry.

The Provider Web Portal will allow only one service type code for an explicit eligibility inquiry request.