

**Committee on Operating Rules for  
Information Exchange (CORE™)**

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Phase III CORE Acknowledgments for v5010 837 Claims Rule  
Certification/Testing Subgroup Draft – March 23, 2010

**CORE Phase III Rules Work Group - Claim Status Subgroup  
DRAFT Proposed Acknowledgements for v5010 837 Claims Rule  
Certification/Testing Subgroup Draft – as of 03-23-10**

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**1 Background Summary**

CORE Phase I Rules focused on improving real time electronic eligibility and benefits verification, as eligibility is the first transaction in the claims process. CORE Phase II Rules focused on extending the value of electronic eligibility by adding additional data content requirements that deliver more robust patient financial liability information, including remaining deductibles and adding more service type codes that must be supported. Building on this, CAQH also determined that CORE Phase II should be extended to include rules around the claim status transaction to allow providers to check in real time the status of a claim electronically, without manual intervention, or confirm claims receipt. In Phase III, CORE has identified these benefits to the use of standard electronic acknowledgments of electronic claims:

- Less staff time spent on phone calls and websites;
- Increased ability to conduct targeted follow-up;
- More accurate and efficient processing and payment of claims.

The inclusion of this CORE Phase III rule for establishing requirements around the use of the standard ASC X12 acknowledgments for claims will facilitate the industry's transition to the v5010 administrative transactions, increase access to the claim acknowledgment transaction, and will encourage CORE-certified entities to build on and extend the infrastructure they have for v4010A1 eligibility (270/271) and claims status (276/277) to the v5010 transactions.

**2 Issue to be Addressed and Business Requirement Justification**

A critical business need of providers is to know as quickly as possible whether or not the health plan received the claim and then whether the claim was rejected or received into the health plan's adjudication system. Oftentimes, the claim is rejected early on in the information exchange path by intermediaries between the provider and health plan, or alternatively, the claim does not enter the health plan's adjudication system. In either case, the provider does not know with certainty that the claim was received by the health plan.

These issues represent not just a single problem to be resolved, but a chain of related but different problems impacting both the claim and the ability of the provider to determine the status of the claim, which requires different solutions along the chain of information exchanges<sup>1</sup>. The information exchange can be as simple as a provider-direct-to-health plan exchange to one much more complex from the provider through one or multiple clearinghouses to the health plan. At each point (node) on this information exchange path the information goes through several processes during which a variety of validations and editing are performed. Some of these validation/editing processes may include:

- Claim scrubbing on behalf of the provider
- Receiving a standard interchange and forwarding it to health plan or health plan's clearinghouse
- Opening the interchange and applying a health plan's business edits on behalf of the health plan
- Opening the interchange and reformatting into a proprietary file format for the health plan

In order to effectively evaluate the opportunity for a CORE Rule and its related requirements it is necessary to understand the problem space to be addressed by the CORE rule. Below are a variety of visual representations of the problem space and information exchanges occurring within it that are the focus of this rule.

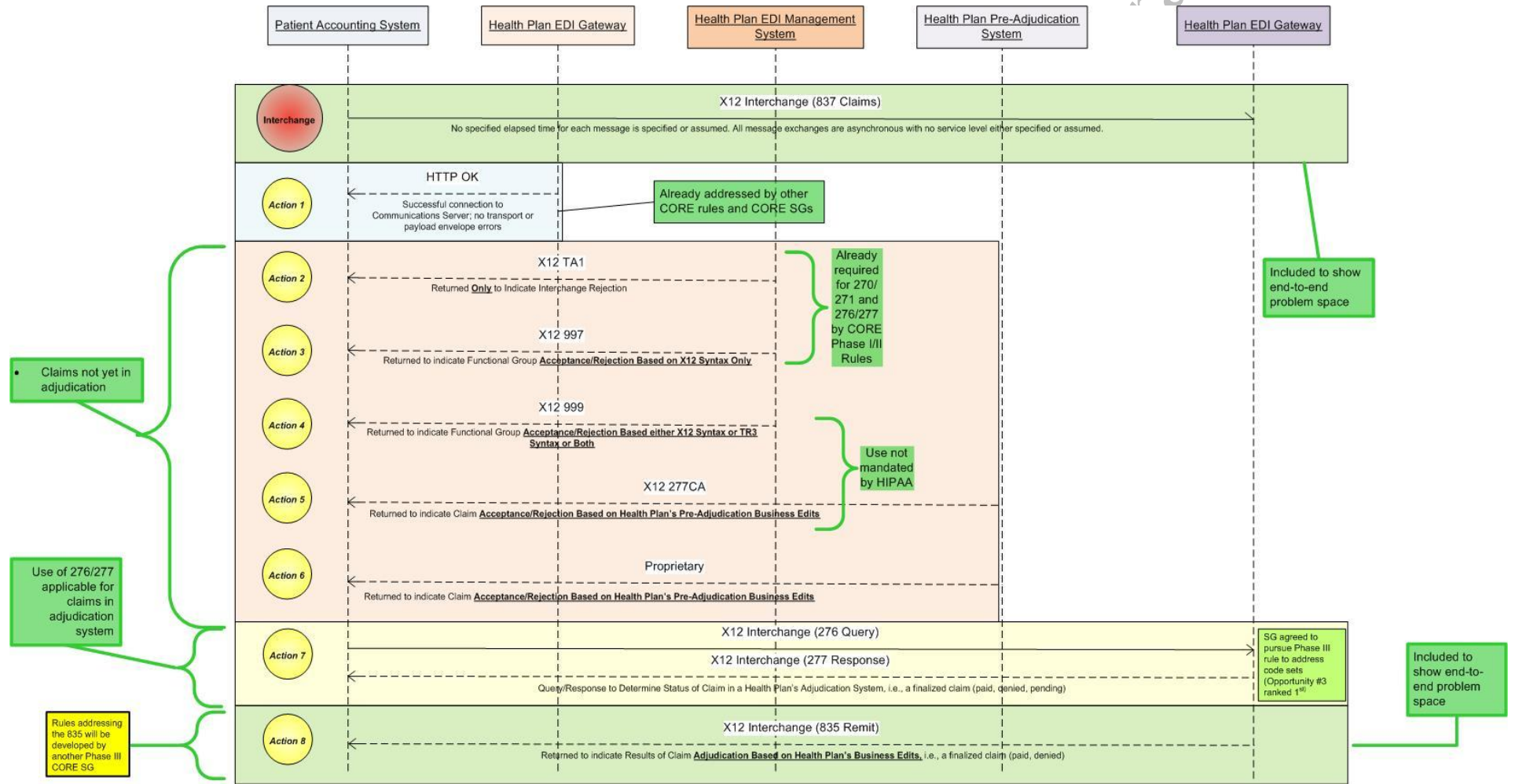
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<sup>1</sup> Currently, the information exchanges can be either an X12 Interchange of an 837 claim, a TA1 Interchange Acknowledgment, a 997 Functional Group Acknowledgment, a 999 Implementation Acknowledgment, a 277 Claim Acknowledgment, or a proprietary report format.

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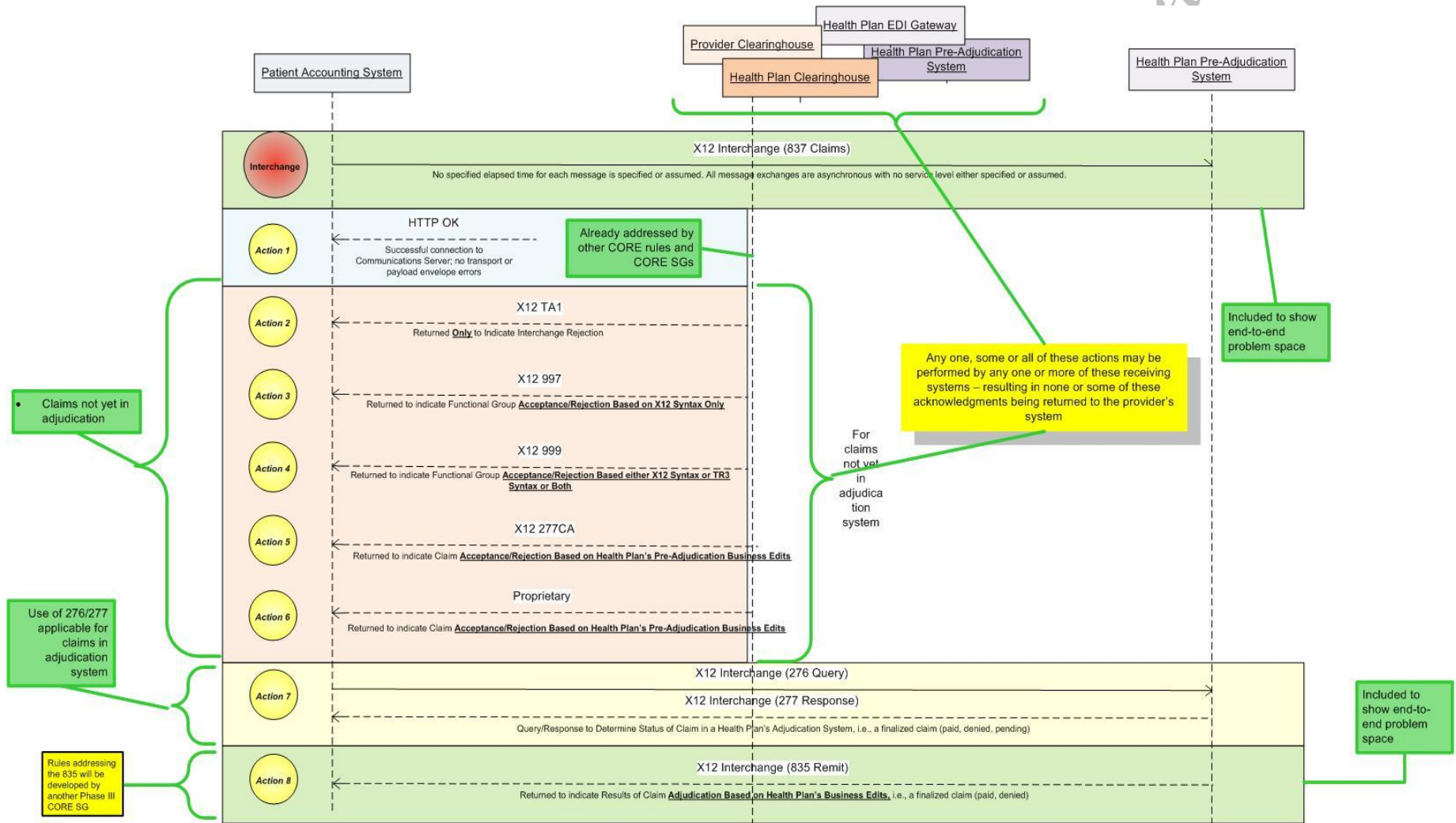
**Figure 1: Provider-Direct-to-Health Plan** Information Exchange Model Batch – Processing Mode Only – Not intended to depict a Real-Time Claim Adjudication Process



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43 **Figure 2: Provider-to-Clearinghouse-to-Health Plan** Information Exchange Model – Batch Processing Mode Only – Not Intended to depict a Real-Time  
 44 Claim Adjudication Process



45  
46

47 Analysis of Figures 1 and 2 above indicates that the problem space can be generally described as “*Providers need*  
48 *to know whether or not the claim is received and then successfully makes it into the payer’s adjudication system.*”  
49 This problem space can be defined to encompass the submission of a claim by a provider to the point that the  
50 claim is accepted into a health plan’s adjudication system. This problem space includes both the direct submission  
51 of a claim to the health plan and also the use of one or more intermediaries (clearinghouses, repricers, etc.)  
52 between the provider and the plan. The actions that can take place within this problem space are that an 837 claim  
53 transaction set undergoes several processing steps before being allowed into the payer’s adjudication system:

- 54 • **Step 1: ASC X12 validation** – does the Interchange, Functional Group, and Transaction Set(s) conform to  
55 the ASC X12 standards (*Actions 2 and 3 in Figures 1 and 2 already addressed in CORE Phase I and*  
56 *Phase II rules for eligibility [270/271] and claim status [276/277] transactions*)
- 57 • **Step 2: TR3 validation** – does the Transaction Set(s) conform to the implementation specification (*Action*  
58 *4 in Figures 1 and 2*)
- 59 • **Step 3: Payer Business Edits** – does the claim pass all payer-specific business edits in order to be deemed  
60 “clean” and allowed to enter into adjudication

61 When an 837 claim transaction set (or a single claim, i.e., unit of work) fails to pass ASC X12 validation, TR3  
62 validation, or payer-specific business edits, at any point in the path towards the payer’s adjudication system, there  
63 is no single adopted and implemented industry-wide mechanism to report such rejections to the provider in a  
64 standard and consistent format using standardized data, codes, error messages, etc., to enable the provider to be  
65 able to reasonably process the myriad reports being received in order to manage their revenue cycle of claim-to-  
66 cash effectively and efficiently.

67 Current methods employed inconsistently across the industry include:

- 68 • 997 Functional Acknowledgment (not designed by ASC X12 to be able to report TR3 compliance errors;  
69 the 999 Implementation Acknowledgement is designed to be used for this purpose)
- 70 • 999 Implementation Acknowledgment (can report both ASC X12 and TR3 compliance errors)
- 71 • 277 Claim Acknowledgment (can report ONLY payer-specific business and TR3 semantic editing results)
- 72 • Proprietary clearinghouse-specific or payer-specific reports

73 *Note: The various X12 standard acknowledgements identified have not been addressed by HIPAA at the present*  
74 *time.*

75 CORE participants participating in the development of this rule achieved substantial consensus that a Phase III  
76 CORE Claim Acknowledgements Rule should address the use of the ASC X12 standard acknowledgements  
77 specified in §3.2 below only for the conduct of v5010 of the HIPAA-adopted 837 health care claim transaction  
78 sets. The CORE participants also agreed that this Phase III CORE rule for claim acknowledgements be applicable  
79 only to:

- 80 • CORE-certified health plans receiving an Interchange of v5010 837 health care claim transaction sets  
81 and
- 82 • receivers of any or all of the specified acknowledgements.

83 CORE participants further agreed that an extension of this Phase III CORE rule to other receivers of an  
84 Interchange of v5010 837 claim transaction sets (e.g., clearinghouses or other intermediaries) will be addressed in  
85 a future phase of CORE rule-writing.

## 86 **3 Scope**

### 87 **3.1 What the Rule Applies To**

88 This CORE rule applies only to the conduct of ASC X12 Interchanges containing Functional Groups of any  
89 HIPAA-adopted v5010 837 health care claim transaction set. (See §6.2 References)

### 90 **3.2 When the Rule Applies**

91 This rule applies when:

- 92 • a Phase III CORE-certified **health plan** processes an ASC X12 Interchange containing one or more  
93 Functional Groups of one or more HIPAA-adopted v5010 837 claim transaction set(s) submitted in a  
94 batch, e.g., institutional, professional, or dental v5010 837 health care claim transaction sets  
95 and
- 96 • a Phase III CORE-certified **health plan** processes an ASC X12 Interchange containing one or more  
97 Functional Groups of one or more HIPAA-adopted v5010 837 claim transaction set(s) submitted in real  
98 time without adjudication, e.g., institutional, professional, or dental 837 health care claim transaction sets  
99 or
- 100 • a Phase III CORE-certified **entity receives a**
  - 101 ○ 005010X231 Implementation Acknowledgement for Health Care Insurance (999) of an ASC X12
  - 102 Functional Group(s) of v5010 837 transaction set(s), or
  - 103 ○ 005010X214 Claim Acknowledgement (277CA) transaction set.

104 This rule does not apply when the provider and the health plan are engaged in the conduct of Real Time Claim  
105 Adjudication<sup>2</sup>.

106 This rule does not apply to clearinghouses and other intermediaries that submit v5010 837 claim transaction set(s)  
107 on behalf of a provider to a health plan.

108 This rule does not apply to the health plan-to-health plan or re-pricer exchange or routing of any HIPAA-adopted  
109 v5010 837 claims.

### 110 **3.3 What the Rule Does Not Require**

111 This rule does not require any CORE-certified entity to:

- 112 • Support the real time submission of v5010 837 claims
- 113 • Adjudicate a claim submitted in real time
- 114 • Engage in the Conduct of Real Time Claim Adjudication
- 115 • Apply any of the Phase I or Phase II infrastructure rules (e.g., the Phase II Connectivity or Identifiers  
116 rules) to the conduct of the v5010 837 claim transactions. However, if any entity wishes to apply the  
117 Phase II infrastructure rules to the conduct of the claim transactions, it may do so at its own discretion.
- 118 • Integrate its current claim processing system components into its current eligibility or claim status  
119 processing system if they are not currently integrated.

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<sup>2</sup> References the Real Time Adjudication (RTA) Process as defined in the Joint ASC X12/WEDI documents under development.

120 **3.4 Outside the Scope of This Rule**

121 Requirements for clearinghouses and other intermediaries when they receive claim data or v5010 837 claim  
122 transactions for submission to a health plan.

123 This rule does not apply to clearinghouses and other intermediaries that submit v5010 837 claim transaction set(s)  
124 on behalf of a provider to a health plan.

125 The data content of any version of the following transactions is not addressed in this rule:

- 126 • 277 Claim Acknowledgement transaction set
- 127 • 837 Health Care Claim transaction set
- 128 • 999 Implementation Acknowledgement transaction set
- 129 • TA1 Interchange Acknowledgement
- 130 • 835 Claim Payment/Remittance Advice transaction set.

131 **3.5 How the Rule Relates to CORE Phase I and II**

132 This rule adds to the Phase I and II CORE infrastructure rules requirements by specifying the use of the ASC X12  
133 005010X231 Implementation Acknowledgement for Health Care Insurance (999), and the 005010X214 Health  
134 Care Claim Acknowledgement (277) when conducting v5010 of the 837 claim transaction set.

135 As with other Phase I and Phase II rules, general CORE policies also apply to Phase III rules and will be outlined  
136 in the CORE Phase III rule set. The CORE policies include:

- 137 • Certification testing for each stakeholder wishing to be awarded a CORE-certified Seal;
- 138 • Entities seeking CORE-certification may use a contracted party to meet CORE rules, e.g., some providers  
139 meet CORE connectivity requirements via their vendor products;
- 140 • A health plan system exemption policy for system migration;
- 141 • Entities only need to test for and meet batch rule requirements for claim transactions. A CORE guiding  
142 principle is to move to real time; thus, CORE rules do not require entities to build real time claim  
143 adjudication capabilities.

144 This rule supports the CORE Guiding Principles that CORE rules will not be based on the least common  
145 denominator but rather will encourage feasible progress, and that CORE rules are a floor and not a ceiling, e.g.,  
146 certified entities can go beyond the Phase III rules.

147 **3.6 Assumptions**

148 A goal of this rule is to adhere to the principles of EDI in assuring that transactions sent are accurately received  
149 and to facilitate correction of errors for electronically submitted health care claims.

150 The following assumptions apply to this rule:

- 151 • A successful communication connection has been established.
- 152 • This rule is a component of the larger set of Phase III CORE rules; as such, all the CORE Guiding  
153 Principles apply to this rule and all other rules.
- 154 • All entities seeking Phase III certification must be Phase I and Phase II certified as CORE Phase I and  
155 CORE Phase II provide a foundation for CORE Phase III.
- 156 • This rule is not a comprehensive companion document addressing any content requirements of the v5010  
157 837 claim transaction sets.

- 158 • Compliance with all CORE rules is a minimum requirement; a CORE-certified entity is free to offer more  
159 than what is required in the rule.
- 160 • Providers, vendors, clearinghouses and health plans all need to meet appropriate aspects of the rule and all  
161 will be tested via CORE certification testing.

## 162 **4 Draft Rule Requirements**

### 163 **4.1 Basic Requirements for Health Plans Receiving Electronic Claims**

#### 164 **4.1.1 Use of the 999, and 277 Claim Acknowledgements**

165 The requirements in this rule section address the requirements for a CORE-certified health plan when it receives  
166 an ASC X12 EDI Interchange containing one or more Functional Groups of v5010 837 Claims, submitted either  
167 in batch or in real time without adjudication. See §4.1.1.1, § 4.1.1.2 and §4.1.1.3 for detailed requirements.

168 The requirements in this section do not apply to the conduct of Real Time Adjudication (RTA) process<sup>3</sup> in which  
169 a health care claim (v5010 837) is submitted to a health plan in real time and the health plan adjudicates that claim  
170 in real time during the same communications session and returns a single response to the submitter.

#### 171 **4.1.1.1 Functional Group and Transaction Set Acknowledgement**

##### 172 **4.1.1.1.1 Requirements When v5010 837 Claims Are Submitted in Batch**

173 A CORE-certified health plan must return

- 174 • a 005010X231 Implementation Acknowledgement for Health Care Insurance (999) for each Functional  
175 Group of v5010 837 Claim Transactions to indicate that the Functional Group was either accepted,  
176 accepted with errors, or rejected

177 and

- 178 • to specify for each included v5010 837 Claim Transaction Set that Transaction Set was either accepted,  
179 accepted with errors, or rejected.

180 When a Functional Group of v5010 837 Claim Transaction Sets and a v5010 837 Claim Transaction Set is either  
181 accepted with errors or rejected, the 005010X231 Implementation Acknowledgement for Health Care Insurance  
182 (999) must report each error detected to the most specific level of detail supported by the 999 Implementation  
183 Acknowledgement.

##### 184 **4.1.1.1.2 Requirements When v5010 837 Claims Are Submitted in Real Time Without Adjudication**

185 A CORE-certified health plan must return

- 186 • a 005010X231 999 Implementation Acknowledgement for each Functional Group of v5010 837 Claim  
187 Transactions only when the Functional Group is rejected

188 or

- 189 • only when an included v5010 837 Claim Transaction Set is rejected.

190 When a Functional Group of v5010 837 Claim Transaction Sets and a v5010 837 Claim Transaction Set is  
191 rejected, the 005010X231 999 Implementation Acknowledgement must report each error detected to the most  
192 specific level of detail supported by the 999 Implementation Acknowledgement.

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<sup>3</sup> References the Real Time Adjudication (RTA) Process as defined in the Joint ASC X12/WEDI documents under development.

193 **4.1.1.2 Claim Acknowledgement**

194 A CORE-certified health plan must acknowledge each claim received in an v5010 837 claim transaction set using  
195 the ASC X12 005010X214 Claim Acknowledgement (277CA) unless previous processing resulted in a rejection  
196 of the Interchange or a Transaction Set in a Functional Group.

197 *Note: §1.4 Business Usage of the ASC X12 005010X214-277 Claim Acknowledgement TR3 states that the “277 is*  
198 *the only notification of pre-adjudication claim status” and that “claims failing the pre-adjudication editing*  
199 *process are not forwarded to the claims adjudication system.”*

200 **4.1.2 Response Time Requirements for Availability of Acknowledgement Addressed in this CORE Rule**

201 Maximum elapsed time for the availability of a 999 or 277CA acknowledgement, specified in §4.1.1 of this rule,  
202 to a v5010 837 claim transaction set that is submitted by a provider, or on a provider’s behalf by a  
203 clearinghouse/switch, by 9:00 pm Eastern time of a business day must be no later than 7:00 am Eastern time the  
204 second business day following submission.

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

208 **4.1.2.1 System Availability Reporting Requirements**

209 In the context of this rule, System is defined as all necessary components required to process a claim to the point  
210 that it is either rejected or accepted into the adjudication system.

211 **Scheduled Downtime:** — a CORE-certified health plan must publish its regularly scheduled system downtime in  
212 an appropriate manner (e.g., on websites or in companion guides) such that the healthcare provider can determine  
213 the health plan’s system availability so that staffing levels can be effectively managed.

214 **Non-Routine Downtime:** — a CORE-certified health plan must publish its schedule of non-routine downtime  
215 (e.g., system upgrade) at least one week in advance.

216 **Unscheduled Downtime:** — a CORE-certified health plan must provide information for unscheduled/emergency  
217 downtime (e.g., system crash), within one hour of realizing downtime will be needed.

218 **No Response Required:** — a CORE-certified health plan is not required to acknowledge claims during scheduled  
219 downtime(s).

220 **Holiday Schedule:** — a CORE-certified health plan may establish its own holiday schedule and publish it in  
221 accordance with the above.

222 **4.2 Basic Requirements for Receivers of Acknowledgments**

223 The receiver (defined in the context of this CORE rule as the system originating the v5010 837 claim transaction  
224 set) of a 005010X231 Implementation Acknowledgement for Health Care Insurance (999) and a 005010X214  
225 Health Care Claim Acknowledgement (277) is required

226 • to recognize all error conditions that can be specified using all standard acknowledgements named in this  
227 rule

228 and

229 • to pass all such error conditions to the end user as appropriate

230 or

231 • to display to the end user text that uniquely describes the specific error condition(s), ensuring that the  
232 actual wording of the text displayed accurately represents the error code and the corresponding error

233 description specified in the related ASC X12 acknowledgement specification without changing the  
234 meaning and intent of the error condition description.

235 The actual wording of the text displayed is at the discretion of the receiver.

## 236 **5 Conformance Requirements**

237 Conformance with this rule is considered achieved when all of the required detailed step-by-step test scripts  
238 specified in the CORE Phase III Certification Test Suite are successfully passed.

239 *The detailed requirements for the certification test scripts and CORE Phase III Certification Test Suite will be*  
240 *developed by the CORE Phase III Testing Subgroup and Technical Work Group.*

241 For Phase III, the certification testing approach is similar to the Phase I and Phase II testing approach. In Phase I  
242 and Phase II, entities were not tested for their compliance with all sections of a rule, rather just certain sections as  
243 testing is not exhaustive and is paired with the CORE Enforcement policy. CORE certification requires entities to  
244 be compliant with all aspects of the rule when working with all trading partners, unless the CORE-certified entity  
245 has an exemption. Refer to the CORE Phase III Certification Test Suite for details.

## 246 **6 Appendix**

### 247 **6.1 Appendix 1: Abbreviations and Definitions Used in this Rule**

### 248 **6.2 Appendix 2: Reference**

- 249 • ASC X12 005010X231 Implementation Acknowledgement for Health Care Insurance (999) Technical  
250 Report Type 3
- 251 • ASC X12 005010X222 Health Care Claim (837) Professional Technical Report Type 3
- 252 • ASC X12 005010X223 Health Care Claim (837) Institutional Technical Report Type 3
- 253 • ASC X12 005010X224 Health Care Claim (837) Dental Technical Report Type 3
- 254 • ASC X12 005010X214 Health Care Claim Acknowledgement (277) Technical Report Type 3