

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

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Phase III CORE Health Care Services Request for  
Review/Response (278) Rule  
Certification/Testing Subgroup Draft – March 23, 2010

**CORE Phase III Rules Work Group  
DRAFT Health Care Services Request for Review/Response (278) Rule  
Certification/Testing Subgroup Draft – as of 03-23-10**

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Attachment: Copy of Companion Guide referenced in Section 4.7

1 **1 Background Summary**

2 CORE Phase I Rules focused on improving electronic eligibility and benefits verification, as eligibility is the  
3 first transaction in the claims process. Thus, if eligibility and benefits are correct, all the transactions that follow  
4 will be more effective and efficient. Building on Phase I, CAQH determined that CORE Phase II should be  
5 extended to include rules around the claim status transaction to allow providers to check the status of a claim  
6 electronically, without manual intervention, or confirm claims receipt.

7 Continuing to build on Phase I and Phase II CORE rules, CAQH determined that CORE Phase III should be  
8 extended to include rules around the health care services request for review and response transaction to allow  
9 the industry to leverage its investment in the Phase I and Phase II CORE infrastructure rules and apply them to  
10 conducting the ASC X12 005010X217 Health Care Services Review – Request and Response transactions  
11 (hereafter referenced as v5010 278 request and v5010 278 response and referred to as prior authorization in  
12 general.) Benefits to the industry in applying these CORE infrastructure rules to the prior authorization  
13 transactions will provide for:

- 14 • Less staff time spent on phone calls and websites
- 15 • Increased ability to conduct targeted follow-up
- 16 • More accurate and efficient processing claim payments

17 The inclusion of this CORE Phase III rule for the v5010 278 request and v5010 278 response continues to  
18 facilitate the industry’s momentum to increase access to the HIPAA-adopted administrative transactions, and  
19 will encourage CORE-certified entities to use the infrastructure they have for eligibility and claim status, and  
20 apply this infrastructure to the prior authorization.

21 **2 Issue to Be Addressed and Business Requirement Justification**

22 A challenge within the industry is that many health plan or utilization management organization (UMO) systems  
23 are not capable of processing a real-time 278 health care service review request and response transactions when  
24 these HIPAA transactions were first mandated for use in October 2001. Only batch transactions were accepted  
25 or if real-time transactions were accepted, the responses would not be returned in real time. Although batch  
26 transaction processing of the 278 Inquiry facilitated the processing of certifications, referrals, admissions, and  
27 authorizations, there is still a heavy reliance on manual processes within the health plan or UMO systems to  
28 generate a response to the 278. The manual process of responding to the 278 does not facilitate a broader  
29 adoption of the transaction since the same information can be obtained more readily from phone or fax options  
30 already commonly used. Although much progress has been made by health plans and UMOs in accepting and  
31 responding to real-time 278 transactions and many of their manual processes have been streamlined, adoption of  
32 the HIPAA-mandated 278 transactions still prove to be a challenge for many entities.

33 Aside from the batch only and the manual processing of the 278, many vendors do not support this transaction  
34 with their software offerings. Providers are required to use the 278 submission tools that each health plan or  
35 UMO provides: often a web tool to submit the 278 request since many practice management and patient  
36 accounting systems do not support the 278 transaction. The development of vendor products for the submission  
37 and receipt of the 278 Health Care Service Review Request and Response transactions is far behind the other  
38 HIPAA-mandated transactions and has caused a less-than-ideal adoption of the 278 transaction across the  
39 industry.

40 By promoting consistent connectivity methods between providers, health plans, UMOs, vendors, and  
41 clearinghouse manual processes for requesting and receiving prior authorization can be reduced and electronic  
42 transaction usage will increase. Defining acceptable acknowledgement response times, appropriate batch and  
43 real-time acknowledgements, system availability, and requiring the publication of a Companion Guide to ensure  
44 that trading partners are informed of the nuances required for successful transaction processing will allow the  
45 industry to more easily adopt the 278 transaction.

46 In Phase I CORE, several “infrastructure” rules were approved which are designed to bring consistency and to  
 47 improve the timely flow of the eligibility transactions. These infrastructure rules require

- 48 • real time exchange of eligibility transactions within 20 seconds or less
- 49 • the consistent use of the ASC X12 standard acknowledgements (TA1 Interchange Acknowledgement  
 50 and 997 Functional Group Acknowledgement) for both real time and batch exchanges
- 51 • 86% system availability of a health plan’s eligibility processing system components over a calendar  
 52 week
- 53 • use of the public internet for connectivity
- 54 • use of a best practices companion guide template for format and flow of companion guides for entities  
 55 that issue them

56 In Phase II CORE, these infrastructure rules were applied to the exchange of the ASC X12 276/277 Claim  
 57 Status Query and Response transaction sets and optionally, entities could go beyond the Phase I connectivity  
 58 requirements by using the Phase II more robust and comprehensive connectivity rule if they wished.

59 During the Phase III CORE rule-making, the Rules Work Group used discussion, research and straw poll results  
 60 to determine which infrastructure requirements should be applied to the exchange of the ASC X12 v5010 278  
 61 Health Care Services Review – Request and Response transaction set. Listed below is an overview of the  
 62 infrastructure requirements incorporated into this rule in §3 and §4.

<b>Phase III Rules Work Group Infrastructure Rules for the v5010 278 Health Care Services Review– Request/Response Transaction</b>	
<b>CORE Infrastructure Rule Description</b>	<b>Apply to Phase III CORE Rule for the 278 Health Care Services Review– Request/Response</b>
Connectivity <i>(essentially Phase II plus minor adjustments in Phase III)</i>	<b>Y</b>
Real Time Response Time <i>(same as Phase I/II)</i>	<b>Y</b>
Batch Response Time <i>(same as Phase I/II)</i>	<b>Y</b>
System Availability <i>(same as Phase I/II)</i>	<b>Y</b>
Companion Guide <i>(same as Phase I/II)</i>	<b>Y</b>
Real Time Interchange Acknowledgement <i>(same as Phase I/II)</i>	<b>Y</b>
Batch Interchange Acknowledgement <i>(same as Phase I/II)</i>	<b>Y</b>
Real Time Implementation Guide (TR3) Acknowledgement (999)	<b>Y</b>
Batch Implementation Guide (TR3) Acknowledgement (999)	<b>Y</b>
Normalize Patient Last Name Rule	<b>N</b>
AAA Error Code Reporting Rule	<b>N</b>

63  
 64 By applying these CORE infrastructure rules to conduct the delivery and use of the prior authorization request  
 65 and response information via the HIPAA-adopted ASC X12 005010X217 Health Care Services Review –  
 66 Request and Response (278) Technical Report Type 3 implementation guide, this CORE Phase III Prior  
 67 Authorization Rule helps provide the information that is necessary to electronically process a prior authorization  
 68 request and thus reduce the current cost of today’s paper-based transaction processes.

69 It is understood that applying the CORE infrastructure rules to the exchange of the v5010 278 does not address  
 70 the transaction data content needs of the industry but rather establishes a ‘highway.’ The next phase of CORE  
 71 rule-making will use the industry’s experience and lessons learned from implementing the v5010 of the 278 for  
 72 developing a CORE rule addressing the data content of this transaction now that Phase III CORE has established  
 73 infrastructure requirements to move the transactions as various entities are testing content approaches.

## 74 **3 Scope**

### 75 **3.1 What the Rule Applies To**

76 This CORE rule builds upon and extends the CORE Phase I and Phase II Infrastructure rules to the conduct of  
77 the HIPAA-adopted ASC X12 005010X217 Health Care Services Review – Request and Response (278)  
78 transaction (hereafter v5010 278.) This rule specifies that a CORE-certified entity must conduct these  
79 transactions in real time, respond within 20 seconds, make their systems available 86% of the time, use the ASC  
80 X12 standard acknowledgments, and support the CORE connectivity safe harbor requirements.

### 81 **3.2 When the Rule Applies**

82 This rule applies when a Phase III CORE-certified entity uses, conducts, or processes v5010 278 transactions.

### 83 **3.3 What the Rule Does Not Require**

84 This rule does not address any v5010 278 transaction content requirements of the HIPAA-adopted ASC X12  
85 005010X217 Health Care Services Review – Request and Response (278) Technical Report Type 3  
86 implementation guide. All Phase III rules applicable to health care services review requests and responses are  
87 related to improving access to the transaction, *not* addressing content requirements. This decision was made due  
88 to the need to establish infrastructure requirements, analyze lessons learned regarding data content needs, and  
89 consider the amount of data content requirements in other Phase III rules.

90 This rule does not require any entity to:

- 91 • Conduct, use, or process the v5010 278 transactions if it currently does not do so or is not required by  
92 federal or state regulation to do so.

### 93 **3.4 Outside the Scope of This Rule**

94 This rule does not address the data content of the v5010 278 request or v5010 278 response transactions.

### 95 **3.5 How the Rule Relates to CORE Phase I and Phase II**

96 This rule adds to the Phase I and II CORE infrastructure rules requirements by specifying the use of the ASC  
97 X12 005010X231 Implementation Acknowledgement for Health Care Insurance (999) when conducting v5010  
98 of the 278 request and v5010 of the 278 response transaction sets.

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

- 101 • Certification testing for each stakeholder wishing to be awarded a CORE-certified Seal;
- 102 • Entities seeking CORE-certification may use a contracted party to meet CORE rules, e.g., some  
103 providers meet CORE connectivity requirements via their vendor products;
- 104 • A health plan system exemption policy for system migration;
- 105 • Entities only need to test for and meet batch rule requirements for the v5010 278 if they currently offer  
106 batch for these transactions. A CORE guiding principle is to move to real time; thus, CORE rules do not  
107 require entities to build batch capabilities.

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

### 111 **3.6 Assumptions**

112 A goal of this rule is to adhere to the principles of EDI in assuring that transactions sent are accurately received  
113 and to facilitate correction of errors for electronically submitted prior authorization requests.

114 The following assumptions apply to this rule:

- 115 • A successful communication connection has been established.
- 116 • This rule is a component of the larger set of Phase III CORE rules; as such, all the CORE Guiding  
117 Principles apply to this rule and all other rules.
- 118 • All entities seeking Phase III certification must be Phase I and Phase II certified as CORE Phase I and  
119 CORE Phase II provide a foundation for CORE Phase III.
- 120 • This rule is not a comprehensive companion document addressing any content requirements of the  
121 v5010 278 request or response transaction sets.
- 122 • Compliance with all CORE rules is a minimum requirement; a CORE-certified entity is free to offer  
123 more than what is required in the rule.
- 124 • Providers, vendors, clearinghouses, and health plans all need to meet appropriate aspects of the rule and  
125 all will be tested via CORE certification testing.

## 126 **4 Draft Rule Requirements**

### 127 **4.1 Health Care Services Review–Request/Response Connectivity Requirements**

128 CORE-certified entities must be able to support the Phase III CORE Connectivity Rule.

129 This requirement addresses usage patterns for batch transactions, the exchange of security identifiers, and  
130 communications-level errors and acknowledgements. It does not attempt to define the specific content of the  
131 message exchanges beyond declaring that the HIPAA-mandated ASC X12 formats must be used between  
132 covered entities and security information must be sent outside of the ASC X12 payload.

133 The Phase III CORE Connectivity Rule is designed to provide a “safe harbor” that application vendors,  
134 providers, and health plans (or other information sources) can be assured will be supported by any CORE-  
135 certified trading partner. All CORE-certified organizations must demonstrate the ability to implement  
136 connectivity as described in this section. These requirements are not intended to require trading partners to  
137 remove existing connections that do not match the rule, nor is it intended to require that all CORE trading  
138 partners must use this method for all new connections. CORE expects that in some technical circumstances,  
139 trading partners may agree to use different communication mechanism(s) and/or security requirements than that  
140 described by these requirements.

### 141 **4.2 Health Care Services Review–Request/Response Real Time Acknowledgement Requirements**

#### 142 **4.2.1 Use of the 999 Implementation Acknowledgements for Real-Time**

143 A CORE-certified health plan (or utilization management organization (UMO)) must return

- 144 • a v5010 999 acknowledgement to indicate that a Functional Group(s) or Transaction Set(s) is rejected.

145 A CORE-certified health plan (or utilization management organization (UMO)) must not return

- 146 • a v5010 999 acknowledgement to indicate that a Functional Group(s) or Transaction Set(s) is accepted  
147 or accepted with errors.

148 Therefore, the submitter of a v5010 278 request in real time will receive only one response from the receiver  
149 (clearinghouse, intermediary, or health plan (utilization management organization [UMO])): a v5010 999  
150 rejection or a v5010 278 response.

151 **4.3 Health Care Services Review–Request/Response Batch Acknowledgement Requirements**

152 **4.3.1 Use of the 999 Implementation Acknowledgements for Batch**

153 These requirements for use of the v5010 999 acknowledgement for batch mode places parallel responsibilities  
154 on both requesters submitting the v5010 278 request (providers) and responders returning the v5010 278  
155 response (health plans, utilization management organizations or UMOs) for sending and accepting v5010 999  
156 acknowledgements. *The goal of this approach is to adhere to the principles of EDI in assuring that transactions  
157 sent are accurately received and to facilitate correction of errors in functional groups of v5010 278 requests  
158 and responses.*

159 The rule assumes a successful communication connection has been established and that all parties in the  
160 transaction routing path are CORE-certified.

161 A CORE-certified entity must return

- 162 • a 005010X231 999 acknowledgement for each Functional Group of v5010 278 request or v5010 278  
163 response transaction set(s) to indicate that the Functional Group(s) was either accepted, accepted with  
164 errors, or rejected

165 and

- 166 • to specify for each included v5010 278 request or v5010 278 response transaction set(s) that the  
167 transaction set was either accepted, accepted with errors, or rejected.

168 When a Functional Group of v5010 278 request or v5010 278 response transaction set(s) is either accepted with  
169 errors or rejected, the 005010X231 999 Implementation Acknowledgement for Health Care Insurance (999)  
170 must report each error detected to the most specific level of detail supported by the 999 Implementation  
171 Acknowledgement.

172 **4.4 Health Care Services Review–Request/Response Real Time Response Time Requirements**

173 Maximum response time when processing in real time mode<sup>1</sup> for the receipt of a v5010 278 response (or in the  
174 case of an error, a 999) from the time of submission of a v5010 278 request must be 20 seconds (or less). 999  
175 response errors must be returned within the same response timeframe.<sup>2</sup> *See §4.6 Prior Authorization System  
176 Availability Requirements for notification process of holidays.*

177 **4.4.1 Conformance Measurement**

178 Conformance with this maximum response time rule shall be considered achieved if 90 percent of all required  
179 responses are returned within the specified maximum response time as measured within a calendar month.

180 Each CORE-certified entity must demonstrate its conformance with this maximum response time rule by  
181 demonstrating its ability to capture, log, audit, match, and report the date (YYYYMMDD), time (HHMMSS),  
182 and control numbers from its own internal systems and the corresponding data received from its trading  
183 partners.

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

186 The actual delivery of statistics by a CORE-certified entity will be required only in response to a verified  
187 compliance complaint. Otherwise, a CORE-certified entity's compliance with the response time requirements  
188 will be based on good faith.

189 All CORE-certified entities are required to conform to this and other CORE rules regardless of the connectivity  
190 mode and methods used between CORE-certified trading partners.

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<sup>1</sup> Real-time mode is defined in the CORE Glossary of Terms.

<sup>2</sup> See §4.2 Prior Authorization Real Time Acknowledgement Requirements.

191 This rule assumes that all parties in the transaction routing path are CORE-certified and compliant.  
192 Refer to the CORE Phase III Certification Test Suite for details.

#### 193 **4.5 Health Care Services Review–Request/Response Batch Response Time Requirements**

194 When v5010 278 requests submitted in batch processing mode are subsequently converted to real-time  
195 processing by any intermediary clearinghouse or switch for further processing by the receiver (health plan or  
196 UMO) before being returned to the submitter as a batch of v5010 278 responses, the Prior Authorization Batch  
197 Response Time Requirements shall apply. (See §4.5.1)

#### 198 **4.5.1 Health Care Services Review–Request/Response Batch Mode Response Time Requirements**

199 Maximum response time when processing in batch mode<sup>3</sup> for the receipt of a v5010 278 response to a v5010  
200 278 request submitted by a provider or on a provider’s behalf by a clearinghouse/switch by 9:00 pm Eastern  
201 time of a business day must be returned by 7:00 am Eastern time the following business day. A business day  
202 consists of the 24 hours commencing with 12:00 am (Midnight or 0000 hours) of each designated day through  
203 11:59 pm (2359 hours) of that same designated day. The actual calendar day(s) constituting business days are  
204 defined by and at the discretion of each health plan or UMO. *See §4.6 Prior Authorization System Availability*  
205 *Requirements for notification process of holidays.*

#### 206 **4.5.1.1 999 Batch Mode Response Time Requirements**

207 v5010 999 acknowledgements must be available to the submitter within one hour of receipt of the batch: to the  
208 requester in the case of a batch of v5010 278 requests and to the health plan (or UMOs) in the case of a batch of  
209 v5010 278 responses.<sup>4</sup>

#### 210 **4.5.2 Conformance Measurement**

211 Conformance with this maximum response time rule shall be considered achieved if 90 percent of all required  
212 responses are returned within the specified maximum response time as measured within a calendar month.

213 Each CORE-certified entity must demonstrate its conformance with this maximum response time requirement  
214 by demonstrating its ability to capture, log, audit, match, and report the date (YYYYMMDD), time (HHMMSS)  
215 and control numbers from its own internal systems and the corresponding data received from its trading  
216 partners.

217 The actual delivery of statistics by a CORE-certified entity will be required only in response to a verified  
218 compliance complaint. Otherwise, a CORE-certified entity’s compliance with the response time requirements  
219 will be based on good faith.

220 All CORE-certified entities are required to conform to this and other CORE rules regardless of the connectivity  
221 mode and methods used between CORE-certified trading partners.

222 This rule assumes that all parties in the transaction routing path are CORE-certified and compliant.

223 Refer to the CORE Phase III Certification Test Suite for details.

#### 224 **4.6 Health Care Services Review–Request/Response System Availability**

225 Many healthcare providers have a need to request prior authorizations outside of the typical business day and  
226 business hours. Additionally, many institutional providers are now allocating staff resources to performing  
227 administrative and financial back-office activities on weekends and evenings. As a result, providers have a  
228 business need to be able to conduct prior authorization transactions at any time.

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<sup>3</sup> Batch mode is defined in the CORE Glossary of Terms

<sup>4</sup> See §4.3 Prior Authorization Batch Acknowledgements Requirements.

229 On the other hand, health plans or UMOs have a business need to take their prior authorization processing and  
230 other systems offline periodically in order to perform the required system maintenance. This typically results in  
231 some systems not being available for timely v5010 278 requests and v5010 278 responses certain nights and  
232 weekends. This rule requirement addresses these conflicting needs.

#### 233 **4.6.1 System Availability Requirements**

234 System availability<sup>5</sup> must be no less than 86 percent per calendar week<sup>6</sup> for both real-time and batch processing  
235 modes. This will allow for health plan (or UMO), clearinghouse/switch or other intermediary system updates to  
236 take place within a maximum of 24 hours per calendar week for regularly scheduled downtime.

#### 237 **4.6.2 Reporting Requirements**

##### 238 **4.6.2.1 Scheduled Downtime**

239 CORE-certified health plans (or UMOs), clearinghouses/switches, or other intermediaries must publish their  
240 regularly scheduled system downtime in an appropriate manner (e.g., on websites or in companion guides) such  
241 that the healthcare provider can determine the health plan's (or UMO's) system availability so that staffing  
242 levels can be effectively managed.

##### 243 **4.6.2.2 Non-Routine Downtime**

244 For non-routine downtime (e.g., system upgrade), a health plan or UMO must publish the schedule of non-  
245 routine downtime at least one week in advance.

##### 246 **4.6.2.3 Unscheduled Downtime**

247 For unscheduled/emergency downtime (e.g., system crash), a health plan, or UMO is required to provide  
248 information within one hour of realizing downtime will be needed.

##### 249 **4.6.2.4 No Response Required**

250 No response is required during scheduled downtime(s).

##### 251 **4.6.2.5 Holiday Schedule**

252 Each health plan, (or UMO) clearinghouse/switch, or other intermediary will establish its own holiday schedule  
253 and publish it in accordance with the rule above.

#### 254 **4.7 Health Care Services Review–Request/Response Companion Guide**

255 Health plans or UMOs have the option of creating a “companion guide” that describes the specifics of how they  
256 will implement the HIPAA transactions. The companion guide is in addition to and supplements the ASC X12  
257 TR3 implementation guide adopted for use under HIPAA.

258 Currently health plans or UMOs have independently created companion guides that vary in format and structure.  
259 Such variance can be confusing to trading partners/providers who must review numerous companion guides  
260 along with the ASC X12 TR3 implementation guides. To address this issue, CORE developed the Companion  
261 Guide Template for health plans, UMOs, or information sources. Using this template, health plans, UMOs, and  
262 information sources can ensure that the structure of their companion guide is similar to other health plan's  
263 documents, making it easier for providers to find information quickly as they consult each health plan's  
264 document on these important industry EDI transactions.

265 Developed with input from multiple health plans, system vendors, provider representatives, and  
266 healthcare/HIPAA industry experts, this template organizes information into several simple sections – General

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<sup>5</sup> System is defined as all necessary components required to process a v5010 278 request and v5010 278 response.

<sup>6</sup> Calendar week is defined as 12:01 a.m. Sunday to 12:00 a.m. the following Sunday.

267 Information (Sections 1-9) and Transaction-Specific Information (Section 10) – accompanied by an appendix.  
268 Note that the companion guide template is presented in the form of an example of a fictitious Acme Health Plan  
269 viewpoint.

270 Although CORE participants believe that a standard template/common structure is desirable, they recognize that  
271 different health plans may have different requirements. The CORE Companion Guide template gives health  
272 plans the flexibility to tailor the document to meet their particular needs.

273 *Note: This Companion Guide template has been adapted from the CAQH/WEDI Best Practices Companion*  
274 *Guide Template originally published January 1, 2003. This Template is not specific to any version of the*  
275 *HIPAA-adopted transactions and thus can be used for v5010. CORE will consider the work product from the*  
276 *joint WEDI/ASC X12 Companion Guide efforts to update the CAQH/WEDI companion guide template for v5010*  
277 *when such work is formally published.*

#### 278 **4.7.1 Health Care Services Review–Request/Response Companion Guide Requirements**

279 All CORE-certified entities’ Companion Guides covering the v5010 278 Health Care Services Review –  
280 Request and Response transaction must follow the format/flow as defined in the CORE Companion Guide  
281 Template for HIPAA Transactions. (See §4.7.2 for template details.)

282 Note: This rule does not require any CORE-certified entity to modify any other existing companion guides that  
283 cover other HIPAA-adopted transaction implementation guides.

#### 284 **4.7.2 Companion Guide Template Details**

285 *(See Attachment to this document)*

### 286 **5 Conformance Requirements**

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

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

### 294 **6 Appendix**

#### 295 **6.1 Appendix 1: Abbreviations and Definitions Used in this Rule**

#### 296 **6.2 Appendix 2: Reference**

- 297 • ASC X12 005010X231 Implementation Acknowledgement for Health Care Insurance (999) Technical  
298 Report Type 3
- 299 • ASC X12 005010X217 Health Care Services Review – Request for Review and Response (278)  
300 Technical Report Type 3 and associated published errata