



## CORE Phase II Certification Test Suite

**Version 2.0.1**  
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### Revision History for CORE Phase II Certification Test Suite

Version	Revision	Description	Date
2.0.0	Major	CORE Phase II Certification Test Suite balloted and approved by CORE members.	July 15, 2008
2.0.1	Minor	Batch connectivity tests scripts added.	Mar 16, 2009
<p>Change Summary for Version 2.0.1</p> <p>Section 3.11.1</p> <ul style="list-style-type: none"> <li>Key Rule Requirement Language updated for clarity and specificity, including the addition of applicable rule section references.</li> </ul> <p>Section 3.11.2</p> <ul style="list-style-type: none"> <li>Conformance Testing Requirement language updated to include Batch connectivity requirements. Batch connectivity testing is required for entities that support Batch communications.</li> </ul> <p>Section 3.11.4</p> <ul style="list-style-type: none"> <li>Detailed Step-by-Step Test Scripts updated to include test scripts #7-12 for Batch connectivity. Test scripts #2 and #4 Expected Result language updated for clarity.</li> </ul>			

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# 1 Introduction to CORE Phase II Certification Test Suite

## 1.1 PURPOSE OF THIS DOCUMENT

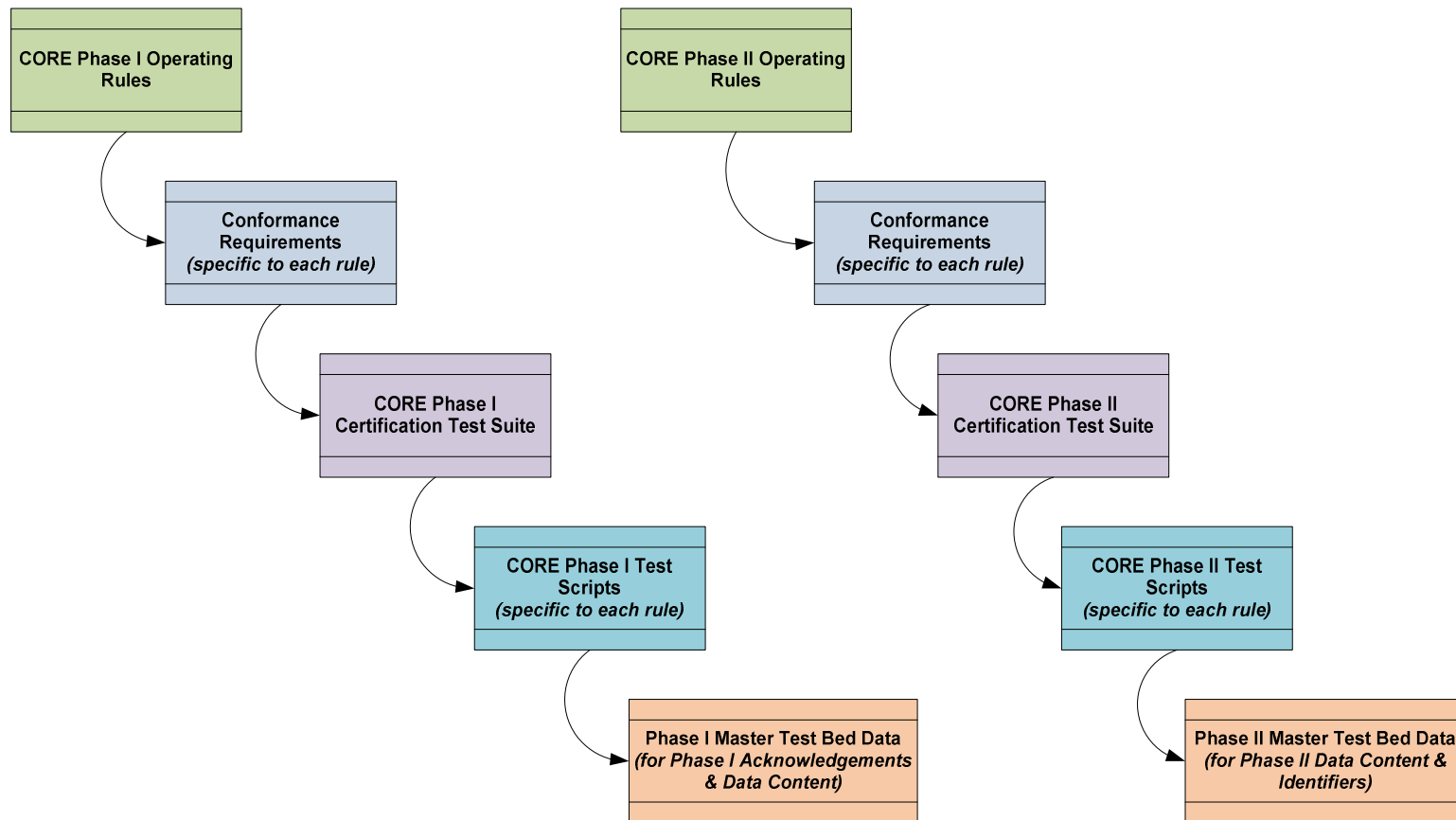
This CORE Certification Test Suite document contains all of the requirements that must be met in order for an entity seeking CORE Certification to be awarded a Phase II CORE Certified Seal. As such, this Test Suite includes:

- Four Master Scenarios describing the end-to-end eligibility information exchange process (see §2.1) and the end-to-end claim status inquiry process in non-technical language (see §2.2).
- The specific conformance requirements and detailed testing for each CORE Phase II Rule (see §1.3, §1.4 and §3).
- The required Certification Testing for each CORE Phase II Rule, including specific detailed step-by-step test scripts by rule. (See §1.5 and §3 for each rule-specific testing requirements.)
- Guidance to help stakeholders better understand the various types of stakeholders to which the CORE rules apply and how to determine when a specific rule detailed test script applies is also included (see §1.4).
- An Appendix that contains the detailed Test Suite Supplement (see §4.1), which provides information and guidance about the Phase II CORE Master Test Bed Data, how the test data is made available, as well as loading and using the Master Test Bed Data. The Test Suite Supplement also includes specific instructions for certain test bed data elements that may be modified when loading and using the test data for certification testing.

Note the CORE Guiding Principles apply to the entire set of rules, including the Test Suite. As with Phase I testing, Phase II testing is not exhaustive and does not use production-level testing.

The figure below depicts the high-level parts of the testing process:

Key Components of Phase I and Phase II CORE Certification Testing



1.2 APPLICABILITY OF THIS DOCUMENT

The CORE Phase II Certification Test Suite must be used by all stakeholders undergoing CORE Phase II Certification Testing. This is required in order to maintain standard and consistent test results and CORE rule compliance. There are no exceptions to this requirement.

### 1.3 THE MASTER SCENARIOS

The CORE Certification Test Suite uses four Master Scenarios (§2) to describe both the real time and batch business processes for end-to-end insurance verification/eligibility inquiries and for end-to-end claim status inquiries using business language, not technical specifications to the extent appropriate.

- Master Scenario #1: Eligibility Single/Dual Clearinghouse Provider-to-Health Plan Model
- Master Scenario #2: Eligibility Provider Direct to Health Plan Model
- Master Scenario #3: Claim Status Single/Dual Clearinghouse Provider-to-Health Plan Model
- Master Scenario #4: Claim Status Provider Direct to Health Plan Model

The overall business process for an insurance verification/eligibility inquiry and for a claim status inquiry does not change from a business viewpoint for each CORE rule. Rather, each CORE rule addresses a critical interoperability activity/task within the common business process.

Using only four Master Scenarios for all rules simplifies rule test scenario development since the key variables for each rule will be only the actual conformance language of the rule and then each test scenario's test objectives, assumptions, and detailed step-by-step test scripts.

### 1.4 STRUCTURE OF TEST SCENARIOS FOR ALL RULES

Each test scenario for each rule contains the following sections:

- Key Rule Requirements (the CORE Rules document contains the actual rule language and is the final authority for all rule requirements)
- Certification conformance requirements by rule
- Test assumptions by rule
- Detailed step-by-step test scripts addressing each conformance requirement by rule for each stakeholder to which the test script applies

Each stakeholder may indicate that a specific test script does not apply to it and is required to provide a rationale for indicating a specific test script is not applicable. (See §1.5.1 for guidance in determining when a specific test script may not apply.)

### 1.5 DETAILED STEP-BY-STEP TEST SCRIPTS

#### 1.5.1 Stakeholder Categories –Determining Test Script Applicability

The Detailed Step-by-Step Test Scripts for each rule specify for which stakeholder type each test script applies. The stakeholder categories are:

- Provider

- Health Plan
- Clearinghouse
- Vendor

Oftentimes Providers and Health Plans outsource various functions to Clearinghouses. In such cases a specific Clearinghouse may be acting on behalf of either a Provider stakeholder or a Health Plan stakeholder. Thus, when establishing a Certification Test Profile with a CORE-authorized Certification Test Vendor, a Clearinghouse may be asked to indicate if it is a Provider/Clearinghouse or a Health Plan/Clearinghouse. When a Provider/Clearinghouse role is selected, the Detailed Step-by-Step Test Scripts applicable to a Provider will apply to a Provider/Clearinghouse. Similarly, when a Health Plan/Clearinghouse role is selected, the Detailed Step-by-Step Test Scripts applicable to a Health Plan will apply to a Health Plan/Clearinghouse.

Vendor stakeholders must certify each specific product separately. (See Guiding Principles and CORE 202 Phase II Certification Policy version 2.0.0.) Thus, when establishing a Certification Test Profile with a CORE-authorized Certification Testing Vendor you will be given the option to indicate if the product you are certifying is a Provider/Vendor product or a Health Plan/Vendor product. The Detailed Step-by-Step Test Scripts applicable to a Provider will apply to a Provider/Vendor product. Similarly, when you are certifying a Health Plan product the Detailed Step-by-Step Test Scripts applicable to a Health Plan will apply to a Health Plan/Vendor product.

#### ***1.5.2 Guidance for Health Plans Seeking CORE Phase II Certification Who Work With a CORE Phase II Certified Clearinghouse***

Health plans seeking CORE Phase II certification that use a clearinghouse to send back eligibility or claim status responses to providers, and to receive eligibility and claim status inquiries from providers, may have some unique CORE certification issues. Because there is a clearinghouse, or similar type of intermediary, between the health plan's eligibility and claim status system and the provider's eligibility system, the clearinghouse will act as a "proxy" for some of the CORE certification requirements outlined in the CORE Phase II Test Suite. Therefore, dependent upon the scenario between the health plan and clearinghouse, the health plan may not have to undergo certification testing for some of the rules, but rather may choose the N/A option for testing for a rule, and then upload a rationale statement explaining the situation to the CORE-authorized testing vendor.

**Reminder:** *There exist varying scenarios for this type of situation. The requirements for meeting the CORE rule requirements for clearinghouses and health plans differ by situation, as such variability is dependent on how the health plan interacts with the clearinghouse and what services (i.e., functions and capabilities) the clearinghouse provides to the health plan. Therefore, please keep in mind that certification testing will differ by scenario.*

#### ***1.5.3 Guidance for Providers Seeking CORE Phase II Certification Who Work With a CORE Phase II Certified Clearinghouse***

Provider organizations seeking CORE Phase II certification that use a clearinghouse to send eligibility or claim status requests to payers, and to receive eligibility and claim status responses from payers, may have some unique CORE certification issues. Because there is a clearinghouse, or similar type of intermediary, between the provider's eligibility and claim status system and the payer's eligibility and claim status system, the clearinghouse will act as a "proxy" for some of the CORE certification requirements outlined in the CORE Phase II Test Suite. Therefore, dependent upon the scenario between the provider and clearinghouse, the provider may not have to undergo certification testing for some of the rules, but rather may choose the N/A option for testing for a rule, and then upload a rationale statement explaining the situation to the CORE-authorized testing vendor.

**Reminder:** *There exist varying scenarios for this type of situation. The requirements for meeting the CORE rule requirements for clearinghouses and providers differ by situation, as such variability is dependent on how the provider interacts with the clearinghouse and what services (i.e., functions and capabilities) the clearinghouse provides to the provider. Therefore, please keep in mind that certification testing will differ by scenario.*

## 1.6 PHASE II TEST SUITE SUPPLEMENT

The CORE Phase II Test Suite Supplement provides additional information and details about the use and format of the Phase II CORE Master Test Bed Data, as it applies to the CORE 258 Normalizing Last Name, the CORE 259 Use of AAA Error Codes for Reporting Errors in Subscriber/Patient Identifiers & Names; and 260 Data Content (270/271) rules. Since the Phase II CORE 250 Claim Status Rule does not address any content requirements for either the 276 Claim Status Request or the 277 Claim Status Response transactions there is no need for Master Test Bed Data specific to these transactions for Phase II certification testing. The supplement is to be used in conjunction with the CORE Certification Test Suite. It does not replace any of the CORE Phase I Policies and Rules or the CORE Phase I Certification Test Suite, but rather is intended to provide additional information and details regarding the use and format of the Phase II CORE Master Test Bed Data. Note that the Phase II CORE Master Test Bed Data only applies to the CORE 258 Normalizing Last Name, the CORE 259 Use of AAA Error Codes for Reporting Errors in Subscriber/Patient Identifiers & Names; and 260 Data Content (270/271) rules; the other CORE Phase II Rules do not require the use of the test data. The other Phase II rules either are testing using paper-based review methods or through Connectivity.

### 1.6.1 Phase II Master Test Bed Data

The scope of the Phase II CORE Master Test Bed Data is limited to data needed for entities seeking to become CORE-certified to create and populate their internal files and/or databases. The Phase II CORE Master Test Bed Data builds upon and extends the Phase I CORE Master Test Bed Data. These data are then used for internal pre-certification testing and CORE certification testing for the CORE rules that require transaction-based testing, e.g., CORE Phase II Rules:

- 258: Normalizing Patient Last Name
- 259: Use of AAA Error Codes for Reporting Errors in Subscriber/Patient Identifiers & Names
- 260: Data Content (270/271)

Thus, CORE-authorized certification testing vendors use only the CORE Master Test Bed Data to conduct CORE certification testing for the CORE 258 Normalizing Last Name, the CORE 259 Use of AAA Error Codes for Reporting Errors in Subscriber/Patient Identifiers & Names; and 260 Data Content (270/271) rules. The other Phase II rules either are tested using paper-based review methods or through Connectivity. The scope of the test bed data is not intended to include all data that an entity may require in order to load their internal systems. Therefore, entities may need to add other data to the master test data when loading internal systems.

Since the CORE Phase II rules do not address the specific use and data content of the ISA and GS control segments, the CORE Master Test Bed Data does not contain nor specify specific values that must be used in these control segments.

Thus, CORE-authorized certification testing vendors will be using only the CORE Master Test Bed Data to conduct CORE certification testing for the CORE 258 Normalizing Last Name, the CORE 259 Use of AAA Error Codes for Reporting Errors in Subscriber/Patient Identifiers & Names; and 260 Data Content (270/271) rules.

The CORE Phase II Master Test Data accompanies this Test Suite.

- All entities seeking CORE certification will be required to test against this Master Test Data Bed.
- This data will be made available to all entities seeking CORE certification for use of pre-certification internal self-testing.

- The Master Test Suite Supplement should be used in accompaniment with the Master Test Data (see Appendix).

#### 1.6.1.1 Applicability of the Phase II Master Test Bed Data

The Phase II Master Test Bed Data is applicable only to the CORE 258 Normalizing Last Name, the CORE 259 Use of AAA Error Codes for Reporting Errors in Subscriber/Patient Identifiers & Names; and 260 Data Content (270/271) rules; however, all CORE Certification Testing related to these two rules will be conducted using the same CORE Master Test Bed Data, thus ensuring reliable and consistent test results for all CORE-authorized certification testing entities.

*The CORE Master Test Bed Data is comprised of base data for several subscribers, dependents and their associated health plan coverage. The Test Suite Supplement provides guidance about the Master Test Bed Data. The CORE Master Test Bed Data is supplied only in an Excel spreadsheet format in a separate Excel Workbook. Although CORE certification testing will use this CORE Master Test Bed Data as presented in the base data, the types of transactions that will be tested against this data are specified in the CORE Test Suite under the Test Scripts for each of the rules.*

The CORE Certification Test Suite requires that all organizations seeking CORE certification be tested using the same Master Test Bed Data. The Phase II CORE Master Test Bed Data is distributed in Excel spreadsheet format so that organizations may easily extract the key data elements and load them into their internal test databases. The CORE-Authorized Certification Testing Vendors will use only the Phase II CORE Master Test Bed Data to conduct CORE certification testing for the CORE 258 Normalizing Last Name, the CORE 259 Use of AAA Error Codes for Reporting Errors in Subscriber/Patient Identifiers & Names; and 260 Data Content (270/271) rules. The Excel document containing the Phase II CORE Master Test Bed Data is available for download at the CAQH/CORE website ([www.caqh.org](http://www.caqh.org)).

## 2 The Master Scenarios

### 2.1 ELIGIBILITY MASTER SCENARIOS

#### 2.1.1 *Single/Dual Clearinghouse Provider-to-Health Plan Business Model*

##### 2.1.1.1 Introduction

This Master CORE Business Process Scenario describes both the real time and batch business processes for end-to-end insurance verification/eligibility inquiries using business language, not technical specifications to the extent appropriate, in which there are either one or two clearinghouses providing services to the healthcare provider and health plan or information source. Since the overall business process for insurance verification/eligibility inquiry does not fundamentally change from a business viewpoint, each CORE rule addresses a critical interoperability activity/task within the common business process. Thus, the focus for this scenario is on the EDI aspects of the overall end-to-end business process and not on attempting to describe all of the activities and tasks typically performed by each of the stakeholders in the process.

##### 2.1.1.2 Background

This scenario describes the healthcare insurance verification/eligibility end-to-end business process and the key activities and tasks conducted between a healthcare provider where each party uses the services of a healthcare clearinghouse. For purposes of CORE Certification Testing, stakeholders include providers, health plans, clearinghouses, switches, other intermediaries, and solution vendors.

Each stakeholder type is equipped with an automated system (the “system”) appropriate to its needs, e.g., a provider would have a hospital (or health) information system, commonly referred to as an HIS, or an automated practice management system (the “system”), commonly referred to as a PMS.

The “system” is defined as all of the components necessary for the stakeholder to conduct its automated business processes, e.g., all necessary network nodes, all platform components delivered by the vendor, and all the vendor components (e.g. documentation) included with the system. The system may consist of one or many workstations, servers and mainframe systems, and may capture patient registration information at the point of patient intake (or scheduling) at the workstation if the stakeholder is a provider.

##### 2.1.1.3 Eligibility Business Process Description

###### 2.1.1.3.1 *Appointment Scheduling Process*

An appointment scheduler at the provider’s office is scheduling an appointment for either an office visit or admission (depending on the type of provider) for a patient in 2 weeks while on the phone with the patient. The scheduler inquires about the reason for the appointment, collects data from the patient following prompts on the workstation and enters all of the necessary information into the PMS/HIS.

When all of the necessary patient demographic and insurance information is entered, the scheduler is prompted to submit an insurance verification transaction by either a menu selection or by clicking an icon (as determined by the PMS/HIS vendor user interface design.)

The PMS/HIS automatically edits the eligibility transaction for completeness and valid data values where applicable and prompts the scheduler to correct any invalid or omitted data. When the transaction editing is completed, the PMS/HIS assigns a unique internal tracking number, records the identification and address of the workstation used by the scheduler, and creates the eligibility inquiry transaction.

Using internal tables/files, the PMS/HIS determines the Internet address for its clearinghouse, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the eligibility inquiry transaction, and establishes a communications session with the clearinghouse's system. The eligibility inquiry transaction created by the PMS/HIS for transfer to its clearinghouse/switch may be either in a proprietary format or a fully enveloped X12 Interchange containing the 270 Eligibility inquiry transaction set.

#### *2.1.1.3.2 Provider Clearinghouse Real Time Eligibility Inquiry Process*

The clearinghouse's Internet portal accepts the provider's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the eligibility inquiry transaction, which is then extracted and passed to the appropriate systems in the clearinghouse for further processing. The clearinghouse's system edits the eligibility transaction for completeness and valid data values where applicable. If the eligibility transaction fails editing, the clearinghouse returns to the provider an appropriate error message or acknowledgement describing the reasons for failure and rejection, thereby allowing the provider to correct and re-submit the eligibility transaction. Such error message or acknowledgement may be either a proprietary or valid X12 Acknowledgement, depending on the type and range of services the clearinghouse is providing.

Using internal tables/files and/or an external directory service, the clearinghouse system determines the Internet address for the clearinghouse serving the health plan specified in the provider's eligibility inquiry transaction, creates and envelops the complete X12 Interchange containing the 270 inquiry, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the X12/270 Interchange, and establishes a communications session with the health plan's clearinghouse. Depending on the range and type of services being provided to the provider by the clearinghouse, the clearinghouse may or may not have responsibility for creating the correct X12 Interchange containing the 270 Eligibility inquiry or for performing other data validation/transformation and/or editing functions prior to forwarding the eligibility inquiry to either the health plan or the health plan's clearinghouse. Upon successful transfer of the X12/270 Interchange to the health plan's clearinghouse, the provider's clearinghouse maintains the communications session open and active until receipt of either a X12/TA1, X12/997 or X12/271 Interchange from the health plan's clearinghouse.<sup>1</sup>

If the X12/270 Interchange fails technical X12 syntax verification at the health plan's clearinghouse, the provider's clearinghouse receives the TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate) indicating the rejection of the Interchange or Functional Group, extracts/reformats the rejection acknowledgement and takes appropriate action to resolve the rejection. This may be by returning it to the provider's PMS/HIS or correcting the errors within the clearinghouse.

When the X12/271 eligibility response transaction is received from the health plan's clearinghouse, the clearinghouse's Internet portal records the message receipt date/time, assigns an internal tracking number to the message linked to the X12/271 Interchange, returns a signal to the health plan's clearinghouse that the X12/271 Interchange payload has been successfully stored into persistent storage, and passes the X12/271 Interchange to the clearinghouse's EDI management system for further processing. The clearinghouse's EDI management system processes (validates) the X12/271 Interchange which may contain either a 271 with AAA Validation Request

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<sup>1</sup> Alternatively, a single clearinghouse may be serving both the provider and the health plan to which the eligibility inquiry transaction is to be transmitted. In this case, the single clearinghouse would not only perform the reformatting of non-standard data and non-standard format received from the provider into the HIPAA-required standard, but would then perform the reformatting of the standard data and standard format into non-standard data and non-standard format required by the health plan. A similar set of functions would be performed when processing the eligibility response transaction received from the health plan. See Health Plan Clearinghouse Real Time Eligibility Inquiry Process section in this document for a complete description of this process.



rejection/error codes or a 271 with the requested benefit data. The EDI management system extracts the 271 response data, creates the required eligibility response transaction required by the provider's PMS/HIS (may be either a proprietary or valid X12/271 Interchange), and transfers the eligibility response transaction to the provider's PMS/HIS.

#### *2.1.1.3.3 Health Plan Clearinghouse Real Time Eligibility Inquiry Process*

The health plan's clearinghouse Internet portal accepts the provider's clearinghouse's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the X12/270 Interchange, returns a signal to the provider's clearinghouse that the X12/270 Interchange payload has been successfully stored into persistent storage, and passes the X12/270 Interchange to the clearinghouse's EDI management system for further processing. The clearinghouse's EDI management system, processes (validates) the X12/270 Interchange.

If the X12/270 Interchange passes technical X12 syntax verification, the EDI management system extracts the eligibility inquiry data from the 270 transaction set, creates the required internal eligibility inquiry transaction required by the health plan. Using internal tables/files and/or an external directory service, the clearinghouse system determines the Internet address for the health plan specified in the provider's eligibility inquiry transaction, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the eligibility inquiry transaction, and establishes a communications session with the health plan if such a communications link is not already open and active. Upon successful transfer of the eligibility inquiry transaction to the health plan, the clearinghouse maintains the communication session open and active pending receipt of the eligibility response transaction from the health plan.

If the X12/270 Interchange fails technical X12 syntax verification, the EDI management system automatically generates the TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate) indicating the rejection of the Interchange or Functional Group, returns the rejection acknowledgement to the provider's clearinghouse, terminates the communications session (if necessary) and discontinues any further processing of the inquiry transaction.

When the eligibility response transaction is received from the health plan, the clearinghouse's EDI management system edits the eligibility response data for correctness and completeness, creates the X12 Interchange containing the 271 eligibility response, passes the X12/271 Interchange to the open communications session which returns the X12/271 Interchange to the provider's clearinghouse. The X12/271 Interchange may contain either a 271 with AAA Validation Request rejection/error codes or a 271 with the requested benefit data.

#### *2.1.1.3.4 Health Plan Real Time Eligibility Inquiry Process*

The health plan's Internet portal accepts the clearinghouse's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the eligibility inquiry transaction, which is then extracted and passed to the health plan's eligibility inquiry system for processing. The eligibility system accesses all of the necessary internal data stores (files, databases, etc.) to process the eligibility inquiry transaction to determine the benefits and status of coverage for the individual identified in the inquiry. The data is then assembled and routed to the health plan's clearinghouse. When the clearinghouse signals successful receipt of the eligibility response transaction to the health plan's system, the communications session may be terminated or maintained open and active as determined between the health plan and its clearinghouse.

#### *2.1.1.3.5 Provider Real Time Eligibility Response Process*

The provider's PMS/HIS receives the eligibility response transaction from its clearinghouse, records the message receipt date/time, assigns an internal tracking number to the message linked to the eligibility response transaction, and matches the tracking number, message receipt date/time to the corresponding eligibility inquiry transaction. The PMS/HIS then processes (validates) the eligibility response transaction, which is routed to the correct workstation for display to the scheduler.

If the eligibility response transaction indicates the inquiry was rejected, the PMS/HIS displays the reasons for such rejection, enabling the scheduler to resolve the rejection by obtaining corrected data as indicated from the patient during the initial appointment/admission scheduling phone call. The PMS/HIS then resubmits the corrected eligibility inquiry.

If the eligibility response transaction contains the requested benefit coverage, benefit status, and patient financial responsibility information, the PMS/HIS displays the benefit information, enabling the scheduler to confirm the benefit coverage and status with the patient and to inform the patient of any co-pay, co-insurance, or deductible amounts during the initial appointment/admission scheduling phone call.

The provider's scheduler then confirms the date and time of the appointment/admission with the patient, reminds the patient of any information required at the time of the appointment/admission and concludes the phone call with the patient.

#### *2.1.1.3.6 Provider Pre-Appointment Batch Eligibility Process*

On a daily basis the provider's PMS/HIS automatically scans all scheduled appointments/admissions for two days in advance of the current date, extracts all of the necessary data, creates one or more batches of eligibility inquiries for each health plan covering the patient appointments/admissions for that date, assigns unique internal tracking numbers and records the date/time for each batch.

Using internal tables/files and/or an external directory service, the PMS/HIS determines the Internet address for each health plan, envelopes the complete X12 Interchange containing the batch of 270 inquiries for each health plan, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the correct batch X12/270 Interchange, establishes a communications session with each health plan's system and transfers the batch of eligibility inquiry transactions in either a proprietary non-standard format or X12/270 Interchange to its clearinghouse for transmission to the health plan's clearinghouse prior to 9:00 pm ET, the daily cut-off time for batch submissions.

#### *2.1.1.3.7 Provider Clearinghouse Batch Eligibility Inquiry Process*

The clearinghouse's Internet portal accepts the provider's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the eligibility inquiry transaction, which is then extracted and passed to the appropriate systems in the clearinghouse for further processing. The clearinghouse's system edits the eligibility transaction for completeness and valid data values where applicable. If the eligibility transaction fails editing, the clearinghouse returns to the provider an appropriate error message or acknowledgement describing the reasons for failure and rejection, thereby allowing the provider to correct and re-submit the eligibility transaction. Such error message or acknowledgement may be either a proprietary or valid X12 Acknowledgement, depending on the type and range of services the clearinghouse is providing.

Using internal tables/files and/or an external directory service, the clearinghouse system determines the Internet address for the clearinghouse serving the health plan specified in the provider's eligibility inquiry transaction, creates and envelopes the complete X12 Interchange containing the 270 inquiry, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the X12/270 Interchange, and establishes a communications session with the health plan's clearinghouse. Depending on the range and type of services being provided to the provider by the clearinghouse, the clearinghouse may or may not have responsibility for

creating the correct X12 Interchange containing the 270 Eligibility inquiry or for performing other data validation/transformation and/or editing functions prior to forwarding the eligibility inquiry to either the health plan or the health plan's clearinghouse. Upon successful transfer of the X12/270 Interchange to the health plan's clearinghouse, the provider's clearinghouse maintains the communications session open and active until receipt of either a X12/TA1, X12/997 or X12/271 Interchange from the health plan's clearinghouse.<sup>2</sup>

If the X12/270 Interchange fails technical X12 syntax verification at the health plan's clearinghouse, the provider's clearinghouse receives the TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate) indicating the rejection of the Interchange or Functional Group, extracts/reformats the rejection acknowledgement and takes appropriate action to resolve the rejection. This may be by returning it to the provider's PMS/HIS or correcting the errors within the clearinghouse.

When the X12/271 eligibility response transaction is received from the health plan's clearinghouse, the clearinghouse's Internet portal records the message receipt date/time, assigns an internal tracking number to the message linked to the X12/271 Interchange, returns a signal to the health plan's clearinghouse that the X12/271 Interchange payload has been successfully stored into persistent storage, and passes the X12/271 Interchange to the clearinghouse's EDI management system for further processing. The clearinghouse's EDI management system processes (validates) the X12/271 Interchange which may contain either a 271 with AAA Validation Request rejection/error codes or a 271 with the requested benefit data. The EDI management system extracts the 271 response data, creates the required eligibility response transaction required by the provider's PMS/HIS (may be either a proprietary or Valid X12/271 Interchange), and transfers the eligibility response transaction to the provider's PMS/HIS.

#### *2.1.1.3.8 Health Plan Clearinghouse Batch Eligibility Inquiry Process*

The health plan's clearinghouse Internet portal accepts the provider's clearinghouse's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the X12/270 Interchange, returns a signal to the provider's clearinghouse that the X12/270 Interchange payload has been successfully stored into persistent storage, and passes the X12/270 Interchange to the clearinghouse's EDI management system for further processing. The clearinghouse's EDI management system, processes (validates) the X12/270 Interchange.

If the X12/270 Interchange passes technical X12 syntax verification, the EDI management system automatically generates the 997 Functional Acknowledgement indicating acceptance of the X12/270 Interchange, returns the X12/997 Interchange to the provider's clearinghouse, extracts the eligibility inquiry data from the 270 transaction set, and creates the required internal eligibility inquiry transactions required by the health plan.

Using internal tables/files and/or an external directory service, the clearinghouse system determines the Internet address for the health plan specified in the provider's eligibility inquiry transaction, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the eligibility inquiry transaction, and establishes a communications session with the health plan if such a communications link is not already open and active. Upon successful transfer of the eligibility inquiry

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<sup>2</sup> Alternatively, a single clearinghouse may be serving both the provider and the health plan to which the eligibility inquiry transaction is to be transmitted. In this case, the single clearinghouse would not only perform the reformatting of non-standard data and non-standard format received from the provider into the HIPAA-required standard, but would then perform the reformatting of the standard data and standard format into non-standard data and non-standard format required by the health plan. A similar set of functions would be performed when processing the eligibility response transaction received from the health plan. See Health Plan Clearinghouse Real Time Eligibility Inquiry Process section in this document for a complete description of this process.

transactions to the health plan, the clearinghouse either terminates (if necessary) or maintains the communication session open and active pending receipt of the eligibility response transactions from the health plan.

If the X12/270 Interchange fails technical X12 syntax verification, the EDI management system automatically generates the TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate) indicating the rejection of the Interchange or Functional Group, returns the rejection acknowledgement to the provider's clearinghouse, terminates the communications session (if necessary) and discontinues any further processing of the inquiry transaction.

When the eligibility response transactions are received from the health plan, the clearinghouse's EDI management system edits the eligibility response data for correctness and completeness, creates the X12 Interchange containing the 271 eligibility responses, passes the X12/271 Interchange to the communications module which returns the X12/271 Interchange to the provider's clearinghouse. The X12/271 Interchange may contain either a 271 with AAA Validation Request rejection/error codes or a 271 with the requested benefit data.

#### *2.1.1.3.9 Health Plan Batch Eligibility Inquiry Process*

The health plan's Internet portal accepts the provider's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the batch X12/270 Interchange, which is then extracted and passed to the health plan's EDI management system for further processing. The health plan's Internet portal returns the correct HTTP message accepted code to the provider's PMS/HIS and terminates the communications session.

The health plan's EDI management system, processes (validates) the batch X12/270 Interchange. If the batch X12/270 Interchange fails technical X12 syntax verification, the EDI management system automatically generates the TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate) indicating the rejection of the Interchange or Functional Group, stages the rejection acknowledgement for subsequent retrieval by the provider's PMS/HIS, and discontinues any further processing of the batch X12/270 Interchange.

If the batch X12/270 Interchange passes technical X12 syntax verification, the EDI management system automatically generates the 997 Functional Acknowledgement indicating the acceptance of the X12/270 Functional Group, and stages the acceptance acknowledgement for subsequent retrieval by the provider's PMS/HIS.

The EDI management system extracts the eligibility inquiry data from the 270 transaction set, creates the required internal inquiry transaction(s) which are routed to the eligibility system for processing. The eligibility system accesses all of the necessary internal data stores (files, databases, etc.) to process the eligibility inquiries to determine the benefits and status of coverage for each of the individuals identified in the inquiries. The data is then assembled and routed to the health plan's EDI management system.

The EDI management system edits the eligibility response data for correctness and completeness, creates the batch(es) X12 Interchange containing the 271 eligibility responses, stages the batch(es) X12/271 Interchange for subsequent retrieval by the provider's PMS/HIS.

#### *2.1.1.3.10 Provider's Pre-Appointment Batch Eligibility Response Process*

Two hours after transferring the batch X12/270 Interchange to the health plan's Internet portal, the provider's PMS/HIS establishes a communications session with each health plan's system, requests either a list of available files for retrieval or specific file(s). Specific file(s) may be either an X12/TA1 Interchange, an X12/997 Interchange, an X12/271 Interchange or any combination of these. The health plan's Internet portal responds appropriately to the provider's PMS/HIS request. The provider's PMS/HIS then retrieves the requested and/or available file(s), records the message receipt date/time, assigns internal tracking number(s) to the message and retrieved file(s) linked to the X12 Interchange(s), and matches the tracking number, message receipt date/time to the corresponding X12/270 Interchange. The PMS/HIS then processes (validates) the X12 Interchange(s) retrieved.

If the batch X12/271 Interchange fails technical X12 syntax verification, the PMS/HIS generates either an X12/TA1 or X12/997 rejection interchange, establishes a communication session with the appropriate health plan's Internet portal and transfers the X12/TA1 or X12/997 interchange to the health plan. The PMS/HIS also generates a notice to the provider's appropriate internal support staff for problem resolution following established internal procedures.

If the X12/271 Interchange passes technical X12 syntax verification, the PMS/HIS extracts the eligibility response data from the 271 transaction set, creates the required internal eligibility response transaction(s) which are routed to the correct workstation for analysis and processing by the designated support staff.

If the 271 eligibility response transaction indicates the inquiry was rejected or that the benefit coverage or status has changed from the earlier inquiry, the PMS/HIS displays the new information, enabling the support staff to contact the patient prior to the appointment/admission to resolve the variances by obtaining corrected data. The PMS/HIS then resubmits the corrected eligibility inquiry.

If the 271 eligibility response transaction contains the requested benefit coverage, benefit status, and patient financial responsibility information, the PMS/HIS displays the benefit information, enabling the support staff to re-confirm the appointment/admission with the patient in advance and remind the patient of any information to bring to the appointment/admission and of any payment responsibilities.

## **2.1.2 *Provider Direct-to-Health Plan Business Model***

### **2.1.2.1 Introduction**

This Master CORE Business Process Scenario describes both the real time and batch business processes for end-to-end insurance verification/eligibility inquiries using business language, not technical specifications to the extent appropriate, in which the healthcare provider submits inquiries directly to the health plan or information source without using the services of a clearinghouse or other intermediary. Since the overall business process for insurance verification/eligibility inquiry does not fundamentally change from a business viewpoint, each CORE rule addresses a critical interoperability activity/task within the common business process. Thus, the focus for this scenario is on the EDI aspects of the overall end-to-end business process and not on attempting to describe all of the activities and tasks typically performed by each of the stakeholders in the process.

### **2.1.2.2 Background**

This scenario describes the healthcare insurance verification/eligibility end-to-end business process and the key activities and tasks conducted between a healthcare provider connecting directly to a health plan. For purposes of CORE Certification Testing, stakeholders include providers, health plans, clearinghouses, switches, other intermediaries, and solution vendors.

Each stakeholder type is equipped with an automated system (the "system") appropriate to its needs, e.g., a provider would have a hospital (or health) information system, commonly referred to as an HIS, or an automated practice management system (the "system"), commonly referred to as a PMS.

The "system" is defined as all of the components necessary for the stakeholder to conduct its automated business processes, e.g., all necessary network nodes, all platform components delivered by the vendor, and all the vendor components (e.g. documentation) included with the system. The system may consist of one or many workstations, servers and mainframe systems, and may include capture patient registration information at the point of patient intake (or scheduling) at the workstation if the stakeholder is a provider.

### 2.1.2.3 Eligibility Business Process Description

#### 2.1.2.3.1 Appointment Scheduling Process

An appointment scheduler at the provider's office is scheduling an appointment for either an office visit or admission (depending on the type of provider) for a patient in 2 weeks while on the phone with the patient. The scheduler inquires about the reason for the appointment, collects data from the patient following prompts on the workstation and enters all of the necessary information into the PMS/HIS.

When all of the necessary patient demographic and insurance information is entered, the scheduler is prompted to submit an insurance verification transaction by either a menu selection or by clicking an icon (as determined by the PMS/HIS vendor user interface design.)

The PMS/HIS automatically edits the eligibility transaction for completeness and valid data values where applicable and prompts the scheduler to correct any invalid or omitted data. When the transaction editing is completed, the PMS/HIS assigns a unique internal tracking number, records the identification and address of the workstation used by the scheduler, and creates the eligibility inquiry transaction.

Using internal tables/files and/or an external directory service, the PMS/HIS determines the Internet address for the health plan identified by the patient, creates and envelopes the complete X12 Interchange containing the 270 inquiry, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the X12/270 Interchange, and establishes a communications session with the health plan's system.

#### 2.1.2.3.2 Health Plan Real Time Eligibility Inquiry Process

The health plan's Internet portal accepts the provider's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the X12/270 Interchange, which is then extracted and passed to the health plan's EDI management system for further processing. The health plan's EDI management system, processes (validates) the X12/270 Interchange.

If the X12/270 Interchange fails technical X12 syntax verification, the EDI management system automatically generates the TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate) indicating the rejection of the Interchange or Functional Group, returns the rejection acknowledgement to the provider, terminates the communications session and discontinues any further processing of the inquiry transaction.

If the X12/270 Interchange passes technical X12 syntax verification, the EDI management system extracts the eligibility inquiry data from the 270 transaction set, creates the required internal inquiry transaction which is routed to the eligibility system for processing. The eligibility system accesses all of the necessary internal data stores (files, databases, etc.) to process the eligibility inquiry to determine the benefits and status of coverage for the individual identified in the inquiry. The data is then assembled and routed to the health plan's EDI management system.

The EDI management system edits the eligibility response data for correctness and completeness, creates the X12 Interchange containing the 271 eligibility response, passes the X12/271 Interchange to the open communications session which returns the X12/271 Interchange to the provider's PMS/HIS. The health plan's Internet portal then terminates the communications session upon successful transfer of the X12/271 Interchange to the provider's system. The X12/271 Interchange may contain either a 271 with AAA Validation Request Validation Request rejection/error codes or a 271 with the requested benefit data.

### *2.1.2.3.3 Provider's Real Time Eligibility Response Process*

The provider's PMS/HIS receives the X12/271 Interchange from the health plan, records the message receipt date/time, assigns an internal tracking number to the message linked to the X12/271 Interchange, and matches the tracking number, message receipt date/time to the corresponding X12/270 Interchange. The PMS/HIS then processes (validates) the X12/271 Interchange.

If the X12/271 Interchange fails technical X12 syntax verification, the PMS/HIS generates a notice to the provider's appropriate internal support staff for problem resolution following established internal procedures. No rejection acknowledgement is returned to the health plan.

If the X12/271 Interchange passes technical X12 syntax verification, the PMS/HIS extracts the eligibility response data from the 271 transaction set, creates the required internal eligibility response transaction which is routed to the correct workstation for display to the scheduler.

If the 271 eligibility response transaction indicates the inquiry was rejected, the PMS/HIS displays the reasons for such rejection, enabling the scheduler to resolve the rejection by obtaining corrected data as indicated from the patient during the initial appointment/admission scheduling phone call. The PMS/HIS then resubmits the corrected eligibility inquiry.

If the 271 eligibility response transaction contains the requested benefit coverage, benefit status, and patient financial responsibility information, the PMS/HIS displays the benefit information, enabling the scheduler to confirm the benefit coverage and status with the patient and to inform the patient of any co-pay, co-insurance, or deductible amounts during the initial appointment/admission scheduling phone call.

The provider's scheduler then confirms the date and time of the appointment/admission with the patient, reminds the patient of any information required at the time of the appointment/admission and concludes the phone call with the patient.

### *2.1.2.3.4 Provider's Pre-Appointment Batch Eligibility Process*

On a daily basis the provider's PMS/HIS automatically scans all scheduled appointments/admissions for two days in advance of the current date, extracts all of the necessary data, creates one or more batches of eligibility inquiries for each health plan covering the patient appointments/admissions for that date, assigns unique internal tracking numbers and records the date/time for each batch.

Using internal tables/files and/or an external directory service, the PMS/HIS determines the Internet address for each health plan, envelopes the complete X12 Interchange containing the batch of 270 inquiries for each health plan, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the correct batch X12/270 Interchange, establishes a communications session with each health plan's system and transfers the batch X12/270 Interchange to the health plan.

### *2.1.2.3.5 Health Plan Batch Eligibility Inquiry Process*

The health plan's Internet portal accepts the provider's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the batch X12/270 Interchange, which is then extracted and passed to the health plan's EDI management system for further processing. The health plan's Internet portal returns the correct HTTP message accepted code to the provider's PMS/HIS and terminates the communications session.

The health plan's EDI management system, processes (validates) the batch X12/270 Interchange. If the batch X12/270 Interchange fails technical X12 syntax verification, the EDI management system automatically generates the TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate) indicating the rejection of the Interchange or Functional Group, stages the rejection acknowledgement for subsequent retrieval by the provider's PMS/HIS, and discontinues any further processing of the batch X12/270 Interchange.

If the batch X12/270 Interchange passes technical X12 syntax verification, the EDI management system automatically generates the 997 Functional Acknowledgement indicating the acceptance of the X12/270 Functional Group, and stages the acceptance acknowledgement for subsequent retrieval by the provider's PMS/HIS.

The EDI management system extracts the eligibility inquiry data from the 270 transaction set, creates the required internal inquiry transaction(s) which are routed to the eligibility system for processing. The eligibility system accesses all of the necessary internal data stores (files, databases, etc.) to process the eligibility inquiries to determine the benefits and status of coverage for each of the individuals identified in the inquiries. The data is then assembled and routed to the health plan's EDI management system.

The EDI management system edits the eligibility response data for correctness and completeness, creates the batch(es) X12 Interchange containing the 271 eligibility responses, stages the batch(es) X12/271 Interchange for subsequent retrieval by the provider's PMS/HIS.

#### *2.1.2.3.6 Provider's Pre-Appointment Batch Eligibility Response Process*

Two hours after transferring the batch X12/270 Interchange to the health plan's Internet portal, the provider's PMS/HIS establishes a communications session with each health plan's system, requests either a list of available files for retrieval or specific file(s). Specific file(s) may be either an X12/TA1 Interchange, an X12/997 Interchange, an X12/271 Interchange or any combination of these. The health plan's Internet portal responds appropriately to the provider's PMS/HIS request. The provider's PMS/HIS then retrieves the requested and/or available file(s), records the message receipt date/time, assigns internal tracking number(s) to the message and retrieved file(s) linked to the X12 Interchange(s), and matches the tracking number, message receipt date/time to the corresponding X12/270 Interchange. The PMS/HIS then processes (validates) the X12 Interchange(s) retrieved.

If the batch X12/271 Interchange fails technical X12 syntax verification, the PMS/HIS generates either an X12/TA1 or X12/997 rejection interchange, establishes a communication session with the appropriate health plan's Internet portal and transfers the X12/TA1 or X12/997 interchange to the health plan. The PMS/HIS also generates a notice to the provider's appropriate internal support staff for problem resolution following established internal procedures.

If the X12/271 Interchange passes technical X12 syntax verification, the PMS/HIS extracts the eligibility response data from the 271 transaction set, creates the required internal eligibility response transaction(s) which are routed to the correct workstation for analysis and processing by the designated support staff.

If the 271 eligibility response transaction indicates the inquiry was rejected or that the benefit coverage or status has changed from the earlier inquiry, the PMS/HIS displays the new information, enabling the support staff to contact the patient prior to the appointment/admission to resolve the variances by obtaining corrected data. The PMS/HIS then resubmits the corrected eligibility inquiry.

If the 271 eligibility response transaction contains the requested benefit coverage, benefit status, and patient financial responsibility information, the PMS/HIS displays the benefit information, enabling the support staff to re-confirm the appointment/admission with the patient in advance and remind the patient of any information to bring to the appointment/admission and of any payment responsibilities.



## 2.2 CLAIM STATUS MASTER SCENARIOS

### 2.2.1 Purpose and Use of the Phase II CORE Master Claim Status Request Business Process Scenarios

#### 2.2.1.1 Purpose of the Business Process Scenarios

For Phase I, CORE developed Business Process Scenarios for the eligibility transaction when used in batch and real-time modes. The same approach is being used with the claims status request transactions in developing the CORE Phase II Operating Rules. The business process scenarios described for claims status request for real-time and batch depict the workflows and information flows that support an efficient management process for health plans and providers. The CORE operating rules for claim status request are designed to support these business processes and their technical components. Creation of CORE claims status request operating rules should promote increased health plan service level performance, stimulate vendors to enhance their products to support claims status request management and encourage providers to utilize these transactions.

These scenarios serve several purposes, including identifying and confirming the placement in the workflow in the provider setting and health plan setting where the following transformations occur:

- Collecting the information to initiate claim status request in the provider's workplace and identifying the individual or role where this takes place.
- The system or mechanism used to create and manage the EDI interchange outbound and inbound from the provider.
- Identify the work and information flows at the health plan upon receiving and validating the claims request transaction.
- Describe the information process at the health plan, including files and databases to be used to collect the information and prepare the response to the claims status request.
- The process to prepare and send the claims status response EDI transaction from the health plan.
- The process at the provider of receiving the claims status response EDI transaction and preparing it for use.
- The identification of the information presentation(s) used at the provider organization to process the information in the claims status response to be used in determining what action to take and by whom within the organization.

It is important to understand each of these touch points as well as the role of one or more clearinghouses between the two trading partners in order to develop the details of the rules, the CORE certification and testing process, the test data, and as a guide toward implementation for the parties involved.

The business processes are vendor neutral, with an understanding that the details about how the work processes are conducted within information systems and are used by members of the workforce will vary depending on the vendor products utilized. Note that in some cases, a provider's clearinghouse may provide some of the functionality described as a provider role in these scenarios. That is a business decision to be made between the provider and its clearinghouse. Likewise, the health plan's clearinghouse may provide some of the functional capabilities for the health plan. Again, this is a business decision between the health plan and the health plan's clearinghouse.

### 2.2.1.2 Current and Future Workflow and Information Flow Processes

Currently in many settings, claims status request process is not well integrated into the business processes of healthcare providers. As a result, many providers are not realizing the benefits of administrative simplification through an automated workflow and process for claim status inquiries. For those providers already using the claim status request transactions, the CORE Phase II Operating Rule improve performance with a greater availability of health plan systems and more consistent/predictable response times to receive claim status request responses. Some providers ignore the process and resubmit claims when they are not adjudicated within a normal or expected timeframe. Other providers ignore the claims status request function and trust that the health plan has received their claim and that eventually it will be adjudicated. Some providers call health plans with their inquiries about claim status. None of these approaches are designed to provide an efficient, integrated business process for providers and health plans to exchange information on the status of claims that are “overdue.”

In some cases, there are vendor products with management tools to support an automated claims status request. However, most vendor products (practice management systems and hospital information systems) either do not have management tools to efficiently support this process, or providers choose not to use them or license them when they do exist. Instead, telephone calls and resubmitted overdue claims are commonly used, both of which consume resources for both the provider and the health plan.

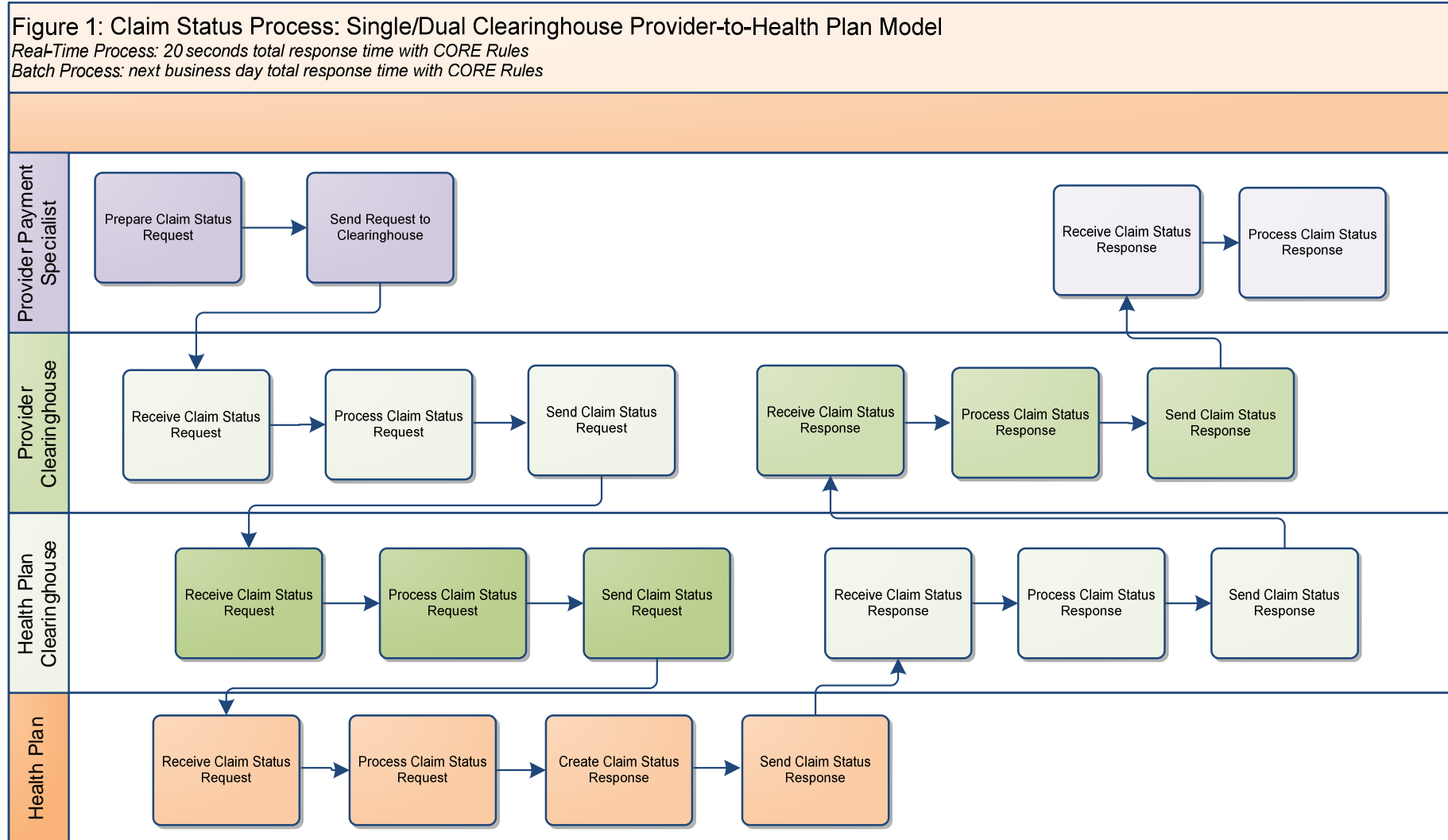
## 2.2.2 *Single/Dual Clearinghouse Provider-to-Health Plan Business Model*

### 2.2.2.1 Introduction

This Master CORE Business Process Scenario describes real time and batch business processes for end-to-end insurance claim status inquiries using business language, not technical specifications to the extent appropriate, in which there are either one or two clearinghouses providing services to the healthcare provider and health plan or information source. Since the overall business process for insurance claim status request does not fundamentally change from a business viewpoint, each CORE rule addresses a critical interoperability activity/task within the common business process. Thus, the focus for this scenario is on the EDI aspects of the overall end-to-end business process and not on attempting to describe all of the activities and tasks typically performed by each of the stakeholders in the process.

### 2.2.2.2 Background

This scenario describes the healthcare insurance claim status request end-to-end business process and the key activities and tasks conducted between a healthcare provider and a health plan where each party uses the services of a healthcare clearinghouse. For purposes of CORE Certification Testing, stakeholders include providers, health plans, clearinghouses, switches, other intermediaries, and solution vendors. The end-to-end information flow is the same whether the claim status request is conducted in real time or batch. It is the CORE Phase I rules that specify the respective response times for real time and for batch processing modes. Figure 1 below depicts this overall information flow.



Each stakeholder type is equipped with an automated system (the “system”) appropriate to its needs, e.g., a provider would have a hospital (or health) information system, commonly referred to as an HIS, or an automated practice management system (the “system”), commonly referred to as a PMS.

The “system” is defined as all of the components necessary for the stakeholder to conduct its automated business processes, e.g., all necessary network nodes, all platform components delivered by the vendor, and all the vendor components (e.g. documentation) included with the system. The system may consist of one or many workstations, servers and mainframe systems, and usually supports payment collection in the business office at the workstation if the stakeholder is a provider.

### **2.2.2.3 Claim Status Request Business Process Description**

#### *2.2.2.3.1 Business Office Claim Payment Management*

A business office insurance payment specialist at the provider’s office is inquiring about a claim that has been submitted, for which the status of adjudication is unknown. The business office insurance payment specialist collects the required data from the “system”, following prompts on the workstation and enters all of the necessary information into the PMS/HIS. In some systems, the request may be initiated automatically based on a past due expected date for adjudication reporting.

When all of the necessary patient demographic and insurance information is entered, the payment specialist is prompted to submit a claim status request transaction by either a menu selection or by clicking an icon (as determined by the PMS/HIS vendor user interface design.)

The PMS/HIS automatically edits the claim status transaction for completeness and valid data values where applicable and prompts the payment specialist to correct any invalid or omitted data. When the transaction editing is completed, the PMS/HIS assigns a unique internal tracking number, records the identification and address of the workstation used by the payment specialist, and creates the claim status request transaction.

Using internal tables/files, the PMS/HIS determines the Internet address for its clearinghouse, creates the message encapsulation envelope, assigns a payload identifier, records the date/time, links the message to the claim status request transaction, and establishes a communications session with the clearinghouse’s system. The claim status request transaction created by the PMS/HIS for transfer to its clearinghouse/switch may be either in a proprietary format or a fully enveloped X12 Interchange containing the 276 claim status request transaction set.

#### *2.2.2.3.2 Provider Clearinghouse Real Time Claim Status Request Process*

The clearinghouse’s Internet portal accepts the provider’s system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the claim status request transaction, which is then extracted and passed to the appropriate systems in the clearinghouse for further processing. The clearinghouse’s system edits the claim status transaction for completeness and valid data values where applicable. If the claim status transaction fails editing, the clearinghouse returns to the provider an appropriate error message or acknowledgement describing the reasons for failure and rejection, thereby allowing the provider to correct and re-submit the claim status transaction. Such error message or acknowledgement may be either a proprietary or valid X12 Acknowledgement, depending on the type and range of services the clearinghouse is providing.

Using internal tables/files and/or an external directory service, the clearinghouse system determines the Internet address for the clearinghouse serving the health plan specified in the provider’s claim status request transaction, creates and envelopes the complete X12 Interchange containing the 276 request, creates the message encapsulation envelope, assigns a payload identifier, records the date/time, links the message to the X12/276 Interchange, and establishes a communications session with the health plan’s clearinghouse. Depending on the range and type of services being provided to the provider by the clearinghouse, the clearinghouse may or may not have responsibility for creating the correct X12 Interchange containing the 276 Claim status request or for performing other data validation/transformation and/or editing

functions prior to forwarding the claim status request to either the health plan or the health plan's clearinghouse. Upon successful transfer of the X12/276 Interchange to the health plan's clearinghouse, the provider's clearinghouse maintains the communications session open and active until receipt of either a X12/TA1, X12/997 or X12/277 Interchange from the health plan's clearinghouse.<sup>3</sup>

If the X12/276 Interchange fails technical X12 syntax verification at the health plan's clearinghouse, the provider's clearinghouse receives the TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate) indicating the rejection of the Interchange or Functional Group, extracts/reformats the rejection acknowledgement and takes appropriate action to resolve the rejection. This may be by returning it to the provider's PMS/HIS or correcting the errors within the clearinghouse.

When the X12/277 claim status response transaction is received from the health plan's clearinghouse, the clearinghouse's Internet portal records the message receipt date/time, assigns an internal tracking number to the message linked to the X12/277 Interchange, returns a signal to the health plan's clearinghouse that the X12/277 Interchange payload has been successfully stored into persistent storage, and passes the X12/277 Interchange to the clearinghouse's EDI management system for further processing. The clearinghouse's EDI management system processes (validates) the X12/277 Interchange which contains the requested claim status data. The EDI management system extracts the 277 response data, creates the required claim status response transaction required by the provider's PMS/HIS (may be either a proprietary or valid X12/277 Interchange), and transfers the claim status response transaction to the provider's PMS/HIS.

#### *2.2.2.3.3 Health Plan Clearinghouse Real Time Claim Status Request Process*

The health plan's clearinghouse Internet portal accepts the provider's clearinghouse's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the X12/276 Interchange, returns a signal to the provider's clearinghouse that the X12/276 Interchange payload has been successfully stored into persistent storage, and passes the X12/276 Interchange to the clearinghouse's EDI management system for further processing. The clearinghouse's EDI management system, processes (validates) the X12/276 Interchange.

If the X12/276 Interchange passes technical X12 syntax verification, the EDI management system extracts the claim status request data from the 276 transaction set, creates the required internal claim status request transaction required by the health plan. Using internal tables/files and/or an external directory service, the clearinghouse system determines the Internet address for the health plan specified in the provider's claim status request transaction, creates the message encapsulation envelope, assigns a payload identifier, records the date/time, links the message to the claim status request transaction, and establishes a communications session with the health plan if such a communications link is not already open and active. Upon successful transfer of the claim status request transaction to the health plan, the clearinghouse maintains the communication session open and active pending receipt of the claim status response transaction from the health plan.

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<sup>3</sup> Alternatively, a single clearinghouse may be serving both the provider and the health plan to which the claims status request transaction is to be transmitted. In this case, the single clearinghouse would not only perform the reformatting of non-standard data and non-standard format received from the provider into the HIPAA-required standard, but would then perform the reformatting of the standard data and standard format into non-standard data and non-standard format required by the health plan. A similar set of functions would be performed when processing the claims status response transaction received from the health plan. See Health Plan Clearinghouse Real Time Claim Status Request Process section in this document for a complete description of this process.

If the X12/276 Interchange fails technical X12 syntax verification, the EDI management system automatically generates the TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate) indicating the rejection of the Interchange or Functional Group, returns the rejection acknowledgement to the provider's clearinghouse, terminates the communications session (if necessary) and discontinues any further processing of the claim status request transaction.

When the claim status response transaction is received from the health plan, the clearinghouse's EDI management system edits the claim status response data for correctness and completeness, creates the X12 Interchange containing the 277 claim status response, passes the X12/277 Interchange to the open communications session which returns the X12/277 Interchange to the provider's clearinghouse.

#### *2.2.2.3.4 Health Plan Real Time Claim Status Request Process*

The health plan's Internet portal accepts the clearinghouse's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the claim status request transaction, which is then extracted and passed to the health plan's claim status request system for processing. The claim status system accesses all of the necessary internal data stores (files, databases, etc.) to process the claim status request transaction to determine the status of the claim identified in the request. The data is then assembled and routed to the health plan's clearinghouse. When the clearinghouse signals successful receipt of the claim status response transaction to the health plan's system, the communications session may be terminated or maintained open and active as determined between the health plan and its clearinghouse.

#### *2.2.2.3.5 Provider Real Time Claim Status Response Process*

The provider's PMS/HIS receives the claim status response transaction from its clearinghouse, records the message receipt date/time, assigns an internal tracking number to the message linked to the claim status response transaction, and matches the tracking number, message receipt date/time to the corresponding claim status request transaction. The PMS/HIS then processes (validates) the claim status response transaction, which is routed to the correct workstation for display to the payment specialist.

The PMS/HIS displays the claim status information, enabling the payment specialist to take appropriate action by obtaining corrected claim data as indicated from the PMS/HIS or other sources and either resubmitting a corrected claim status request or a corrected claim.

If the claim status response transaction contains the requested information, the PMS/HIS displays the claim status information, enabling the payment specialist to confirm the claim status. Status of the claim within the health plan's adjudication process may include pre-adjudication acceptance/rejection, incorrect or incomplete claim pending, claim suspended/additional information is being requested, or claim finalized. Subsequent activities may include calling the patient or health plan, or pending further action to a later date. The claim status information as represented by the status and category codes received in the 271 response and the date of the request are stored in the PMS/HIS.

#### *2.2.2.3.6 Provider Batch Claim Status Process*

On a daily basis the provider's PMS/HIS automatically scans all past due claim adjudication responses for the current date, extracts all of the necessary data, creates one or more batches of claim status inquiries for each health plan covering the overdue adjudication responses for that date, assigns unique internal tracking numbers and records the date/time for each batch.

Using internal tables/files and/or an external directory service, the PMS/HIS determines the Internet address for each health plan, envelopes the complete X12 Interchange containing the batch of 276 inquiries for each health plan, creates the message encapsulation envelope, assigns a payload identifier, records the date/time, links the message to the correct batch X12/276 Interchange, establishes a communications session with each health plan's system and transfers the batch of claim status request

transactions in either a proprietary non-standard format or X12/276 Interchange to its clearinghouse for transmission to the health plan's clearinghouse prior to 9:00 pm ET, the daily cut-off time for batch submissions.

#### *2.2.2.3.7 Provider Clearinghouse Batch Claim Status Request Process*

The clearinghouse's Internet portal accepts the provider's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the claim status request transaction, which is then extracted and passed to the appropriate systems in the clearinghouse for further processing. The clearinghouse's system edits the claim status transaction for completeness and valid data values where applicable. If the claim status transaction fails editing, the clearinghouse returns to the provider an appropriate error message or acknowledgement describing the reasons for failure and rejection, thereby allowing the provider to correct and re-submit the claim status transaction. Such error message or acknowledgement may be either a proprietary or valid X12 Acknowledgement, depending on the type and range of services the clearinghouse is providing.

Using internal tables/files and/or an external directory service, the clearinghouse system determines the Internet address for the clearinghouse serving the health plan specified in the provider's claim status request transaction, creates and envelopes the complete X12 Interchange containing the 276 request, creates the message encapsulation envelope, assigns a payload identifier, records the date/time, links the message to the X12/276 Interchange, and establishes a communications session with the health plan's clearinghouse. Depending on the range and type of services being provided to the provider by the clearinghouse, the clearinghouse may or may not have responsibility for creating the correct X12 Interchange containing the 276 Claim Status Request or for performing other data validation/transformation and/or editing functions prior to forwarding the claim status request to either the health plan or the health plan's clearinghouse. Upon successful transfer of the X12/276 Interchange to the health plan's clearinghouse, the provider's clearinghouse maintains the communications session open and active until receipt of either a X12/TA1, X12/997 or X12/277 Interchange from the health plan's clearinghouse.<sup>4</sup>

If the X12/276 Interchange fails technical X12 syntax verification at the health plan's clearinghouse, the provider's clearinghouse receives the TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate) indicating the rejection of the Interchange or Functional Group, extracts/reformats the rejection acknowledgement and takes appropriate action to resolve the rejection. This may be by returning it to the provider's PMS/HIS or correcting the errors within the clearinghouse.

When the X12/277 claim status response transaction is received from the health plan's clearinghouse, the clearinghouse's Internet portal records the message receipt date/time, assigns an internal tracking number to the message linked to the X12/277 Interchange, returns a signal to the health plan's clearinghouse that the X12/277 Interchange payload has been successfully stored into persistent storage, and passes the X12/277 Interchange to the clearinghouse's EDI management system for further processing. The clearinghouse's EDI management system processes (validates) the X12/277 Interchange which contains the requested claim status data. The EDI management system extracts the 277 response data, creates the required claim status response transaction required by the provider's PMS/HIS (may be either a proprietary or valid X12/277 Interchange), and transfers the claim status response transaction to the provider's PMS/HIS.

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<sup>4</sup> Alternatively, a single clearinghouse may be serving both the provider and the health plan to which the claims status request transaction is to be transmitted. In this case, the single clearinghouse would not only perform the reformatting of non-standard data and non-standard format received from the provider into the HIPAA-required standard, but would then perform the reformatting of the standard data and standard format into non-standard data and non-standard format required by the health plan. A similar set of functions would be performed when processing the claims status response transaction received from the health plan. See Health Plan Clearinghouse Real Time Claim Status Request Process section in this document for a complete description of this process.

#### *2.2.2.3.8 Health Plan Clearinghouse Batch Claim Status Request Process*

The health plan's clearinghouse Internet portal accepts the provider's clearinghouse's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the X12/276 Interchange, returns a signal to the provider's clearinghouse that the X12/276 Interchange payload has been successfully stored into persistent storage, and passes the X12/276 Interchange to the clearinghouse's EDI management system for further processing. The clearinghouse's EDI management system, processes (validates) the X12/276 Interchange.

If the X12/276 Interchange passes technical X12 syntax verification, the EDI management system automatically generates the 997 Functional Acknowledgement indicating acceptance of the X12/276 Interchange, returns the X12/997 Interchange to the provider's clearinghouse, extracts the claim status request data from the 276 transaction set, and creates the required internal claim status request transactions required by the health plan.

Using internal tables/files and/or an external directory service, the clearinghouse system determines the Internet address for the health plan specified in the provider's claim status request transaction, creates the message encapsulation envelope, assigns a payload identifier, records the date/time, links the message to the claim status request transaction, and establishes a communications session with the health plan if such a communications link is not already open and active. Upon successful transfer of the claim status request transactions to the health plan, the clearinghouse either terminates (if necessary) or maintains the communication session open and active pending receipt of the claim status response transactions from the health plan.

If the X12/276 Interchange fails technical X12 syntax verification, the EDI management system automatically generates the TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate) indicating the rejection of the Interchange or Functional Group, returns the rejection acknowledgement to the provider's clearinghouse, terminates the communications session (if necessary) and discontinues any further processing of the request transaction.

When the claim status response transactions are received from the health plan, the clearinghouse's EDI management system edits the claim status response data for correctness and completeness, creates the X12 Interchange containing the 277 claim status responses, passes the X12/277 Interchange to the communications module which returns the X12/277 Interchange to the provider's clearinghouse. The clearinghouse's EDI management system processes (validates) the X12/277 Interchange which contains the requested claim status data.

#### *2.2.2.3.9 Health Plan Batch Claim Status Request Process*

The health plan's Internet portal accepts the provider's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the batch X12/276 Interchange, which is then extracted and passed to the health plan's EDI management system for further processing. The health plan's Internet portal returns the correct HTTP message accepted code to the provider's PMS/HIS and terminates the communications session.

The health plan's EDI management system, processes (validates) the batch X12/276 Interchange. If the batch X12/276 Interchange fails technical X12 syntax verification, the EDI management system automatically generates the TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate) indicating the rejection of the Interchange or Functional Group, stages the rejection acknowledgement for subsequent retrieval by the provider's PMS/HIS, and discontinues any further processing of the batch X12/276 Interchange.

If the batch X12/276 Interchange passes technical X12 syntax verification, the EDI management system automatically generates the 997 Functional Acknowledgement indicating the acceptance of the X12/276 Functional Group, and stages the acceptance acknowledgement for subsequent retrieval by the provider's PMS/HIS.



The EDI management system extracts the claim status request data from the 276 transaction set, creates the required internal request transaction(s) which are routed to the claim status system for processing. The claim status system accesses all of the necessary internal data stores (files, databases, etc.) to process the claim status inquiries to determine the claim status for each of the inquiries. The data is then assembled and routed to the health plan's EDI management system.

The EDI management system edits the claim status response data for correctness and completeness, creates the batch(es) X12 Interchange containing the 277 claim status responses, stages the batch(es) X12/277 Interchange for subsequent retrieval by the provider's PMS/HIS.

#### *2.2.2.3.10 Provider's Batch Claim Status Response Process*

Two hours after transferring the batch X12/276 Interchange to the health plan's Internet portal, the provider's PMS/HIS establishes a communications session with each health plan's system, requests either a list of available files for retrieval or specific file(s). Specific file(s) may be either an X12/TA1 Interchange, an X12/997 Interchange, an X12/277 Interchange or any combination of these. The health plan's Internet portal responds appropriately to the provider's PMS/HIS request. The provider's PMS/HIS then retrieves the requested and/or available file(s), records the message receipt date/time, assigns internal tracking number(s) to the message and retrieved file(s) linked to the X12 Interchange(s), and matches the tracking number, message receipt date/time to the corresponding X12/276 Interchange. The PMS/HIS then processes (validates) the X12 Interchange(s) retrieved.

If the batch X12/277 Interchange fails technical X12 syntax verification, the PMS/HIS generates either an X12/TA1 or X12/997 rejection interchange, establishes a communication session with the appropriate health plan's Internet portal and transfers the X12/TA1 or X12/997 interchange to the health plan. The PMS/HIS also generates a notice to the provider's appropriate internal support staff for problem resolution following established internal procedures.

If the X12/277 Interchange passes technical X12 syntax verification, the PMS/HIS extracts the claim status response data from the 277 transaction set, creates the required internal claim status response transaction(s) which are routed to the correct workstation for analysis and processing by the designated support staff.

The PMS/HIS displays the claim status information, enabling the payment specialist to take appropriate action by obtaining corrected claim data as indicated from the PMS/HIS or other sources and either resubmitting a corrected claim status request or a corrected claim.

If the 277 claim status response transaction contains the requested claim status information, the PMS/HIS displays the information, enabling the payment specialist staff to extend the expected adjudication date, contact the patient, or contact the health plan by telephone, fax or other means to resolve problems associated with completing adjudication.

### **2.2.3 Provider Direct-to-Health Plan Business Model**

#### **2.2.3.1 Introduction**

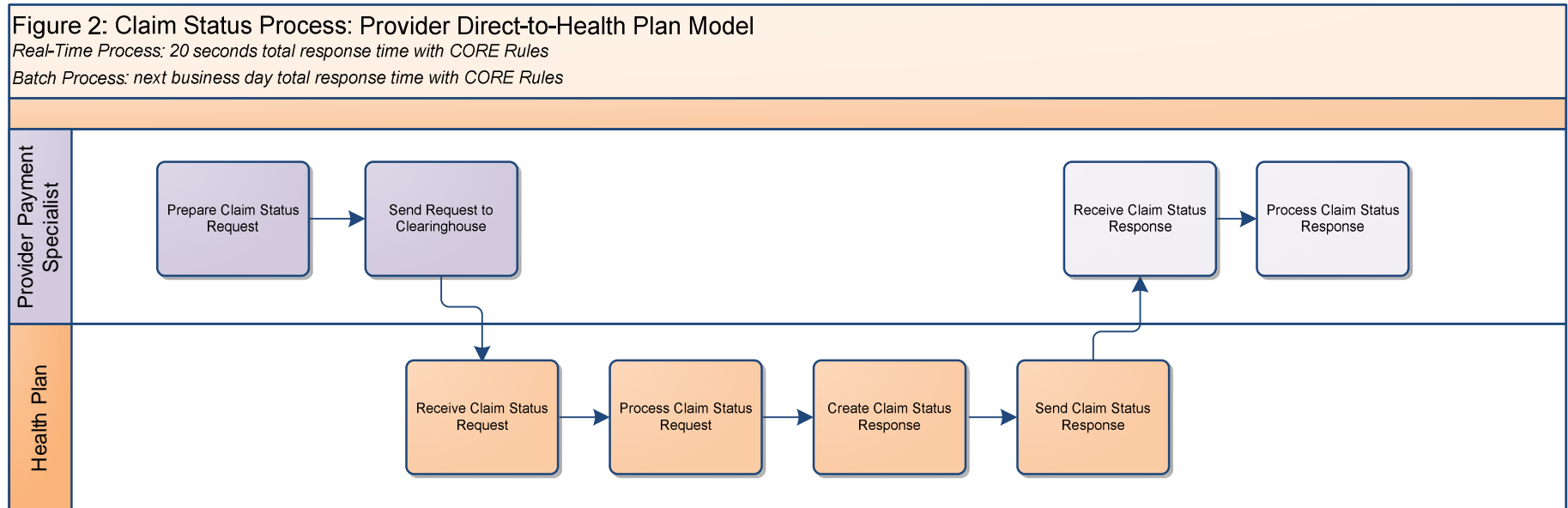
This Master CORE Business Process Scenario describes real time and batch business processes for end-to-end insurance verification/claim status inquiries using business language, not technical specifications to the extent appropriate, in which the healthcare provider submits inquiries directly to the health plan or information source without using the services of a clearinghouse or other intermediary. Since the overall business process for insurance verification/claim status request does not fundamentally change from a business viewpoint, each CORE rule addresses a critical interoperability activity/task within the common business process. Thus, the focus for this scenario is on the EDI aspects of the overall end-to-end business process and not on attempting to describe all of the activities and tasks typically performed by each of the stakeholders in the process.

2.2.3.2 Background

This scenario describes the healthcare insurance verification/claim status end-to-end business process and the key activities and tasks conducted between a healthcare provider connecting directly to a health plan. For purposes of CORE Certification Testing for this scenario, stakeholders include providers, health plans and solution vendors.

Each stakeholder type is equipped with an automated system (the “system”) appropriate to its needs, e.g., a provider would have a hospital (or health) information system, commonly referred to as a HIS, or an automated practice management system (the “system”), commonly referred to as a PMS.

The “system” is defined as all of the components necessary for the stakeholder to conduct its automated business processes, e.g., all necessary network nodes, all platform components delivered by the vendor, and all the vendor components (e.g. documentation) included with the system. The system may consist of one or many workstations, servers and mainframe systems, and usually supports payment collection in the business office at the workstation if the stakeholder is a provider. The end-to-end information flow is the same whether the claim status request is conducted in real time or batch. It is the CORE Phase I rules that specify the respective response times for real time and for batch processing modes. Figure 2 below depicts this overall information flow.



### 2.2.3.3 Claim Status Request Business Process Description

#### 2.2.3.3.1 Business Office Claim Payment Management

A business office insurance specialist at the provider's office is inquiring about a claim that has been submitted, for which adjudication and response is overdue. The business office insurance payment specialist collects the required data from the "system" following prompts on the workstation and enters all of the necessary information into the PMS/HIS. In some systems, the request may be initiated automatically based on a past due expected date for adjudication reporting.

When all of the necessary patient demographic and insurance information is entered, the payment specialist is prompted to submit a claim status request transaction by either a menu selection or by clicking an icon (as determined by the PMS/HIS vendor user interface design.)

The PMS/HIS automatically edits the claim status transaction for completeness and valid data values where applicable and prompts the payment specialist to correct any invalid or omitted data. When the transaction editing is completed, the PMS/HIS assigns a unique internal tracking number, records the identification and address of the workstation used by the payment specialist, and creates the claim status request transaction.

Using internal tables/files and/or an external directory service, the PMS/HIS determines the Internet address for the health plan where the claim was submitted, creates and envelopes the complete X12 Interchange containing the 276 request, creates the message encapsulation envelope, assigns a payload identifier, records the date/time, links the message to the X12/276 Interchange, and establishes a communications session with the health plan's system.

#### 2.2.3.3.2 Health Plan Real Time Claim status Request Process

The health plan's Internet portal accepts the provider's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the X12/276 Interchange, which is then extracted and passed to the health plan's EDI management system for further processing. The health plan's EDI management system, processes (validates) the X12/276 Interchange.

If the X12/276 Interchange fails technical X12 syntax verification, the EDI management system automatically generates the TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate) indicating the rejection of the Interchange or Functional Group, returns the rejection acknowledgement to the provider, terminates the communications session and discontinues any further processing of the request transaction.

If the X12/276 Interchange passes technical X12 syntax verification, the EDI management system extracts the claim status request data from the 276 transaction set, creates the required internal request transaction which is routed to the claim status system for processing. The claim status system accesses all of the necessary internal data stores (files, databases, etc.) to process the claim status request to determine the status of the claim identified in the request. The data is then assembled and routed to the health plan's EDI management system.

The EDI management system edits the claim status response data for correctness and completeness, creates the X12 Interchange containing the 277 claim status response, passes the X12/277 Interchange to the open communications session which returns the X12/277 Interchange to the provider's PMS/HIS. The health plan's Internet portal then terminates the communications session upon successful transfer of the X12/277 Interchange to the provider's system.

#### 2.2.3.3.3 Provider's Real Time Claim Status Response Process

The provider's PMS/HIS receives the X12/277 Interchange from the health plan, records the message receipt date/time, assigns an internal tracking number to the message linked to the X12/277 Interchange, and matches the tracking number, message receipt date/time to the corresponding X12/276 Interchange. The PMS/HIS then processes (validates) the X12/277 Interchange.

If the X12/277 Interchange fails technical X12 syntax verification, the PMS/HIS generates a notice to the provider's appropriate internal support staff for problem resolution following established internal procedures. No rejection acknowledgement is returned to the health plan.

If the X12/277 Interchange passes technical X12 syntax verification, the PMS/HIS extracts the claim status response data from the 277 transaction set, creates the required internal claim status response transaction which is routed to the correct workstation for display to the scheduler.

The PMS/HIS displays the claim status information, enabling the payment specialist to take appropriate action by obtaining corrected claim data as indicated from the PMS/HIS or other sources and either resubmitting a corrected claim status request or a corrected claim.

If the 277 claim status response transaction contains the requested information, the PMS/HIS displays the information, enabling the payment specialist to confirm the claim status. Status of the claim within the health plan's adjudication process may include pre-adjudication acceptance/rejection, incorrect or incomplete claim pending, claim suspended/additional information being requested, or claim finalized. Subsequent activities may include calling the patient or the health plan, or pending further action to a later date. Status codes and the date of the request are stored in the PMS/HIS.

#### *2.2.3.3.4 Provider's Batch Claim Status Process*

On a daily basis the provider's PMS/HIS automatically scans all past due claim adjudication responses for the current date, extracts all of the necessary data, creates one or more batches of claim status inquiries for each health plan covering the overdue adjudication responses for that date, assigns unique internal tracking numbers and records the date/time for each batch.

Using internal tables/files and/or an external directory service, the PMS/HIS determines the Internet address for each health plan, envelopes the complete X12 Interchange containing the batch of 276 inquiries for each health plan, creates the message encapsulation envelope, assigns a payload identifier, records the date/time, links the message to the correct batch X12/276 Interchange, establishes a communications session with each health plan's system and transfers the batch X12/276 Interchange to the health plan.

#### *2.2.3.3.5 Health Plan Batch Claim Status Request Process*

The health plan's Internet portal accepts the provider's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the batch X12/276 Interchange, which is then extracted and passed to the health plan's EDI management system for further processing. The health plan's Internet portal returns the correct HTTP message accepted code to the provider's PMS/HIS and terminates the communications session.

The health plan's EDI management system, processes (validates) the batch X12/276 Interchange. If the batch X12/276 Interchange fails technical X12 syntax verification, the EDI management system automatically generates the TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate) indicating the rejection of the Interchange or Functional Group, stages the rejection acknowledgement for subsequent retrieval by the provider's PMS/HIS, and discontinues any further processing of the batch X12/276 Interchange.

If the batch X12/276 Interchange passes technical X12 syntax verification, the EDI management system automatically generates the 997 Functional Acknowledgement indicating the acceptance of the X12/276 Functional Group, and stages the acceptance acknowledgement for subsequent retrieval by the provider's PMS/HIS.

The EDI management system extracts the claim status request data from the 276 transaction set, creates the required internal request transaction(s) which are routed to the claim status system for processing. The claim status system accesses all of the necessary internal data stores (files, databases, etc.) to process the claim status inquiries to determine the claim status for each of the inquiries. The data is then assembled and routed to the health plan's EDI management system.

The EDI management system edits the claim status response data for correctness and completeness, creates the batch(es) X12 Interchange containing the 277 claim status responses, stages the batch(es) X12/277 Interchange for subsequent retrieval by the provider's PMS/HIS.

#### *2.2.3.3.6 Provider's Batch Claim Status Response Process*

Two hours after transferring the batch X12/276 Interchange to the health plan's Internet portal, the provider's PMS/HIS establishes a communications session with each health plan's system, requests either a list of available files for retrieval or specific file(s). Specific file(s) may be either an X12/TA1 Interchange, an X12/997 Interchange, an X12/277 Interchange or any combination of these. The health plan's Internet portal responds appropriately to the provider's PMS/HIS request. The provider's PMS/HIS then retrieves the requested and/or available file(s), records the message receipt date/time, assigns internal tracking number(s) to the message and retrieved file(s) linked to the X12 Interchange(s), and matches the tracking number, message receipt date/time to the corresponding X12/276 Interchange. The PMS/HIS then processes (validates) the X12 Interchange(s) retrieved.

If the batch X12/277 Interchange fails technical X12 syntax verification, the PMS/HIS generates either an X12/TA1 or X12/997 rejection interchange, establishes a communication session with the appropriate health plan's Internet portal and transfers the X12/TA1 or X12/997 interchange to the health plan. The PMS/HIS also generates a notice to the provider's appropriate internal support staff for problem resolution following established internal procedures.

If the X12/277 Interchange passes technical X12 syntax verification, the PMS/HIS extracts the claim status response data from the 277 transaction set, creates the required internal claim status response transaction(s) which are routed to the correct workstation for analysis and processing by the designated support staff.

The PMS/HIS displays the claim status information, enabling the payment specialist to take appropriate action by obtaining corrected claim data as indicated from the PMS/HIS or other sources and either resubmitting a corrected claim status request or a corrected claim.

If the 277 claim status response transaction contains the requested claim status information, the PMS/HIS displays the information, enabling the payment specialist staff to extend the expected adjudication date, contact the patient, or contact the health plan by telephone, fax or other means to resolve problems associated with completing adjudication.

### **3 Test Scenarios by Rule**

The following sections cover certification testing requirements specific to each CORE Phase II Rule.

### 3.1 CORE 250 CLAIM STATUS RULE BATCH ACKNOWLEDGEMENTS TEST SCENARIO

#### 3.1.1 Key Rule Requirements

**Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.**

Requires that

1. A TA1 is returned ONLY to indicate an Interchange error resulting in the rejection of the entire Interchange; the ISA 14-I13 Acknowledgement Requested field is ignored. (§4.3.1.1)
2. A TA1 must NOT be returned if there are no errors in the Interchange control segments. (§4.3.1.1)
3. A 997 is returned to indicate either acceptance of the batch or rejection of a Functional Group (including the enclosed Transaction Set) error resulting in the rejection of the entire Functional Group. (§4.3.1.2)
4. A 997 must ALWAYS be returned if there are no errors in the Functional Group and enclosed Transaction Set. (§4.3.1.2)
5. A 277 claim status response transaction must ALWAYS be returned for an Interchange, Functional Group and Transaction Set that complies with X12 standard syntax requirements. (§4.3.1.2)
6. A 277 claim status response transaction containing the appropriate STC data segments containing the requested claim status details. (§4.3.1.2)

### 3.1.2 *Conformance Testing Requirements*

These scenarios test the following conformance requirements of the CORE Batch Acknowledgement Rule. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario.

1. A TA1 is returned ONLY to indicate an Interchange error resulting in the rejection of the entire Interchange; the ISA 14-I13 Acknowledgement Requested field is ignored.
  - a. A TA1 must NOT be returned if there are no errors in the Interchange control segments.
2. A 997 is returned to indicate either acceptance of the batch or rejection of a Functional Group (including the enclosed Transaction Set) error resulting in the rejection of the entire Functional Group.
  - a. A 997 must ALWAYS be returned if there are no errors in the Functional Group and enclosed Transaction Set.
3. A 277 claim status response transaction must ALWAYS be returned for an Interchange, Functional Group and Transaction Set that complies with X12 standard syntax requirements.
  - a. A 277 claim status response transaction containing the appropriate STC data segments containing the requested claim status details.



**3.1.3 Test Scripts Assumptions**

1. All communications sessions and logon's are valid; no error conditions are created or encountered.
2. Test scripts will test ONLY for valid and invalid X12 Interchange, Functional Group, Transaction Set and will not test for 277 data content.
3. Test scripts will test the following error conditions:
  - a. Invalid X12 Interchange (ISA control number match error)
  - b. Invalid Functional Group (GS/GE control number match error)
  - c. Invalid Transaction Set (missing required segment)
4. Test scripts will test the following valid conditions:
  - a. Valid X12 Interchange Control Segments
  - b. Valid Functional Group Control Segments
  - c. Valid X12 Transaction Set
5. The CORE test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

3.1.4 Detailed Step-By-Step Test Script

**REMINDER:** CORE testing is not exhaustive. The CORE test suite does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

**NOTE:** The references in parentheses after each test script are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the “Stakeholder” column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>5</sup>				
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>6</sup>
1.	A TA1 is returned on an invalid X12 Interchange (Key Rule Requirement #1)	An X12 Interchange containing only a TA1 rejecting the entire interchange		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2.	A TA1 is not returned on a valid X12 Interchange (Key Rule Requirement #2)	No TA1 is returned		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	A 997 is returned on an invalid Functional Group (Key Rule Requirement #3)	An X12 Interchange containing only a 997 FA		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	A 997 is returned on a valid X12 Interchange (Key Rule Requirement #4)	An X12 Interchange containing only a 997 FA		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	A 277 claim status response transaction set is always returned for a valid 276 claim status	An X12 Interchange is returned containing only a 277		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

<sup>5</sup> A checkmark in the box indicates the stakeholder type to which the test applies.

<sup>6</sup> If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>5</sup>				
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>6</sup>
	inquiry transaction set (Key Rule Requirement #5)	transaction set								

### 3.2 CORE 250 CLAIM STATUS RULE REAL TIME ACKNOWLEDGEMENTS TEST SCENARIO

#### 3.2.1 Key Rule Requirements

**Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.**

Requires that

1. A TA1 is returned ONLY to indicate an Interchange error resulting in the rejection of the entire Interchange; the ISA 14-I13 Acknowledgement Requested field is ignored. (§4.2.1.1)
2. A TA1 must NOT be returned if there are no errors in the Interchange control segments. (§4.2.1.1)
3. A 997 is returned ONLY to indicate a Functional Group (including the enclosed Transaction Set) error resulting in the rejection of the entire Functional Group. (§4.2.1.1)
4. A 997 must NOT be returned if there are no errors in the Functional Group and enclosed Transaction Set. (§4.2.1.1)
5. A 277 claim status response transaction must ALWAYS be returned for an Interchange, Functional Group and Transaction Set that complies with X12 standard syntax requirements. (§4.2.1.2)
6. A 277 claim status response transaction containing the appropriate STC data segments containing the requested claim status details. (§4.2.1.2)

### 3.2.2 Conformance Testing Requirements

**Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.**

These scenarios test the following conformance requirements of the CORE Real Time Acknowledgement Rule. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario.

1. A TA1 is returned ONLY to indicate an Interchange error resulting in the rejection of the entire Interchange; the ISA 14-I13 Acknowledgement Requested field is ignored.
2. A TA1 must NOT be returned if there are no errors in the Interchange control segments.
3. A 997 is returned ONLY to indicate a Functional Group (including the enclosed Transaction Set) error resulting in the rejection of the entire Functional Group.
4. A 997 must NOT be returned if there are no errors in the Functional Group and enclosed Transaction Set.
5. A 277 claim status response transaction must ALWAYS be returned for an Interchange, Functional Group and Transaction Set that complies with X12 standard syntax requirements.
6. A 277 claim status response transaction containing the appropriate STC data segments containing the requested claim status details.

**3.2.3 Test Scripts Assumptions**

1. All communications sessions and logon's are valid; no error conditions are created or encountered.
2. Test scripts will test ONLY for valid and invalid X12 Interchange, Functional Group, Transaction Set and will not test for 277 data content.
3. Test scripts will test the following error conditions:
  - a. Invalid X12 Interchange (ISA control number match error)
  - b. Invalid Functional Group (GS/GE control number match error)
  - c. Invalid Transaction Set (missing required segment)
4. Test scripts will test the following valid conditions:
  - a. Valid X12 Interchange Control Segments
  - b. Valid Functional Group Control Segments
  - c. Valid X12 Transaction Set
5. The CORE test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

3.2.4 Detailed Step-By-Step Test Script

**REMINDER:** CORE testing is not exhaustive. The CORE test suite does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

**NOTE:** The references in parentheses after each test script are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the “Stakeholder” column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>7</sup>				
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>8</sup>
1.	A TA1 is returned on an invalid X12 Interchange (Key Rule Requirement #1)	An X12 Interchange containing only a TA1 rejecting the entire interchange		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2.	A TA1 is not returned on a valid X12 Interchange (Key Rule Requirement #2)	No TA1 is returned		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	A 997 is returned on an invalid Functional Group (Key Rule Requirement #3)	An X12 Interchange containing only a 997 FA		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

<sup>7</sup> A checkmark in the box indicates the stakeholder type to which the test applies.

<sup>8</sup> If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>7</sup>				
				<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	Provider	Health Plan	Clearing house	Vendor	N/A <sup>8</sup>
4.	A 997 is not returned on a valid X12 Interchange (Key Rule Requirement #4)	No 997 is returned		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	A 277 Claim Status Response transaction set is always returned for a valid 276 Claim Status Inquiry Transaction set (Key Rule Requirement #5)	An X12 Interchange is returned containing only a 277 transaction set		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



### 3.3 CORE 250 CLAIM STATUS RULE COMPANION GUIDE TEST SCENARIO

#### 3.3.1 Key Rule Requirements

**Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.**

All CORE-certified entities' Companion Guides covering the 276/277 claim status inquiry and response transactions must follow the format/flow as defined in the CORE 276/277 Companion Guide Template for HIPAA Transactions. (§4.7.1)

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

#### 3.3.2 Conformance Testing Requirements

These scenarios test the following conformance requirements of the CORE Companion Document Rule. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario.

Conformance with this rule is considered achieved by health plans (or information sources) if all of the following criteria are achieved:

Submission to an authorized CORE certification testing company the following:

1. A copy of the table of contents of its official 276/277 companion document.
2. A copy of a page of its official 276/277 companion document depicting its conformance with the format for specifying the 276/277 data content requirements.

Such submission may be in the form of a hard copy paper document, an electronic document, or a URL where the table of contents and an example of the 276/277 content requirements of the companion document is located.

**3.3.3 Test Scripts Assumptions**

1. The detailed content of the 276/277 companion document will not be submitted to the authorized CORE certification testing company.
2. The detailed content of the 276/277 companion document will not be examined nor evaluated.
3. Test script will test ONLY that the table of contents of the companion document is:
  - a. Customized and specific to the entity undergoing this test
  - b. Conforms to the flow as specified in the Table of Contents of the CORE 276/277 Companion Document Template
  - c. Conforms to the presentation format for depicting segments, data elements and codes as specified in the CORE 276/277 Companion Document Template
4. The CORE test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

3.3.4 Detailed Step-By-Step Test Script

**REMINDER:** CORE testing is not exhaustive. The CORE test suite does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

**NOTE:** The references in parentheses after each test script are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the “Stakeholder” column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>9</sup>				
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>10</sup>
1.	Companion Document conforms to the flow and format of the CORE 276/277 Companion Document Template	Submission of the Table of Contents of the 276/277 companion document, including a example of the 276/277 content requirements		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2.	Companion Document conforms to the format for presenting each segment, data element and code flow and format of the CORE 276/277 Companion Document Template	Submission of a page of the 276/277 companion document depicting the presentation of segments, data elements and codes showing conformance to the required presentation format		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

<sup>9</sup> A checkmark in the box indicates the stakeholder type to which the test applies.

<sup>10</sup> If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

### 3.4 CORE 250 CLAIM STATUS RULE CONNECTIVITY TEST SCENARIO

#### 3.4.1 Key Rule Requirements

**Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.**

#### Real time requests

1. Must include a single inquiry or submission (e.g. one eligibility inquiry to one information source for one patient). (§4.1.3)

#### Batch requests

2. Are sent in the same way as real time requests. (§4.1.4)

#### Batch submissions

3. Response must be only the standard HTTP message indicating whether the request was accepted or rejected (See below for error reporting.) (§4.1.4)
4. Message receivers must not respond to a batch submission with an X12 response such as a TA1 or 997 as described in the CORE 250: Claim Status Rule Batch Acknowledgement version 2.0.0 in the HTTP response to the batch request, even if their systems' capabilities allow such a response. (See the CORE 250: Claim Status Rule Batch Response Time version 2.0.0 for the response time requirements for TA1 or 997.) (§4.1.4)

#### Batch responses

5. Should be picked up after the message receiver has had a chance to process a batch submission. (See the CORE 250: Claim Status Rule Batch Response Time version 2.0.0 for details on timing.) (§4.1.4.1)

#### Required Data Elements

6. Certain business data elements: authorization information, a payload identifier, and date and time stamps, must be included in the HTTP message body outside of the X12 data. (§4.1.5.1)
7. Information Sources must publish their detailed specification for the message format in their publicly available Companion Guide. (§4.1.5.1)
8. In order to comply with the CORE 250: Claim Status Rule Response Time version 2.0.0, message receivers will be required to track the times of any received inbound messages, and respond with the outbound message for that payload ID. (§4.1.5.1)

9. Message senders must include the date and time the message was sent in the HTTP Message Header tags. (§4.1.5.1)

### **Date and Time Requirements**

10. Date must be sent and logged using 8 digits (YYYYMMDD). (§4.1.5.2)
11. Time must be sent and logged using a minimum of 6 digits (HHMMSS). (§4.1.5.2)

### **Security**

12. The HTTP/S protocol, all information exchanged between the sender and receiver is encrypted by a session-level private key negotiated at connection time. (§4.1.6)

### **User ID and Password**

13. CORE participants will employ User ID and Password as the default minimum criteria authentication mechanism. (§4.1.6.1)
14. Issuance, maintenance and control of password requirements may vary by participant and should be issued in accordance with the organizations' HIPAA Security Compliance policies. (§4.1.6.1)
15. The User ID and Password authentication must be encrypted by the HTTP/S protocol, but passed outside of the X12 payload information as described in the HTTP Message format section. (§4.1.6.1)
16. The receiver may require the message sender to register the IP address for the host or subnet originating the transaction, and may refuse to process transactions whose source is not registered or does not correspond to the ID used. (§4.1.6.1)
17. Due to programming requirements of POSTing over HTTP/S, use of a digital certificate is required to establish communications. CORE-certified participants will make available information on how to obtain the receiver's root public certificate. (§4.1.6.1)
18. No additional security for file transmissions, such as the separate encryption of the X12 payload data, is required in this Phase I CORE Rule for connectivity. By mutual consent, organizations can implement additional encryption, but HTTP/S provides sufficient security to protect healthcare data as it travels the Internet. (§4.1.6.1)

### **Response Time, Time Out Parameters and Re-transmission**

19. If the HTTP Post Reply Message is not received within the 60 second response period, the provider's system should send a duplicate transaction no sooner than 90 seconds after the original attempt was sent. (§4.1.7)
20. If no response is received after the second attempt, the provider's system should submit no more than 5 duplicate transactions within the next 15 minutes.

(§4.1.7)

21. If the additional attempts result in the same timeout termination, the provider's system should notify the provider to contact the health plan or information source directly to determine if system availability problems exist or if there are known Internet traffic constraints causing the delay. (§4.1.7)

### **Authorization Errors**

22. If the username and/or password included in the request are not valid according to the message receiver, the message receiver must send back an HTTP 403 Forbidden error response with no data content. (§4.1.8.1)

### **Batch Submission Acknowledgement**

23. At the message acknowledgement level, a message receiver must send back a response with a status code of HTTP 202 Accepted once the message has been received. This does not imply that the X12 content has been validated or approved. (§4.1.8.2)

### **Real Time Response or Response to Batch Response Pickup**

24. When a message receiver is responding to a real time request or a batch response pickup request, assuming that the message authorization passed, the receiver must respond with an HTTP 200 Ok status code and the X12 data content as specified by the CORE 250 Claim Status Rule Batch and Real Time Acknowledgements version 2.0.0. (§4.1.8.3)

### **Server Errors**

25. It is possible that the HTTP server is not able to process a real time or batch request. In this case, the message receiver must respond with a standard HTTP 5xx series error such as HTTP 500 Internal Server Error or HTTP 503 Service Unavailable. (§4.1.8.4)
26. If a sender receives a response with this error code, they will need to resubmit the request at a later time, because this indicates that the message receiver will never process this message. (§4.1.8.4)

#### **3.4.2 Option for Claim Status Key Rule Requirements & Certification Testing**

When an organization uses a different communications gateway for claims status processing it may elect to certify that gateway for the CORE Phase II Connectivity Rule requirements rather than this Claim Status Rule Connectivity requirement . To complete certification testing for this case, follow these steps:

1. Check N/A for Test Scripts 1, 2, and 3 in §3.4.5.
2. Submit a statement indicating the entity undergoing certification will be certifying more than one gateway for the CORE Phase II Connectivity Rule.

3. Remediate the claim status communications gateway to comply with the CORE Phase II Connectivity Rule.
4. Complete the CORE Phase II Connectivity Rule Detailed Step-by-Step Test Scripts for your claim status processing gateway.

When an organization uses a single communications gateway for eligibility and claim status processing, that entity is required to complete the Phase II Connectivity Rule certification requirements rather than the certification requirements specified here. To complete the Phase II Connectivity certification testing for this case, follow these steps:

1. Check N/A for Test Scripts 1, 2, and 3 in §3.4.5.
2. Submit a statement indicating the entity undergoing certification will be certifying a single gateway for both eligibility and claim status connectivity.
3. Complete the CORE Phase II Connectivity Rule Detailed Step-by-Step Test Scripts for your claim status processing gateway.

### **3.4.3 Conformance Testing Requirements**

These scenarios test the following conformance requirements of the CORE Connectivity Rule. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario.

1. The Information Source must demonstrate the ability to respond in their production environment to valid and invalid logon/connection requests with the appropriate HTTP errors as described in the Response Message Options & Error Notification section of this rule.
2. The Information Source must demonstrate the ability to log, audit, track and report the required data elements as described in the HTTP Message Format section of this rule.

### **3.4.4 Test Scripts Assumptions**

1. Each HTTP/S message must contain an X12 Interchange as the payload.
2. No editing or validation of the X12 Interchange will be performed.
3. All communications sessions and logon's are valid; no error conditions are created or encountered.
4. Test scripts will test for valid and invalid logon attempts.

5. Test scripts will test for the ability to log, audit, track and report on the required data elements.
6. The CORE test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.



3.4.5 Detailed Step-By-Step Test Script

**REMINDER:** CORE testing is not exhaustive. The CORE test suite does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

**NOTE:** The references in parentheses after each test script are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the “Stakeholder” column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>11</sup>				
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>12</sup>
1.	Valid Logon Attempt (Key Rule Requirement #24)	HTTP 200 OK		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2.	Invalid Logon Attempt (Key Rule Requirement #22)	HTTP 403 Forbidden response		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	Verify that communications server/module creates, assigns, logs, links the required data elements to HTTP message payload (Key Rule Requirement #8)	Output a system generated audit log report showing all required data elements		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

<sup>11</sup> A checkmark in the box indicates the stakeholder type to which the test applies.

<sup>12</sup> If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

### 3.5 CORE 250 CLAIM STATUS RULE BATCH RESPONSE TIME TEST SCENARIO

#### 3.5.1 Key Rule Requirements

**Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.**

##### Batch Mode Response Time Requirements

1. Maximum response time when processing in batch mode for the receipt of a 277 response to a 276 inquiry submitted by a provider or on a provider's behalf by a clearinghouse/switch by 9:00pm Eastern time of a business day must be returned by 7:00am Eastern time the following business day. A business day consists of the 24 hours commencing with 12:00am (Midnight or 0000 hours) of each designated day through 11:59pm (2359 hours) of that same designated day. The actual calendar day(s) constituting business days are defined by and at the discretion of each health plan or information source. (§4.5.1)
2. TA1 or 997 responses must be available to the submitter within one hour of receipt of the batch: to the provider in the case of a batch of 276 inquiries and to the health plan (or information source) in the case of a batch of 277 responses. (§4.5.1.1)
3. Conformance with this maximum response time rule shall be considered achieved if 90 percent of all required responses as specified in the CORE 250: Claim Status Rule Batch Acknowledgement version 2.0.0 are returned within the specified maximum response time as measured within a calendar month. (§4.5.2)
4. Each CORE-certified entity must demonstrate its conformance with this maximum response time rule by demonstrating its ability to 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. (§4.5.2)

#### 3.5.2 Conformance Testing Requirements

These scenarios test the following conformance requirements of the CORE Batch Response Time Rule. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario.

1. Capturing, logging, auditing, matching and reporting the date (YYYYMMDD), time (HHMMSS) and control numbers from its own internal systems and its trading partners.

**3.5.3 Test Scripts Assumptions**

1. All transactions, data, communications session are valid; no error conditions are created or encountered.
2. The provider's PMS/HIS system generates all of the required data necessary for its clearinghouse to generate the batch X12/276 claim status inquiries.
3. The provider's clearinghouse's EDI management system generates a syntactically correct X12 interchange containing the 276 claim status inquiry, therefore, no TA1 or 997 acknowledgement is to be returned by the health plan's system.
4. All HTTP/S communications sessions between all parties are successfully established with the respective Internet portals communications servers; therefore, no HTTP POST error messages are created by any of communications servers.
5. The health plan's system successfully locates and verifies the claim identified in the 276 inquiry and outputs the required data required by its EDI management system to successfully generate a syntactically correct X12 interchange containing the 277 response.
6. The health plan's EDI management system generates a syntactically correct X12 interchange containing the 277 claim status response.
7. The CORE test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

3.5.4 Detailed Step-By-Step Test Script:

**REMINDER:** CORE testing is not exhaustive. The CORE test suite does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

**NOTE:** The references in parentheses after each test script are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the “Stakeholder” column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>13</sup>				
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>14</sup>

<sup>13</sup> A checkmark in the box indicates the stakeholder type to which the test applies.

<sup>14</sup> If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>13</sup>				
						Provider	Health Plan	Clearing house	Vendor	N/A <sup>14</sup>
1.	Verify that outer most communications module(s) transmits all required data elements in the claim status inquiry message. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the X12 transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent (Key Rule Requirement #4)	Output a system-generated audit log report showing all required data elements		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2.	Verify that outer most communications module(s) captures, assigns, logs and links all required data elements from the X12/277 Interchange to the submitted X12/276 Interchange. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the X12 transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent (Key Rule Requirement #4)	Output a system-generated audit log report showing all required data elements		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>13</sup>				
				<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	Provider	Health Plan	Clearing house	Vendor	N/A <sup>14</sup>
3.	Verify that outer most communications module(s) transmits all required data elements in the claim status response message. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the X12 transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent (Key Rule Requirement #4)	Output a system-generated audit log report showing all required data elements		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>13</sup>				
				<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	Provider	Health Plan	Clearing house	Vendor	N/A <sup>14</sup>
4.	Verify that outer most communications module(s) captures, assigns, logs and links all required data elements from the X12/276 Interchange to the submitted X12/277 Interchange. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the X12 transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent (Key Rule Requirement #4)	Output a system-generated audit log report showing all required data elements		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

### 3.6 CORE 250 CLAIM STATUS RULE REAL TIME RESPONSE TIME TEST SCENARIO

#### 3.6.1 Key Rule Requirements

**Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.**

##### Real Time Mode Response Time Requirements

1. Maximum response time when processing in real time mode<sup>15</sup> for the receipt of a 277 (or in the case of an error, a TA1 or 997) response from the time of submission of a 276 inquiry must be 20 seconds (or less). TA1 and 997 response errors must be returned within the same response timeframe. (§4.4)
2. Conformance with this maximum response time rule shall be considered achieved if 90 percent of all required responses are returned within the specified maximum response time as measured within a calendar month. (§4.4.1)
3. Each CORE-certified entity must demonstrate its conformance with this maximum response time rule by demonstrating its ability to 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. (§4.4.1)

#### 3.6.2 Conformance Testing Requirements

These scenarios test the following conformance requirements of the CORE Real Time Response Time Rule. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario.

1. Capturing, logging, auditing, matching and reporting the date (YYYYMMDD), time (HHMMSS) and control numbers from its own internal systems and its trading partners.

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<sup>15</sup> Real-time mode is defined in the CORE Glossary of Terms.



**3.6.3 Test Scripts Assumptions**

1. All transactions, data, communications session are valid; no error conditions are created or encountered.
2. The provider's PMS/HIS system generates a syntactically correct X12 interchange containing the 276 claim status inquiry, therefore, no TA1 or 997 acknowledgement is to be returned by the health plan's system.
3. The provider's PMS/HIS system's communications module successfully establishes the HTTP/S communication session with the health plan's Internet portal communications server; therefore, no HTTP POST error message is created by the health plan's communications server.
4. The health plan's system successfully locates and verifies the claim identified in the 276 inquiry and outputs the required data required by its EDI management system to successfully generate a syntactically correct X12 interchange containing the 277 response.
5. The health plan's EDI management system generates a syntactically correct X12 interchange containing the 277 claim status response.
6. The CORE test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

3.6.4 Detailed Step-By-Step Test Script:

**REMINDER:** CORE testing is not exhaustive. The CORE test suite does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

**NOTE:** The references in parentheses after each test script are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the “Stakeholder” column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>16</sup>				
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>17</sup>
1.	Verify that outer most communications module(s) transmits all required data elements in the claim status inquiry message. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the X12 transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent (Key Rule	Output a system-generated audit log report showing all required data elements		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

<sup>16</sup> A checkmark in the box indicates the stakeholder type to which the test applies.

<sup>17</sup> If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>16</sup>				
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>17</sup>
	Requirement #3)									
2.	Verify that outer most communications module(s) captures, assigns, logs and links all required data elements from the X12/277 Interchange to the submitted X12/276 Interchange. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the X12 transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent (Key Rule Requirement #3)	Output a system-generated audit log report showing all required data elements		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>16</sup>				
				<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>17</sup>
3.	Verify that outer most communications module(s) transmits all required data elements in the claim status response message. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the X12 transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent (Key Rule Requirement #3)	Output a system-generated audit log report showing all required data elements		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>16</sup>				
				<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>17</sup>
4.	Verify that outer most communications module(s) captures, assigns, logs and links all required data elements from the X12/276 Interchange to the submitted X12/277 Interchange. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the X12 transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent (Key Rule Requirement #3)	Output a system-generated audit log report showing all required data elements		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

### 3.7 CORE 250 CLAIM STATUS RULE SYSTEM AVAILABILITY TEST SCENARIO

#### 3.7.1 Key Rule Requirements

**Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.**

#### System Availability Requirements

1. System availability must be no less than 86 percent per calendar week for both real-time and batch processing modes. This will allow for health plan, (or other information source) clearinghouse/switch or other intermediary system updates to take place within a maximum of 24 hours per calendar week for regularly scheduled downtime. (§4.6.1)

#### Reporting Requirements

##### 2. Scheduled Downtime

CORE-certified health plans (or information sources), clearinghouses/switches or other intermediaries must publish their regularly scheduled system downtime in an appropriate manner (e.g., on websites or in companion guides) such that the healthcare provider can determine the health plan's system availability so that staffing levels can be effectively managed. (§4.6.2.1)

##### 3. Non-Routine Downtime

For non-routine downtime (e.g., system upgrade), an information source must publish the schedule of non-routine downtime at least one week in advance. (§4.6.2.2)

##### 4. Unscheduled Downtime

For unscheduled/emergency downtime (e.g., system crash), an information source will be required to provide information within one hour of realizing downtime will be needed. (§4.6.2.3)

#### Other Requirements

5. No response is required during scheduled downtime(s). (§4.6.2.4)
6. Each health plan, (or other information source) clearinghouse/switch or other intermediary will establish its own holiday schedule and publish it in accordance with the rule above. (§4.6.2.5)

**3.7.2 Conformance Testing Requirements**

These scenarios test the following conformance requirements of the CORE System Availability Rule. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario.

Demonstrate its ability to publish to its trading partner community the following schedules:

1. Its regularly scheduled downtime schedule, including holidays.
2. Its notice of non-routine downtime showing schedule of times down.
3. A notice of unscheduled/emergency downtime notice.

**3.7.3 Test Scripts Assumptions**

1. The entity has implemented in its production environments the necessary policies, procedures and method(s) required to conform to the requirements of the System Availability rule.
2. The CORE test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

3.7.4 Detailed Step-By-Step Test Script

**REMINDER:** CORE testing is not exhaustive. The CORE test suite does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

**NOTE:** The references in parentheses after each test script are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the “Stakeholder” column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>18</sup>				
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>19</sup>
1.	Publication of regularly scheduled downtime, including holidays and method(s) for such publication (Key Rule Requirement #2.a)	Submission of actual published copies of regularly scheduled downtime including holidays and method(s) of publishing		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2.	Publication of non-routine downtime notice and method(s) for such publication (Key Rule Requirement #3.a)	Submission of a sample notice of non-routine downtime including scheduled of down time and method(s) of publishing		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

<sup>18</sup> A checkmark in the box indicates the stakeholder type to which the test applies.

<sup>19</sup> If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.



Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>18</sup>				
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>19</sup>
3.	Publication of unscheduled/emergency downtime notice and method(s) for such publication (Key Rule Requirement #4.a)	Submission of a sample notice of unscheduled/emergency downtime including method(s) of publishing		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

### 3.8 CORE 258 NORMALIZING PATIENT LAST NAME RULE CERTIFICATION TESTING

#### 3.8.1 Key Rule Requirements

Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.

**Requires a CORE-Certified health plan (or information source) to:**

1. Normalize the last name submitted on the 270 before using submitted last name. (§4.2.1)<sup>20</sup>
2. Normalize internally-stored last name before using internally-stored last name. (§4.2.1)
3. Return the 271 response with AAA segment using appropriate error code(s) as required by the CORE Phase II Use of AAA Error Codes for Reporting Errors in Subscriber/Patient Identifiers & Names Rule when normalized names are not successfully matched or validated. (§4.3)
4. Return the un-normalized internally-stored last name when it does not match the un-normalized submitted last name in the NM103-1035 data element and return the INS segment as specified in Table 4.3-1. (§4.3)
5. Return the 271 response as required by the CORE Phase II Data Content Rule when normalized names are successfully matched or validated. (§4.2.1)

**Requires a receiver of the 271 response to:**

6. Detect all data elements addressed by the rule as returned in the 271 response. (§4.4)
7. Display to the end user text uniquely describing the specific error condition(s) and data elements returned in the 271. (§4.4)
8. Ensure that displayed text accurately represents the Follow Up Action without changing meaning and intent of the Follow Up Action. (§4.4)

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<sup>20</sup>The CORE normalization process is specified in §4.2.1.

**3.8.1 Key Rule Requirements****Recommendations for submitters of the 270:**

9. Submit a person's name suffix in the NM107-1039 data element when submitter's system enables capture and storage of a name suffix in a separate data field. (§4.1.1)
10. Separate a person's name suffix from the last name using either a space, comma or forward slash when the submitter's system does not enable the capture and storage of a name suffix in a separate data field. (§4.1.2)
11. Attempt to identify and parse the last name data element to extract any name suffix and to submit the suffix in the NM107-1039 data element. (§4.1.2)

### 3.8.2 Conformance Testing Requirements

The CORE Detailed Step-By-Step Test Scripts will not include comprehensive testing requirements for all possible permutations of the CORE Phase II Normalizing Patient Last Name Rule.

Conformance must be demonstrated by successful completion of the Detailed Step-By-Step Test Scripts specified below with a CORE-authorized testing vendor.

The Detailed Step-By-Step Test Scripts specify each specific test that must be completed by each stakeholder type. There are one or more Detailed Step-By-Step Test Scripts for each of the following conformance testing requirements of the CORE Phase II Normalizing Patient Last Name Rule.

There may be other requirements of the rule not specified here or in The Detailed Step-By-Step Test Scripts. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in these Conformance Testing Requirements and Detailed Step-by-Step Test Scripts.

1. The health plan must demonstrate its system capability to normalize both submitted and internally stored last names and return the required AAA errors when normalized names do not match.
2. The health plan must demonstrate its system has the capability to normalize both submitted and internally stored last names and:
  - a. Return the internally stored un-normalized last name when both submitted and internally stored un-normalized last names do not match and the normalized last names do match.
  - b. Return the required INS segment.
  - c. Return the 271 response required by the CORE Phase II Data Content rule.
3. The receiver of the 271 response must demonstrate its system has the capability to extract and make available to the end user
  - a. The AAA and corresponding CORE Error Condition Descriptions.
  - b. The INS segment information.
4. The last name returned by the health plan.

**3.8.3 Test Scripts & Assumptions**

1. Entity is CORE Phase I certified.
2. The health plan has loaded into its testing system the CORE master test bed data which contains all of the values necessary to generate a response transaction covering each of the requirements specified in the Conformance Testing Section above and in the Detailed Step-by-Step Test Scripts below.
3. The CORE-authorized Certification Testing Vendor's test system has transmitted to the health plan a 270 in which the subscriber last name data element contains either one of the character strings (§4.2.2) and/or special characters (§3.7) specified in the rule.
4. A syntactically correct X12 Interchange containing the 270 inquiry transaction set is created by the submitter's system; therefore no TA1 or 997 acknowledgement is to be returned by the health plan's system.
5. A communications session between all parties is successfully established in compliance with the CORE Phase II Connectivity Rule; therefore, no error messages are created by any of communications servers.
6. The health plan's EDI management system generates a syntactically correct X12 interchange containing the 271 eligibility response.
7. The CORE test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

3.8.4 Detailed Step-by-Step Test Scripts

**REMINDER:** CORE testing is not exhaustive. The CORE test suite does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

**NOTE:** The references in parentheses after each test script are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the “Stakeholder” column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

Note: The CORE-authorized Certification Testing Vendors will generate one or more randomly generated 270 inquiries based on the Master Test Bed Data that will cause the health plan to encounter each of the described error conditions in Test Scripts #1 and #2.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>21</sup>				
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>22</sup>
1.	Create a valid 271 response transaction indicating that the normalized submitted and internally-stored last names do not match (Key Rule Requirement #3)	Output a valid 271 transaction containing the AAA segment with AAA03=73 Invalid/Missing Subscriber/Insured Name		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

<sup>21</sup> The checkmark in each box below indicates the stakeholder type to which the test script applies.

<sup>22</sup> If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>21</sup>				
				<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>22</sup>
2.	Create a valid 271 response transaction in which the un-normalized internally-stored last name is returned when the normalized submitted and internally-stored last names match (Key Rule Requirement #4)	Output a valid 271 transaction containing the INS segment as required by the CORE Name Normalization rule in which the NM103-1035 in Loop 2100C contains the un-normalized internally-stored last name		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	Extract from a valid 271 response transaction the patient identification data elements received in the NM1 and DMG segments in Loop 2100C and the information contained in the AAA segment (Key Rule Requirement #6, #7, and #8)	Provide a screen print of the output from Test #1 showing that the required information is displayed to the information requester		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	Extract from a valid 271 response transaction the last name as received in the NM103-1035 in Loop 2100C and the information contained in the INS segment (Key Rule Requirement #6, #7, and #8)	Provide a screen print of the output from Test #2 showing that the required information is displayed to the information requester		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

### 3.9 CORE 259 AAA ERROR CODE REPORTING RULE

#### 3.9.1 Key Rule Requirements

**Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.**

**Requires a CORE-Certified health plan (or information source) to:**

1. Return a AAA segment for each error condition detected. (§4.1, §4.5)
2. Return code “N” in the AAA01 Valid Request Indicator data element. (§4.1)
3. Return the specified Reject Reason Code in AAA03 as specified for the error condition detected. (§4.1)
4. Return code “C” in the AAA04 Follow-up Action Code data element. (§4.1)
5. Return submitted data elements used. (§4.1)
6. Return a AAA segment for each error condition detected along with submitted data elements used when conducting a pre-query evaluation. (§4.3)
7. Return a AAA segment for each missing and required data element when conducting a pre-query evaluation. (§4.3.1)
8. Return a AAA segment for an invalid MID when conducting a pre-query evaluation. (§4.3.2)
9. Return a AAA segment for an invalid DOB when conducting a pre-query evaluation. (§4.3.2)
10. Return a AAA segment for each error condition detected along with submitted data elements used when conducting a post-query evaluation. (§4.4)

**Requires a receiver of the 271 response to:**

11. Detect all combinations of error conditions from the AAA segments in the 271 response. (§4.2)
12. Detect all data elements addressed by the rule as returned in the 271 response. (§4.2)
13. Display to the end user text uniquely describing the specific error condition(s) and data elements returned in the 271. (§4.2)
14. Ensure that displayed text accurately represents the AAA03 error code and corresponding Error Condition Description without changing meaning and intent of the Error Condition Description. (§4.2, §4.5)



**3.9.1 Key Rule Requirements****Defines:**

15. Pre-query evaluation of patient identification elements. (§3.2)
16. Post-query evaluation of patient identification elements. (§3.2)
17. Query using one or more of submitted patient identification data elements. (§3.2)

**Not Required of health plans:**

18. To use any specific search and match criteria or logic. (§3.3)
19. To use any specific combination of submitted identification data elements. (§3.3)
20. To perform a pre-query evaluation. (§3.3)
21. To perform DOB validation. (§3.3)

**3.9.2 Conformance Testing Requirements**

The CORE Detailed Step-By-Step Test Scripts will not include comprehensive testing requirements for all possible permutations of the CORE Phase II AAA Error Code Reporting Rule.

Conformance must be demonstrated by successful completion of The Detailed Step-By-Step Test Scripts specified below with a CORE-authorized testing vendor.

The Detailed Step-By-Step Test Scripts specify each specific test that must be completed by each stakeholder type. There are one or more Detailed Step-By-Step Test Scripts for each of the following conformance testing requirements of the CORE Phase II AAA Error Code Reporting Rule.

There may be other requirements of the rule not specified here or in The Detailed Step-By-Step Test Scripts. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in these Conformance Testing Requirements and Detailed Step-by-Step Test Scripts.

1. The health plan must demonstrate its system capability to detect the various error conditions described and return the required AAA errors and submitted data elements when each error condition is detected.
2. The receiver of the 271 must demonstrate its system capability to appropriately display text to the end user of the AAA errors code, the Error Condition Descriptions and the returned data elements.

**3.9.3 Test Scripts Assumptions**

1. Entity is CORE Phase I certified.
2. The health plan has loaded into its testing system the CORE master test bed data which contains all of the values necessary to generate a response transaction covering each of the requirements specified in the Conformance Testing Section above and in the Detailed Step-by-Step Test Scripts below.
3. The CORE-authorized Certification Testing Vendor's test system has transmitted to the health plan a 270 which may contain one or more of the error conditions described in the rule (§4.5, Table 4.5-1).
4. A syntactically correct X12 Interchange containing the 270 inquiry transaction set is created by the submitter's system; therefore no TA1 or 997 acknowledgement is to be returned by the health plan's system.
5. A communications session between all parties is successfully established in compliance with the CORE Phase II Connectivity Rule; therefore, no error messages are created by any of communications servers.
6. The health plan's EDI management system generates a syntactically correct X12 interchange containing the 271 eligibility response.
7. The CORE test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

3.9.4 Detailed Step-by-Step Test Script

**REMINDER:** CORE testing is not exhaustive. The CORE test suite does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

**NOTE:** The references in parentheses after each test script are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the “Stakeholder” column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

Note: The CORE-authorized Certification Testing Vendors will generate one or more randomly generated 270 inquiries based on the Master Test Bed Data that will cause the health plan to encounter each of the described error conditions in Test Scripts #1 and #2.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>23</sup>				
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>24</sup>

<sup>23</sup> The checkmark in each box below indicates the stakeholder type to which the test script applies.

<sup>24</sup> If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>23</sup>				
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>24</sup>
1.	Create a valid 271 response transaction indicating that the 270 inquiry is being rejected because the health plan could not correctly identify the patient (Key Rule Requirement #1, #2, #3, #4, and #5)	Output a valid 271 transaction containing the patient identifying data elements submitted and used, the AAA segment with AAA Reject Reason Code corresponding to the error condition detected and other required AAA segment data elements and codes as specified		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2.	Extract from a valid 271 response transaction the patient identification data elements received in Loop 2100C and the information contained in the AAA segment (Key Rule Requirement #13 and #14)	Provide a screen print of the output from Test #1 showing that the required information is displayed to the information requester		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**3.10 CORE 260 DATA CONTENT (270/271) RULE CERTIFICATION TESTING****3.10.1 Key Rule Requirements**

**Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.**

**Requires a CORE-Certified health plan (or information source) to:**

1. Respond to an explicit inquiry for a CORE-required service type with patient financial responsibility. (§4.1.1.2, and §4.1.2 through §4.1.4)<sup>25</sup>
2. Specify when a service type covered by this rule is a covered benefit only for in-network providers and not a covered benefit for out-of-network providers. (§4.1.2)
3. Specify the Health Plan base deductible amount only on the EB segment where EB03=30-Health Benefit Plan Coverage. (§4.1.3.1.1)
4. Specify the Health Plan remaining deductible amount that is the patient's financial responsibility only on the EB segment where EB03=30-Health Benefit Plan Coverage. (§4.1.3.1.2)
5. Return the benefit-specific (service type) remaining deductible amount for each benefit (service type) only when the amount is different than for the health plan. (§4.1.3.1.2)
6. Return the benefit-specific (service type) base deductible amount for each benefit (service type) only when the amount is different than for the health plan. (§4.1.3.1.1)
7. Return patient liability information (co-pay, co-insurance, and deductible information) for a CORE-required explicit 270 inquiry. (§4.1.1.2 and §4.1.1.3)
8. Return both family and individual Health Plan base and remaining deductible amounts as applicable to the health plan coverage. (§4.1.3.1.1 and §4.1.3.1.2)
9. Not return base and remaining deductible amounts for a specific benefit (service type) when the amount is not different than for the health plan. (§4.1.3.1.1 and §4.1.3.1.2)
10. Return deductible amounts only in U.S. amounts. (§4.1.3.1)

<sup>25</sup> Section numbers reference the specific section in the CORE Phase II Data Content Rule that specifies the details of this requirement.

**3.10.1 Key Rule Requirements**

11. Return the date(s) for the Health Plan base deductible only if different than the Health Plan Coverage date. (§4.1.4.3)
12. Return the date(s) for a Benefit-specific base deductible only if different than the Health Plan Coverage date. (§4.1.4.4)
13. Return the date on which active coverage begins for the individual only in either Loop 2100C or Loop 2100D. (§4.1.4. 1)

**Prohibits a CORE-Certified health plan (or information source) from:**

14. Redundantly returning the Health Plan base and remaining deductible amounts on any EB segment where EB03≠30-Health Benefit Plan Coverage when these amounts are not different for that specific service type. (§4.1.3.1.1 and §4.1.3.1.2)

**Allows a CORE-Certified health plan (or information source) to:**

15. Return patient liability information (co-pay, co-insurance, and deductible information) at its discretion for 8 specified Service Type Codes. (§4.1.3)

**Specifies that:**

16. Only Code 29-Remaining can be used in EB06 data element to specify the remaining deductible amount. (§4.1.3.1.2 and §4.1.3.1.4)
17. An additional 39 service type codes that must be supported for an explicit inquiry in addition to the nine required codes in Phase I. (§4.1.1.2)

**Requires a CORE-Certified Receiver of the 271 Response to:**

18. Detect and extract all data elements to which the rule applies. (§4.2)
19. Display to the end user text that appropriately describes these data elements. (§4.2)

### 3.10.2 Conformance Testing Requirements

The CORE Detailed Step-By-Step Test Scripts will not include comprehensive testing requirements for all possible permutations of the CORE Phase II Data Content Rule.

Conformance must be demonstrated by successful completion of the Detailed Step-By-Step Test Scripts specified below with a CORE-authorized testing vendor.

The Detailed Step-By-Step Test Scripts specify each specific test that must be completed by each stakeholder type. There are one or more Detailed Step-By-Step Test Scripts for each of the following conformance testing requirements of the CORE Phase II Data Content Rule.

There may be other requirements of the rule not specified here or in The Detailed Step-By-Step Test Scripts. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in these Conformance Testing Requirements and Detailed Step-by-Step Test Scripts.

1. A health plan (or information source) must demonstrate that its eligibility system returns the Health Plan remaining deductible amount only on the EB segment where EB03=30 Health Benefit Plan coverage and not on any other EB segment.
2. A health plan (or information source) must demonstrate that their eligibility system returns a benefit-specific remaining deductible amount only when that amount is different than the Health Plan remaining deductible amount.
3. A health plan (or information source) must demonstrate that its eligibility systems returns patient liability amounts for an inquiry for a CORE-required explicit service type.
4. A health plan (or information source) must demonstrate that its eligibility systems returns the date(s) applicable to the Health Plan base deductible for the health plan covering the individual only if different than the Health Plan Coverage date.
5. A health plan (or information source) must demonstrate that their eligibility system returns the date(s) applicable to a specific benefit's base deductible only if different than the Health Plan Coverage date.
6. A health plan (or information source) must demonstrate that its eligibility systems returns the date on which active coverage begins for an individual only in Loops 2100C or 2100D as applicable.
7. A system receiving the 271 response must demonstrate its capability to detect and extract the data elements addressed in this rule and display such data and appropriate text to the end user.

**3.10.3 Test Scripts Assumptions**

1. Entity is CORE Phase I certified.
2. A syntactically correct X12 Interchange containing the 270 inquiry transaction set is created by the submitter's system; therefore no TAI or 997 acknowledgement is to be returned by the health plan's system.
3. A communications session between all parties is successfully established in compliance with the CORE Phase II Connectivity Rule; therefore, no error messages are created by any of communications servers.
4. Automated transaction certification testing will be conducted between the entity and its selected authorized CORE certification testing vendor using the CORE Phase II Connectivity rule.
5. The health plan's eligibility system successfully locates and verifies the individual identified in the 270 inquiry and outputs the data required to successfully generate the 271 eligibility response required by this rule.
6. The health plan's EDI management system generates a syntactically correct X12 interchange containing the 271 eligibility response.
7. The CORE master test bed data contains all of the values necessary to enable the entity to generate a response transaction covering the Detailed Step-by-Step Test Scripts.
8. The CORE test scripts will not include comprehensive testing requirements to test for all possible permutations of health plan benefit status or patient financial responsibility for all of the CORE required benefits addressed in the 271 response.



**REMINDER:** CORE testing is not exhaustive. The CORE test suite does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

**NOTE:** The references in parentheses after each test script are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the “Stakeholder” column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

**3.10.4 Detailed Step-by-Step Test Scripts**

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>26</sup>				
				<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>27</sup>
1.	Create a valid 271 response transaction as defined in the CORE rule specifying the Health Plan remaining deductible amount (Key Rule Reference #4)	Output a valid fully enveloped 271 eligibility response transaction set with the correct Health Plan remaining deductible amount		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

<sup>26</sup> The checkmark in each box below indicates the stakeholder type to which the test script applies.

<sup>27</sup> If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>26</sup>				
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>27</sup>
2.	Create a valid 271 response transaction as defined in the CORE rule specifying a benefit-specific remaining deductible amount different than the Health Plan remaining deductible amount (Key Rule Reference #5)	Output a valid fully enveloped 271 eligibility response transaction set with the correct benefit-specific remaining deductible amount		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	Create a valid 271 response transaction as defined in the CORE rule specifying patient liability for a CORE-required explicit service type (Key Rule Reference #7)	Output a valid fully enveloped 271 eligibility response transaction set with the correct patient liability for the requested service type		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	Create a valid 271 response transaction as defined in the CORE rule indicating the date(s) for the Health Plan base deductible for the health plan covering the individual only if different than the Health Plan Coverage date (Key Rule Reference #11)	Output a valid fully enveloped 271 eligibility response transaction set with the date(s) applicable to the Health Plan Base deductible only if different than the Health Plan Coverage date		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>26</sup>				
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>27</sup>
5.	Create a valid 271 response transaction as defined in the CORE rule indicating the date(s) for a benefit-specific base deductible only if different than the Health Plan Coverage date (Key Rule Reference #12)	Output a valid fully enveloped 271 eligibility response transaction set with the date(s) applicable to the benefit-specific base deductible only if different than the Health Plan Coverage date		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	Create a valid 271 response transaction as defined in the CORE rule indicating begin date of active coverage for the individual in Loop 2100C (Key Rule Reference #13)	Output a valid fully enveloped 271 eligibility response transaction set with begin date of active coverage for the individual		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7.	Extract from a valid 271 response transaction as defined in the CORE rule the data required to be returned by a health plan in Test Scripts #1 through #6 (Key Rule Reference #17 and #18)	Provide a screen print of the output from Tests #1 through #6 showing that the required information is displayed to the end user		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

### 3.11 CORE 270 CONNECTIVITY RULE CERTIFICATION TESTING

#### 3.11.1 Key Rule Requirements

**Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.**

**Requires a CORE-Certified Health Plan and Health Plan Vendor to implement a Server and to:**

1. Implement Server capability to support both Message Envelope Standards and Message Exchanges specified in the rule for Real Time. (§4.1.1, §4.2, §6.3.1)<sup>28</sup>
2. Implement Server capability to support both Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered. (§4.1.1, §4.2, §6.3.2)
3. Implement Server capability and enforce one of two specified Submitter Authentication Standards for both Real Time and/or Batch. (§4.1.1)
4. Have a capacity plan such that it can receive and process a large number of single concurrent real-time transactions via an equivalent number of concurrent connections. (§4.3.5.1)
5. Have the capability to receive and process large batch transaction files if batch is supported. (§4.3.5.2)
6. Publish detailed specifications in a Connectivity Companion Guide on its public web site as required by the appropriate CORE Phase I or Phase II Companion Guide Rule. (§4.3.7)

**If a CORE-Certified Health Plan and Health Plan Vendor elects to optionally implement a Client, it is required to:**

7. Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified in the rule for Real Time. (§4.1.1, §4.2, §6.3.1)
8. Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered. (§4.1.1, §4.2, §6.3.2)
9. Implement Client capability to support both specified Submitter Authentication Standards for both Real Time and/or Batch. (§4.1.1)

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<sup>28</sup> Section numbers reference the specific section in the CORE Phase II Connectivity Rule that specifies the details of this requirement.

**3.11.1 Key Rule Requirements****Requires a CORE-Certified Clearinghouse and other Intermediaries to implement a Server and to:**

10. Implement Server capability to support both Message Envelope Standards and Message Exchanges specified in the rule for Real Time. (§4.1.2, §4.2, §6.3.1)
11. Implement Server capability to support both Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered. (§4.1.2, §4.2, §6.3.2)
12. Implement Server capability and enforce one of two specified Submitter Authentication Standards for both Real Time and/or Batch. (§4.1.2)
13. Have a capacity plan such that it can receive and process a large number of single concurrent real-time transactions via an equivalent number of concurrent connections. (§4.3.5.1)
14. Have the capability to receive and process large batch transaction files if batch is supported. (§4.3.5.2)
15. Publish detailed specifications in a Connectivity Companion Guide on its public web site as required by the appropriate CORE Phase I or Phase II Companion Guide Rule. (§4.3.7)

**Requires a CORE-Certified Clearinghouse and other Intermediaries to implement a Client and to:**

16. Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified in the rule for Real Time. (§4.1.2, §4.2, §6.3.1)
17. Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered. (§4.1.2, §4.2, §6.3.2)
18. Implement Client capability to support both specified Submitter Authentication Standards for both Real Time and/or Batch. (§4.1.2)

**3.11.1 Key Rule Requirements****Requires a CORE-Certified Provider and Provider Vendor to implement a Client and to:**

19. Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified in the rule for Real Time. (§4.1.3, §4.2, §6.3.1)
20. Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered. (§4.1.3, §4.2, §6.3.2)
21. Implement Client capability to support both specified Submitter Authentication Standards for both Real Time and/or Batch. (§4.1.3)

**If a CORE-Certified Provider and Provider Vendor elects to optionally implement a Server, it is required to:**

22. Implement Server capability to support both Message Envelope Standards and Message Exchanges specified in the rule for Real Time. (§4.1.3, §4.2, §6.3.1)
23. Implement Server capability to support one of two Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered. (§4.1.3, §4.2, §6.3.2)
24. Implement Server capability and enforce one of two both specified Submitter Authentication Standards for both Real Time and/or Batch. (§4.1.3)

**Requires all CORE-Certified Message Receivers to:**

25. Track the times of any received inbound messages. (§4.3.4.1)
26. Respond with the outbound message for the received inbound message. (§4.3.4.1)
27. Include the date and time the message was sent in HTTP+MIME or SOAP+WSDL Message Header tags. (§4.3.4.1)

**3.11.1 Key Rule Requirements****Specifies:**

28. Message Enveloping specifications for HTTP MIME Multipart (Envelope Standard A). (§4.2.1)
29. HTTP MIME Multipart payload attachment handling. (§4.2.1.8)
30. Message Enveloping specifications for SOAP+WSDL (Envelope Standard B). (§4.2.2)
31. XML Schema specification for SOAP. (§4.2.2.1)
32. Web Services Definition Language (WSDL) specification. (§4.2.2.2)
33. SOAP payload attachment handling. (§4.2.2.11)
34. Request and response handling for real time, batch, and batch response pickup. (§4.3.1)
35. Submitter authentication and authorization handling. (§4.3.2)
36. Error handling for both Envelope Messaging Standards. (§4.3.3)
37. Envelope metadata fields, including descriptions, intended use syntax and value-sets applicable to both Enveloping Messaging Standards. (§4.4)

### 3.11.2 Conformance Testing Requirements

The CORE Detailed Step-By-Step Test Scripts will not include comprehensive testing requirements for all possible permutations of the CORE Phase II Connectivity Rule.

Conformance must be demonstrated by successful completion of the Detailed Step-By-Step Test Scripts specified below with a CORE-authorized testing vendor.

The Detailed Step-By-Step Test Scripts specify each specific test that must be completed by each stakeholder type for both Real Time and Batch communications. There are one or more Detailed Step-By-Step Test Scripts for each of the following conformance testing requirements of the CORE Phase II Connectivity Rule. Batch Connectivity Test Scripts are only required to be completed if an entity supports Batch communications.

There may be other requirements of the rule not specified here or in The Detailed Step-By-Step Test Scripts. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in these Conformance Testing Requirements and Detailed Step-by-Step Test Scripts.

1. A health plan or health plan vendor must demonstrate it has implemented the server specifications for both Message Enveloping Standards.
2. A health plan or health plan vendor must demonstrate it has implemented one of the two submitter authentication standards.
3. A clearinghouse, switch or other intermediary must demonstrate it has implemented the server specifications for both Message Envelope Standards.
4. A clearinghouse, switch or other intermediary must demonstrate it has implemented the client specifications for one of the two Message Envelope Standards.
5. A clearinghouse that handles submissions to health plan must demonstrate it has implemented both submitter authentication standards.
6. A provider or provider vendor must demonstrate it has implemented the client specifications for one of the two Message Envelope Standards.
7. A provider or provider vendor must demonstrate it has implemented both submitter authentication standards.



**3.11.3 Test Scripts Assumptions**

1. Entity is CORE Phase I certified.
2. All tests will be conducted over HTTP/S.
3. The message payload is an X12 Interchange.
4. No editing or validation of the message payload will be performed.
5. All submitter authentications are valid; no error conditions are created or encountered.
6. Testing will not be exhaustive for all possible levels of submitter authentication.
7. Test scripts will test for the ability to log, audit, track and report on the required data elements.
8. Rule specifications addressing payload attachment handling are not being tested.
9. Rule specifications addressing error handling are not being tested.
10. The CORE test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

3.11.4 Detailed Step-by-Step Test Script

**REMINDER:** CORE testing is not exhaustive. The CORE test suite does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

**NOTE:** The references in parentheses after each test script are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the “Stakeholder” column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>29</sup>					
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>30</sup>	
<b>Real Time Connectivity Test Scripts</b>											
1.	Implement and enforce <b>one of two</b> Submitter Authentication standards on communications <b>server</b> (Key Rule Requirement #3 and #12)										
1.1	Implement and enforce use of Username/Password over SSL on communications <b>server</b> (Key Rule Requirement #3 and #12)	Communications server accepts a valid logon by a client using Username/Password, which is embedded in the message envelope as specified in CORE Phase II Connectivity Rule		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

<sup>29</sup> The checkmark in each box below indicates the stakeholder type to which the test script applies.

<sup>30</sup> If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>29</sup>				
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>30</sup>
1.2	Implement and enforce use of X.509 Certificate over SSL on communications <b>server</b> (Key Rule Requirement #3 and #12)	Communications server accepts a valid logon by a client using X.509 Certificate over SSL		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2.	On the authenticated connection as per Test #1, implement capability to support <b>both</b> Message Envelope Standards and envelope metadata for Real Time as a communications <b>server</b> (Key Rule Requirement #1, #10 and #37)									
2.1	Implement SOAP+WSDL Message Envelope Standard and envelope metadata as a communications <b>server</b> (Key Rule Requirement #1, #10 and #37)	Communications server accepts a valid logon by a client conforming to the SOAP+WSDL envelope and metadata specifications, and successfully completes the Real-time message interactions as specified in §6.3.1 of Connectivity Rule.		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2.2	Implement HTTP MIME Multipart Message Envelope Standard and envelope metadata as a communications <b>server</b> (Key Rule Requirement #1, #10 and #37)	Communications server accepts a valid logon by a client conforming to the HTTP MIME Multipart envelope and metadata specifications, and successfully completes the Real-time message interactions as specified in §6.3.1 of Connectivity Rule.		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	Implement capability to support <b>both</b> Submitter Authentication standards as a communications <b>client</b> (Key Rule Requirement #18, #21)									
3.1	Implement Username/Password submitter authentication method	Client successfully logs on to a communications server with		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>29</sup>				
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>30</sup>
	as a communications <b>client</b> (Key Rule Requirement #18, #21, and #24)	Username/Password, which is embedded in the message envelope as specified in CORE Phase II Connectivity Rule.								
3.2	Implement X.509 certificate submitter authentication method as a communications <b>client</b> (Key Rule Requirement #18, #21, #24)	Client successfully logs on to a communications server with X.509 certificate		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	On the authenticated connection as per Test #3, implement capability to support <b>one of two</b> Message Envelope Standards and envelope metadata for Real Time as a communications <b>client</b> (Key Rule Requirement #16, #19 and #37)									
4.1	Implement SOAP+WSDL Message Envelope Standard and envelope metadata as a communications <b>client</b> (Key Rule Requirement #16, #19 and #37)	Communications client successfully logs on to a communications server using the SOAP+WSDL Message Envelope Standard and envelope metadata specifications, and successfully completes the Real-time message interactions as specified in §6.3.1 of Connectivity Rule.		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>29</sup>				
				<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>30</sup>
4.2	Implement HTTP MIME Multipart Message Envelope Standard and envelope metadata as a communications <b>client</b> (Key Rule Requirement #16, #19 and #37)	Communications client successfully logs on to a communications server using the HTTP MIME Multipart Message Envelope Standard and envelope metadata specifications, and successfully completes the Real-time message interactions as specified in §6.3.1 of Connectivity Rule.		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	Verify that communications <b>server</b> creates, assigns, logs, links the required metadata elements to message payload (Key Rule Requirement #25 and #27)	Output a system generated audit log report showing all required data elements		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	Verify that communications <b>client</b> creates, assigns, logs, links the required metadata elements to message payload (Key Rule Requirement #25 and #27)	Output a system generated audit log report showing all required data elements		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>Batch Connectivity Test Scripts (Required only if Batch is supported)</b>										
7.	Implement and enforce <b>one of two</b> Submitter Authentication standards on communications <b>server</b> (Key Rule Requirement #3 and #12)									

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>29</sup>				
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>30</sup>
7.1	Implement and enforce use of Username/Password over SSL on communications <b>server</b> (Key Rule Requirement #3 and #12)	Communications server accepts a valid logon by a client using Username/Password, which is embedded in the message envelope as specified in CORE Phase II Connectivity Rule		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7.2	Implement and enforce use of X.509 Certificate over SSL on communications <b>server</b> (Key Rule Requirement #3 and #12)	Communications server accepts a valid logon by a client using X.509 Certificate over SSL		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8.	On the authenticated connection as per Test #7, implement capability to support <b>both</b> Message Envelope Standards and envelope metadata for Batch as a communications <b>server</b> (Key Rule Requirement #2, #11 and #37)									
8.1	Implement SOAP+WSDL Message Envelope Standard and envelope metadata as a communications <b>server</b> (Key Rule Requirement #2, #11 and #37)	Communications server accepts a valid logon by a client conforming to the SOAP+WSDL envelope and metadata specifications, and successfully completes the Batch message interactions as specified in §6.3.2 of Connectivity Rule.		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>29</sup>				
				<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>30</sup>
8.2	Implement HTTP MIME Multipart Message Envelope Standard and envelope metadata as a communications <b>server</b> (Key Rule Requirement #2, #11 and #37)	Communications server accepts a valid logon by a client conforming to the HTTP MIME Multipart envelope and metadata specifications, and successfully completes the Batch message interactions as specified in §6.3.2 of Connectivity Rule.		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9.	Implement capability to support <b>both</b> Submitter Authentication standards as a communications <b>client</b> (Key Rule Requirement #18, #21)									
9.1	Implement Username/Password submitter authentication method as a communications <b>client</b> (Key Rule Requirement #18, #21, and #24)	Client successfully logs on to a communications server with Username/Password, which is embedded in the message envelope as specified in CORE Phase II Connectivity Rule.		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9.2	Implement X.509 certificate submitter authentication method as a communications <b>client</b> (Key Rule Requirement #18, #21, #24)	Client successfully logs on to a communications server with X.509 certificate		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10.	On the authenticated connection as per Test #9, implement capability to support <b>one of two</b> Message Envelope Standards and envelope metadata for Batch as a communications <b>client</b> (Key Rule Requirement #16, #19 and #37)									

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>29</sup>				
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>30</sup>
10.1	Implement SOAP+WSDL Message Envelope Standard and envelope metadata as a communications <b>client</b> (Key Rule Requirement #17, #20 and #37)	Communications client successfully logs on to a communications server using the SOAP+WSDL Message Envelope Standard and envelope metadata specifications, and successfully completes the Batch message interactions as specified in §6.3.2 of Connectivity Rule.		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10.2	Implement HTTP MIME Multipart Message Envelope Standard and envelope metadata as a communications <b>client</b> (Key Rule Requirement #17, #20 and #37)	Communications client successfully logs on to a communications server using the HTTP MIME Multipart Message Envelope Standard and envelope metadata specifications, and successfully completes the Batch message interactions as specified in §6.3.2 of Connectivity Rule.		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
11.	Verify that communications <b>server</b> creates, assigns, logs, links the required metadata elements to message payload (Key Rule Requirement #25 and #27)	Output a system generated audit log report showing all required data elements		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder <sup>29</sup>				
						Provider	Health Plan	Clearinghouse	Vendor	N/A <sup>30</sup>
12.	Verify that communications <b>client</b> creates, assigns, logs, links the required metadata elements to message payload (Key Rule Requirement #25 and #27)	Output a system generated audit log report showing all required data elements		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

## 4 Appendix

### 4.1 TEST SUITE SUPPLEMENT

#### 4.1.1 Using This Supplement

This Supplement is to be used in conjunction with the CORE Phase II Certification Test Suite. It does not replace any of the CORE Phase II Policies and Rules, but rather provides additional information and details regarding the use and format of the CORE Phase II Master Test Bed Data as it applies to the CORE 260: Data Content (270/271) Rule. Only the CORE 260: Data Content (270/271) Rule requires the use of the CORE Phase II Master Test Bed Data.

Topics in this Supplement are organized as follows:

§4.1.2 and subsections provides a high-level overview of the CORE Phase II Master Test Bed Data, where the data is found, and how that document is organized

§4.1.3 is a high-level overview of the use of the CORE Phase II Master Test Bed Data by the CORE authorized testing vendor(s)

§4.1.4 and subsections identifies specific allowable exceptions for users when loading the CORE Phase II Master Test Bed Data into their respective system; allowable exceptions relate to the modification or non-use of some of the test data elements

§4.1.5 specifies that only the CORE Phase II Master Test Bed Data can be used for certification testing along with identifying certain data that is not included in the master test bed data

§4.1.6 discusses at a high level the CORE Phase II Certification Test Suite certification testing requirements

§4.1.7 provides an example of the mapping of some of the CORE test bed data elements to the X12 270 transaction set

#### 4.1.2 CORE Phase II Certification Master Test Bed Data

##### 4.1.2.1 About the Base Test Data and Format

The CORE Phase II Master Test Bed Data (specified in a separate Excel workbook) is comprised of 24 base test “cases” consisting of 16 subscriber only cases and 8 subscriber-with-dependent cases. Also included in the master test bed are data for 13 health plans. Each beneficiary (subscriber and dependent) is assigned to a specific health plan. This CORE Phase II Master Test Bed Data incorporates, builds upon and extends the CORE Phase I Master Test Bed Data. The base test data are specified in a human-readable format in a separate Excel workbook, described in detail below. Although actual CORE Phase II certification testing will use this CORE Phase II Master Test Bed Data as presented in the base test data, the types of transactions that will be tested against this data are specified in the CORE Phase II Test Suite Version 2.0.1 under the Detailed Test Script for the CORE 260 Data Content (270/271) Rule.

Note: The CORE Phase II Master Test Bed Data includes all of the CORE Phase I Master Test Bed Data along with additional data necessary for appropriate testing of the Phase II CORE 260 Data Content (270/271) Rule. Data elements added for Phase II are identified in the Excel workbook

Users should extract all of the test bed data for health plans and beneficiaries from the Excel workbook. Beneficiaries who are dependents of a subscriber are identified as a dependent in the test bed data. Beneficiaries marked as a dependent should be extracted and may be loaded as subscriber to accommodate those health plans that require the assignment of a unique member ID to each beneficiary. In the context of this Appendix and the CORE Phase II Master Test Bed Data, CORE defines beneficiary to mean a person who is eligible to receive benefits under a health benefits plan whether or not the person is the subscriber or a dependent.

The test bed data is provided only in an Excel spreadsheet format. The Excel workbook contains multiple tabs (spreadsheets) as follows:

- Tab 1: The title page of the workbook
- Tabs 2 - 25: Beneficiary test data
- Tabs 26 - 38: Health plan test data

Test bed data is provided in both upper and lower case characters for ease of human readability. Users with systems that require all upper case characters will need to convert lower case characters accordingly when loading the data into their internal system.

Remember, the CORE Phase II Master Test Bed Data applies only to the CORE 260: Data Content (270/271) Rule.

#### ***4.1.3 Loading the Test Data and How Vendors Use the Data***

Users may load the test data into their internal systems via manual data entry or by exporting the data into any file format supported by Excel for further automatic processing.

The CORE authorized certification testing vendors will use only the master test bed data to test each entity according to their stakeholder type. Since CORE certification testing is not exhaustive, not all test beneficiaries (subscribers/dependents) and their associated health plans may be used in Phase II testing. Nevertheless, users should extract and load all of the master test bed data into their internal systems. The specific internal system into which the master test bed data is loaded is determined by each user, e.g., a development or production or test system, and may vary by user.

There are fields (cells) in both the Health Plan and Beneficiary data that can be modified in the CORE Phase II Master Test Bed Data. The specific fields are outlined below and highlighted in the actual CORE Phase II Master Test Bed Excel file. Many of the modifiable fields are data elements that are not addressed in or required by the Phase II rule, but are needed for testing. This said, users are not permitted to modify:

- Dates
- Deductible and co-pay amounts that are explicitly shown as zero dollar (0\$) amounts
- Any patient demographic

Should an entity determine it needs to modify any of CORE Phase II Master Test Bed Data in order to load it into their internal systems, such modifications and how the data was adjusted should be reported to CAQH so lessons learned can be applied to later Phases of CORE.

#### ***4.1.4 Allowable Exceptions When Loading Specific Test Data***

Exceptions identified below are the same as for the CORE Phase I Master Test Bed Data. These exceptions are included here for ease of reference.

##### **4.1.4.1 Health Plan Data Options**

###### ***4.1.4.1.1 Group #***

The Group number is not validated by either of the CORE-authorized certification testing vendors in any of the certification test scripts. Therefore the Group number can be modified, or not used, by any health plan or information source based on its eligibility system requirements for Group number when undergoing certification testing.

###### ***4.1.4.1.2 Health Plan #***

The Health Plan number is not validated by either of the CORE-authorized certification testing vendor(s) in any of the certification test scripts. Therefore the Health Plan number can be modified, or not used, by any health plan or information source based on its eligibility system requirements for Plan number when undergoing certification testing.

#### *4.1.4.1.3 Health Plan Name*

The Health Plan Name is required by the CORE rule and its presence in the 271 response transaction is validated by the CORE-authorized certification testing vendor(s). However, the actual name value of the Health Plan Name is not validated by the CORE-authorized certification testing vendor(s) in any of the certification test scripts. Therefore, while the Health Plan Name must be loaded into an entity's testing system, the name value can be modified by any health plan or information source based on its eligibility system requirements for Health Plan Name when undergoing certification testing. When a user modifies the Health Plan Name for any of the health plan test data tabs it must also modify the Health Plan Name on the corresponding beneficiary test data tab in order to retain the appropriate association of the beneficiary to the correct health plan.

#### *4.1.4.1.4 Health Plan Coverage Level*

The CORE-authorized certification testing vendor(s) can accommodate a health plan or information source modifying the Coverage Level (EB02) from Employee to Individual as needed in order to load the benefit into its eligibility system. Therefore the Coverage Level can be modified by any health plan or information source based on its eligibility system requirements for coverage level when undergoing certification testing.

#### *4.1.4.1.5 Health Plan Patient Liability*

The CORE-authorized certification testing vendor(s) can accommodate a health plan or information source modifying the data value for Patient Liability data (In-Network and Out-of-Network Annual Base and Remaining Deductible, Co-Payment and Co-Insurance) as needed in order to load the benefit into its eligibility system. When the cell contains a data value that is not an explicit zero dollar (0\$) amount, the actual data value may be modified to an appropriate data value for loading into the eligibility system, but a value MUST be loaded. Additionally, all zero dollar (0\$) amounts MUST be loaded. Therefore, some of the Patient Liability amounts can be modified by any health plan or information source based on its eligibility system requirements for such data when undergoing certification testing. The constraints for not allowing modification of zero dollar (0\$) amounts are related to the CORE 260 Data Content (270/271) Rule requirements in §4.1.3.1.1 through §4.1.3.3 which specify requirements for using a zero dollar (0\$) amount in the 277 response transaction.

#### *4.1.4.1.6 X12 Information Source Name*

The name "PlanA Certification Payer" is used only in the NM103 segment in the 2100A Information Source loop. The name of the Information Source is not validated by the CORE-authorized certification testing vendor(s) in any of the certification test scripts. Therefore this value can be modified by any health plan or information source based on its eligibility system requirements when undergoing certification testing.

### **4.1.4.2 Beneficiary Data Options**

#### *4.1.4.2.1 Member ID*

The CORE-authorized certification testing vendor(s) can accommodate health plan and information source needs (e.g., length, format, datatype) regarding Member ID (MID) in their testing products. Thus, a health plan or information source may modify the MID in the CORE Phase II Master Test Bed Data in order to load the test data into its eligibility system.

#### *4.1.4.2.2 Dependent Beneficiary*

The CORE-authorized certification testing vendor(s) can accommodate health plan or information source needs regarding loading dependents in the CORE Phase II Master Test Bed Data with a unique Member ID (MID) into the health plan or information source eligibility systems as follows:

A health plan or information source may load the subscriber in its eligibility system using the MID as specified in the CORE Phase II Master Test Bed Data for the subscriber and then separately load the dependent from the CORE Master Test Bed Data into its eligibility system as a subscriber using the MID as specified in the CORE Master Test Bed Data for the dependent.

Or alternatively

A health plan or information source may modify the dependent's MID in the CORE Phase II Master Test Bed Data to correspond to the subscriber's MID as specified in the Master Test Bed Data and then load the dependent appropriately in its eligibility system.

#### *4.1.4.2.3 Employee ID*

The Employee ID is not validated by the CORE-authorized certification testing vendor(s) in any of the certification test scripts. Therefore the Employee ID can be modified, or not used, by a health plan or information source based on its eligibility system requirements for Employee ID when undergoing certification testing.

#### *4.1.4.2.4 Provider Name*

The Provider Name is not validated by the CORE-authorized certification testing vendor(s) in any of the certification test scripts. Therefore the Provider Name can be modified, or not used, by a health plan or information source based on its eligibility system requirements for Provider Name when undergoing certification testing.

#### *4.1.4.2.5 NPI (National Provider ID)*

The NPI is not validated by the CORE-authorized certification testing vendor(s) in any of the certification test scripts. Therefore the NPI can be modified by a health plan or information source based on its eligibility system requirements for NPI when undergoing certification testing.

#### *4.1.4.2.6 Gender*

The Gender of a beneficiary is not validated by the CORE-authorized certification testing vendor(s) in any of the certification test scripts. Therefore Gender can be modified, or not used, by a health plan or information source based on its eligibility system requirements for Gender when undergoing certification testing.

#### *4.1.4.2.7 X12 Information Receiver Name*

The Information Receiver Name is used only in the NM103 segment in the 2100B Information Receiver loop. The name of the Information Receiver is not validated by the CORE-authorized certification testing vendor(s) in any of the certification test scripts. Therefore this value can be modified by any health plan or information source based on its eligibility system requirements when undergoing certification testing.

#### *4.1.4.2.8 Identifiers and Other Data on the X12 Control Segments*

The CORE Phase II Rules do not address the specific use and data content of the ISA, GS and ST Control Segments. However, some test scripts for the CORE 260: Data Content (270/271) Rule require that the entity undergoing certification testing must be able to conduct a valid X12 Interchange containing either a 270 inquiry or 271 response transaction set.

The Master Test Bed Data does not specify any specific values that must be used in these control segments. Users are referred to the X12N HIPAA-adopted 270/271 Implementation Guide Appendix for the proper use and values.

**4.1.5 Using the Test Data**

All CORE-authorized certification testing vendor(s) will use only data from the CORE Phase II Master Test Bed Data, combined with the CORE Phase II Test Suite Scenarios and Detailed Test Scripts, when conducting CORE certification testing for the CORE 260: Data Content (270/271) Rule.

Although the CORE Phase II Master Test Bed Data is comprised of 32 beneficiaries (subscribers/dependents) and 13 associated health plans, the actual CORE Certification Testing does not include all beneficiaries (subscribers/dependents) and associated health plans. Each CORE-authorized certification testing vendor will determine which of the beneficiaries (subscribers/dependents) and associated health plans will be used during actual certification testing. This means that CORE-authorized certification testing vendor(s) will only create 270s and 271s and accept corresponding 270s and 271s that match the actual or modified beneficiary and health plan information in the CORE Phase II Master Test Bed Data.

The CORE Phase II Master Test Bed Data does not contain ISA/GS sender and receiver IDs. The actual 270 and 271 transaction sets sent during certification testing should have appropriate ISA/GS sender and receiver IDs as agreed to between the CORE-authorized certification testing vendor and the user, as well as appropriate control numbers at the ISA/GS/ST/BHT03 levels as required by the ASC X12 Standards and the HIPAA-adopted 270/271 Implementation Guides. Batch test transaction cases may contain multiple eligibility requests and responses in each message. Therefore, organizations planning to undergo CORE-certification testing with a CORE-authorized certification testing vendor should extract the CORE Phase II Master Test Bed Data needed to appropriately load their internal databases for internal testing and CORE-certification testing purposes.

The CORE Phase II Master Test Bed Data is not intended to provide all of the data elements that the user may need to completely populate its internal test file or test database in order to test for CORE compliance against the Detailed Test Scripts. Depending upon their specific database structure requirements, users may be required to add other test data, or modify the CORE Phase II Master Test Bed Data as outlined in §4.1.3.

**4.1.6 Test Data and CORE Certification**

The CORE Phase II Certification Test Suite defines specific certification testing requirements and detailed Test Scripts for each of the CORE Phase II rules. These detailed Test Scripts are not intended to exhaustively and comprehensively test all requirements of the CORE Phase II rules. Rather, the Test Scripts focus on a key subset of each rule’s requirements. Consequently, the scope of the CORE Phase II Master Test Bed Data is limited to data needed for the entity seeking to become CORE-certified to create and populate its internal files and/or databases for internal pre-certification testing and CORE certification testing for the CORE 260: Data Content (270/271) Rule.

Use of any non-CORE base test bed data for CORE certification testing outside of the guidelines set forth in §4.1 may result in unsuccessful testing results, which will not be accepted by CAQH.

**4.1.7 CORE Certification Master Test Bed Data References**

**4.1.7.1 270/271 X12 Reference Sheet**

This table provides an example of the data mapping from the CORE Phase II Master Test Bed base data to its respective X12 data element.

HEALTH PLAN				X12 Mapping
Field	Min Len	Max Len	Data Attributes	Loop/Segment
NPI	10	10	Alpha Numeric	2100B/NM109 with 2100B / NM108 = "XX"

HEALTH PLAN				X12 Mapping
Field	Min Len	Max Len	Data Attributes	Loop/Segment
Subscriber ID	2	30	Alpha Numeric	2100C/NM109 with NM108 = "M1"
Subscriber First Name	1	25	Alpha Numeric	2100C/NM104
Subscriber Last Name	1	35	Alpha Numeric	2100C/NM103
Subscriber DOB	1	35	CCYYMMDD	2100C/DMG02 with DMG01 = "D8"
Service Type Code	1	2	Alpha Numeric	2110C or 2110D/EB03
Dependent First Name	1	25	Alpha Numeric	2100D/NM104
Dependent Last Name	1	35	Alpha Numeric	2100D/NM103
Dependent DOB	1	35	CCYYMMDD	2100D/DMG02 with DMG01 = "D8"
Health Plan Name	1	50	Alpha Numeric	2110C or 2110D/EB05
Health Plan Number	1	17	Alpha Numeric	2100C/REF02 with REF01 = "18"
Group Number	1	17	Alpha Numeric	2100C/REF02 with REF01 = "6P"

In addition to the CORE Master Test Bed data, the following reference sources will be of assistance when conducting CORE-certification testing:

- CORE 260: Data Content (270/271) Rule
- CORE Phase II Certification Test Suite
- CORE Phase II Master Test Bed Data
- HIPAA adopted X12N 270/271 Implementation Guides
- ASC X12 Standards Version 004010