Analysis & Planning Guide for Implementing the CORE Payment & Remittance Operating Rules
March 2024

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1. Introduction: Analysis & Planning for CORE Operating Rule Implementation

This CORE Analysis & Planning Guide provides a resource for entities preparing to implement the CORE Payment & Remittance Operating Rules. A solid understanding of the CORE Payment & Remittance Operating Rules, combined with an effective planning effort, is the basis for a successful implementation project.

This document provides guidance for Project Managers, Business Analysts, System Analysts, Architects, and other project staff to complete the first step of a typical systems development life cycle: Systems Analysis & Planning. The purpose of this guide is to enable Project Managers and other staff to:

- Understand the applicability of the CORE Payment & Remittance Operating Rule requirements to your organization's systems and business processes that support EFT & ERA transactions.
- Identify and inventory all impacted external and internal systems, business processes (manual and automated), and outsourced vendors and agents[1] (e.g., Business Associate) that process EFT and/or ERA transactions or perform other requirements of the CORE Payment & Remittance Operating Rules.
- Perform a detailed rule requirements gap analysis to identify system(s) that may require remediation in order to conform to the CORE Payment & Remittance Operating Rule requirements and to identify business process which may be impacted by the CORE Payment & Remittance Operating Rules (e.g., need for internal testing, project management, EFT & ERA resources, etc.).

The appendices of this CORE Analysis & Planning Guide include the following:

- **Stakeholder & Business Type Evaluation**: Use to determine your stakeholder type(s) and understand the role of your intermediaries and agents (Business Associate) that process the EFT and/or ERA transactions.
- **Systems Inventory & Impact Assessment Worksheet**: Use to do a high-level inventory of all external and internal systems that process the EFT and/or ERA transactions and are impacted by the CORE Payment & Remittance Operating Rules.
- **Gap Analysis Worksheet**: Use to determine the level of system(s) remediation necessary for implementing the business requirements of the CORE Payment & Remittance Operating Rules.
- **Dollars and Data Flow Diagram**: Use to assist with planning for the various entities that may be involved in your CORE Payment & Remittance Operating Rules implementation.

NOTES:

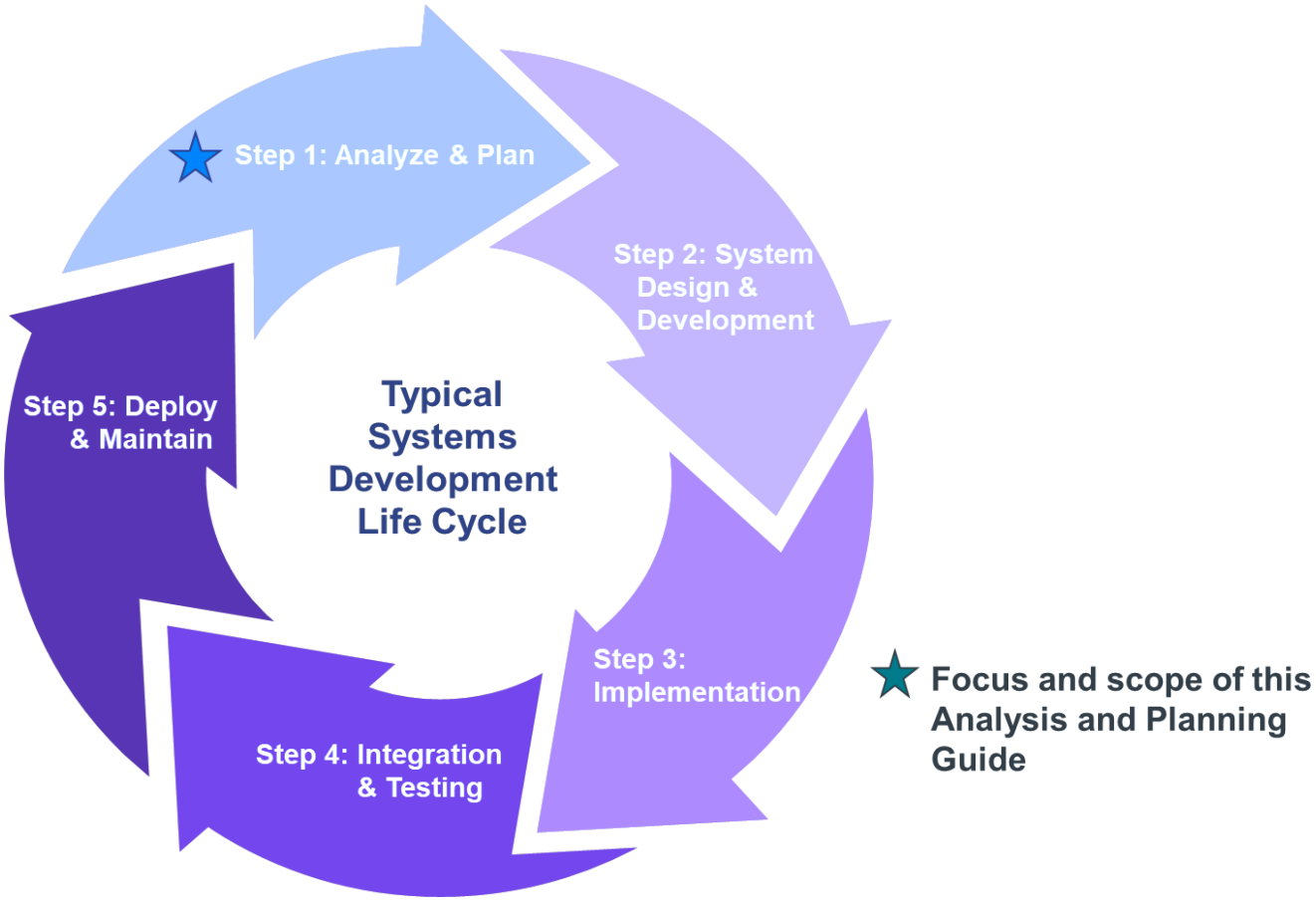
- This document is for educational purposes only; in the case of a question between this document and CORE Operating Rule text or Federal regulations, the latter take precedence.
- This Analysis & Planning Guide is scoped to *general* implementation planning of the CORE Payment & Remittance Operating Rules and can assist with compliance with the ACA Section 1104 mandate or detailed voluntary CORE Certification (these are, however, separate projects requiring analysis and planning beyond that described in this document).

[1] The term "agent" as used in this document describes entities that provide outsourced functions/activities on behalf of health plans providers (e.g., Business Associate). The full definition of Business Associate can be found in the **Electronic Code of Federal Regulations** (Title 45, Subtitle A, Subchapter C, Part 160.103).

2. Systems Development Life Cycle

The diagram below illustrates a typical systems development life cycle (SDLC) for developing or remediating information systems. SDLC includes five key steps, beginning with analysis and planning through deployment and ongoing maintenance. This Analysis & Planning Guide is scoped to assist your organization in the first step of an SDLC for the implementation of the CORE Payment & Remittance Operating Rules given Step 1 sets the stage for all other steps. Note: The impacted system(s) may include an in-house developed system, COTS (commercial off-the-shelf) system, or an outsourced solution from a third party. The "system" in certain cases may also be a manual process or even include activities performed on your behalf by one or more agents.

Typical Systems Development Life Cycle



3. Analysis & Planning for the CORE Payment and Remittance Operating Rules: Key Tasks

The following table outlines the key tasks necessary to complete Step 1: Analyze & Plan of a Systems Development Life Cycle. When the analysis and planning is completed, you will have created a high-level systems impact analysis and developed a detailed project plan for adopting the CORE Payment & Remittance Operating Rule requirements.

Analysis and Planning: Key Tasks	
Task	**Activity**
Task A – Complete Staff Education and Training on the CORE Payment & Remittance Operating Rules	• Thoroughly review and understand the CORE Payment & Remittance Operating Rules. • Conduct general education and awareness of the CORE Payment & Remittance Operating Rules for the impacted areas in your organization (see Section 4 of this document for additional resources available to educate staff on the CORE Operating Rules).
Task B – Determine Your Organization's Stakeholder & Business Type(s) (Stakeholder & Business Type Evaluation) *CORE Payment & Remittance Operating Rule requirements are tied to applicable stakeholder type(s): provider, health plan, clearinghouse, and vendor* *Please note that some stakeholder types are not necessarily HIPAA-covered entities (e.g., software or service vendors) and may not be directly required to implement the rule requirements but may need to because of being an agent of a HIPAA-covered entity.*	• Determine your stakeholder and business type(s) to understand which CORE Payment & Remittance Operating Rules apply to your organization. • Understand the role of intermediaries and agents that provide EFT and/or ERA services or process these transactions on your behalf. • Consider the following based on your stakeholder type(s):
	• If your organization is a health plan: – The majority of the CORE Payment & Remittance Operating Rule requirements will apply to your systems. – Health plans that outsource to a clearinghouse or agent the processing of the X12 v5010 835 or Healthcare EFT Standard[2] transactions to providers may have some unique implementation considerations. Depending on the scenario between the health plan and its clearinghouse/intermediary or its agent, the health plan may not need to implement some rule requirements directly and the clearinghouse/intermediary or its agent will need to implement them on behalf of the health plan. For the EFT and ERA transactions, intermediaries, or its agent, may include other types of entities not involved in the implementation of the ACA-mandated CORE Eligibility & Benefits and Claim Status Operating Rules, such as third-party payment vendors. The health plan, therefore, might have different trading partners to consider when implementing the CORE Payment & Remittance Operating Rules. (See Appendix D for a diagram of dollars and data flow that may assist with identifying all entities involved.)
	• If your organization is a provider: – You likely are outsourcing some of the CORE Payment & Remittance Operating Rule requirements to a clearinghouse or agent (e.g., your software vendor or a third-party billing/collection service). Provider organizations using a clearinghouse, a software

[2] In January 2012, HHS issued an Interim Final Rule with Comment (IFC) adopting the NACHA ACH CCD plus Addenda Record (CCD+) and the X12 835 TR3 TRN Segment as the Healthcare EFT Standards. (CMS-0024-IFC: Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.) The IFC requires health plans to input the X12 835 TR3 TRN Segment into the Addenda Record of the CCD+; specifically, the X12 835 TR3 TRN Segment must be placed in Field 3 of the Addenda Entry Record ("7 Record") of a CCD+.

Analysis and Planning: Key Tasks	
Task	**Activity**
	vendor, or a third-party billing/collection service to process the X12 v5010 835 or Healthcare EFT Standard transactions with health plans may have some unique implementation considerations, as the clearinghouse, software vendor, or billing/collection service is performing some functions on behalf of the provider as an agent.
	• If your organization is a clearinghouse: – You are responsible for implementing the CORE Payment & Remittance Operating Rule requirements applicable to you as a clearinghouse. – Additionally, if a health plan and/or provider outsource(s) certain functions to you to perform on their behalf, you are responsible for implementing all CORE Payment & Remittance Operating Rule requirements which have been outsourced to you. In this instance, your organization will need to work with your business partners to determine applicable rule requirements.
	• If your organization is a software or services vendor: – You may be responsible for implementing many of the CORE Payment & Remittance Operating Rule requirements into your services or software as a result of being an agent of a HIPAA covered entity. – Note: If your services or software are provider-facing, you will have a unique set of requirements to implement that are different than a health plan-facing vendor's services or software. • If your organization is a third-party billing vendor or third-party payment vendor: – You may be responsible for implementing many of the CORE Payment & Remittance Operating Rule requirements into your services or software as a result of being an agent of a HIPAA covered entity. – Note: Vendors (and their financial institutions) sending health care transactions over the ACH Network should also be familiar with the NACHA Operating Rules, which include requirements for Health Care Payments via ACH.
Task C - Conduct a Systems Inventory (Systems Inventory & Impact Assessment Worksheet)	*Relative to your stakeholder type(s):* • Identify and inventory all impacted external and internal systems and outsourced vendors that process the v5010 X12 835 and Healthcare EFT Standard transactions. ○ NOTE: Especially with respect to the CORE EFT and ERA Enrollment Data Rules, these internal systems may include manual as well as automated processes. • Determine which functions for each identified impacted system/outsourced vendor are in-house developed and maintained, commercial off the shelf (COTS) system, or outsourced to a third party. • Determine potential options for addressing the CORE Payment & Remittance Operating Rule requirements, applicable to your stakeholder type(s) (e.g., remediate an in-house

Analysis and Planning: Key Tasks	
Task	**Activity**
	developed system, replace, or upgrade any COTS system, or work with third party vendor to ensure they meet CORE Payment & Remittance Operating Rule requirements).
Task D - Conduct Detailed Rule Requirements Gap Analysis (Gap Analysis Worksheet)	• Identify the impacted systems (identified via the *Systems Inventory & Impact Assessment Worksheet*) responsible for satisfying each requirement of the CORE Payment & Remittance Operating Rules. • Determine and document any gaps between the existing system's capability and each rule requirement. • Identify and document any business process which may also be impacted by each CORE Payment & Remittance Rule requirement and to what extent the process is impacted. ○ For example, a health plan must proactively inform the healthcare provider during EFT (Healthcare EFT Standards) and ERA (v5010 X12 835) enrollment that the healthcare provider will need to contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for successful reassociation of the EFT payment with the ERA remittance advice, and a healthcare provider must proactively contact its financial institution to arrange for the delivery of those CORE-required Minimum CCD+ Data Elements.

Task E - Develop a Detailed Project Plan	• A detailed project plan typically outlines steps for completion of the following key activities as Steps 2-5 of the System Development Life Cycle:
	  – Determine required resources to complete the project (i.e., estimate resources, time, system release schedules, and money).
	  – Develop a detailed Functional Requirements Document.
	  – Create a detailed Systems Design Document describing, in detail, the required functions and capabilities necessary to implement the CORE Payment & Remittance Operating Rules.
	  – Implement necessary system(s) enhancements.
	  – Test impacted systems to ensure conformance to the requirements set forth in the Functional Requirements Document.
	  – Deploy (i.e., implement system(s) into production environment).
	  – Conduct trading partners implementation testing.

Analysis and Planning: Key Tasks	
Task	**Activity**
Other Considerations – CORE Certification	• Consider CORE Certification as part of your project plan[3] – CORE offers CORE Certification to the four stakeholder types that create, transmit or use EFT and ERA data: health plans, providers, software/services vendors, and clearinghouses. – Key benefits to completing CORE Certification include: ▪ Certification Testing provides an online mechanism for a stakeholder to test its systems ability to exchange eligibility and claim status data with its trading partners using the CORE Payment & Remittance Operation Rules. ▪ Demonstrates via a recognized industry "Seal" your organization's adoption of the CORE Payment & Remittance Operating Rules to the industry. ▪ Encourages trading partners to work together on transaction data content, infrastructure, and connectivity needs. ▪ Promotes maximum ROI when all stakeholders in the information exchange are known to conform with the CORE Payment & Remittance Operating Rules. • More information on the CORE Certification process is available on the CAQH website.

[3] **NOTE:** The CORE Certification Program offered by CORE is separate from the CMS Federal operating rules compliance program mandated by the ACA. Information on the CMS compliance program regarding operating rules is under development and can be found **HERE.**

4. Additional Resources

Beyond the information provided in this CORE Analysis & Planning Guide, there are additional resources for entities preparing to implement the CORE Payment & Remittance Operating Rules:

- **CORE Payment & Remittance Operating Rules.**
- **Payment & Remittance CORE Certification Master Test Suite** (initially developed for CORE Certification but same concepts, e.g., role of trading partners, apply for general adoption of the CORE Operating Rules).
- **CORE FAQs** address typical questions regarding the CORE Operating Rules.
    - If your question is not answered by the FAQ, email question to **CORE@caqh.org** to have it entered into the formal CORE Request Process.
- Upcoming CORE **Education Sessions** (as well as presentations and recordings from previous sessions) for further clarification on rule requirements.
- January 2012 Interim Final Rule with Comment (**CMS-0024-IFC**): Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice.
- August 2012 Interim Final Rule with Comment (**CMS-0028-IFC**): Administrative Simplification: Adoption of Operating Rules for Health Care Electronic Funds Transfers (EFT) and Remittance Advice Transactions.
- **CMS FAQs** (FAQs on a wide range of topics).
- **X12 Requests for Interpretation** provide information related to the meaning, use, and interpretation of X12 Standards, Guidelines, and Technical Reports, including implementation guidelines for the transactions can be obtained from X12.
- CARCs/RARCs Resources: **Claim Adjustment Reason Codes List and related FAQs** and **Remittance Advice Remark Codes List and related FAQs** (Washington Publishing Company).
- ***NACHA Operating Rules***, which include requirements around Health Care Payments via ACH.
    - Any questions related to the *NACHA Operating Rules* can be directed to **NACHA.**

Entities seeking to implement the CORE Payment & Remittance Operating Rules are encouraged to note the following:

- The CORE Payment & Remittance Operating Rules assume that any HIPAA covered entity implementing the operating rules is compliant with the most recently mandated version of HIPAA; HIPAA compliance is not defined by CORE.
- The CORE Payment & Remittance Operating Rule requirements are tied to the applicable stakeholder type(s). The applicability of a specific CORE Payment & Remittance Operating Rule requirement may vary according to trading partner relationship, contracted services, and other arrangements. If you have specific questions concerning applicability, please **contact CORE Staff**.

CORE staff is available to assist with questions about understanding the requirements of the CORE Payment & Remittance Operating Rules in regard to your stakeholder type(s); implementing entities are responsible for gap analysis and systems remediation.

5. Appendix

Appendix A: CORE Stakeholder & Business Type Evaluation

Purpose: After becoming educated on the CORE Payment & Remittance Operating Rules, you will need to determine your stakeholder type(s). The *CORE Payment & Remittance Stakeholder & Business Type Evaluation* below will assist you in determining which CORE Payment & Remittance Operating Rules apply to your organization and which trading partners you need to work with on planning and implementation. Knowing your stakeholder type(s) will help you complete the *Systems Inventory & Assessment Worksheet.*

NOTE: Applicability of a specific rule requirement may vary according to trading partner relationship, contracted services, and other arrangements. Some example business models include:

- Provider direct-to-health plan connection:
  - Health plan implements all requirements of the CORE Payment & Remittance Operating Rules.
  - Large payer organizations' treasury management functions will play a role.
- Single/dual clearinghouse-to-health plan connection:
  - Health plan outsources infrastructure and connectivity functions to a clearinghouse.
  - Health plan-facing clearinghouse acts as a proxy for health plan's Rule conformance for the contracted services.
- Provider-to-clearinghouse/vendor:
  - Provider outsources ERA retrieval function to clearinghouse/vendor.
  - Provider-facing clearinghouse or vendor solution acts as a proxy for provider's conformance for the contracted services.
  - Provider might engage (and therefore need to consider) agents specific to EFT/ERA that were not involved in implementation of other Operating Rules, such as collection/billing services vendors.
- Health plan-to-clearinghouse/vendor:
  - Health plan outsources the creation of the EFT transaction to a third-party payment vendor.
  - Health plan outsources the creation of the ERA transaction to a clearinghouse or agent.

Key Takeaway: Understand what aspects of your business and/or outsourced functions are impacted by the CORE Payment & Remittance Operating Rules (e.g., products, business lines, etc.).

Stakeholder & Business Type Evaluation		
Question	**Points for Consideration**	**Your Response**
1. What is your stakeholder type(s): health plan, provider, vendor, or clearinghouse? (See question 3 for more information on other trading partners)	The CORE Payment & Remittance Operating Rules define four stakeholder types that implement the operating rules: health plan, clearinghouse, provider, and vendor; the applicability of specific CORE Payment & Remittance Operating Rule requirements vary according to stakeholder type.	
2. What role and responsibilities does my organization have for implementing the CORE Payment & Remittance Operating Rules, given our stakeholder type(s) (e.g., health care electronic funds transfers and/or electronic remittance advice)?	The CORE Payment & Remittance Operating Rules outline the specific roles and responsibilities for each stakeholder type; review CORE Payment & Remittance Operating Rule text for more detail.	
3. Does my organization rely on trading partners (e.g., software vendors, clearinghouses, banks/financial services institutions, third-party payment vendors, collection/billing services vendors) to assist with health care electronic funds transfers and/or electronic remittance advice?	The applicability of a specific CORE Payment & Remittance Operating Rule requirement may vary according to trading partner relationship, contracted services, and other arrangements. If your organization relies on a software vendor or a clearinghouse or other agent to meet any of the CORE Payment & Remittance Operating Rule requirements you will need to coordinate with that entity as part of your pre-implementation planning and outline the applicability of each requirement to the vendor, clearinghouse, or agent. See Section 4 of this document (above) for additional resources. Ensure appropriate agent agreements are in place with necessary stakeholders (e.g., third-party payment vendors, collection/billing services vendors).	

Appendix B: CORE Systems Inventory & Impact Assessment Worksheet
Purpose: After you complete the *Stakeholder & Business Type Evaluation,* your next step is to complete the *CORE Systems Inventory & Impact Assessment Worksheet* which enables you to identify and inventory all impacted systems that process health care electronic funds transfers and/or electronic remittance advice transactions.

This assessment worksheet will help you identify your systems impacted by the implementation of the CORE Payment & Remittance Operating Rules, including in-house developed and maintained systems, COTS systems, those functions outsourced to a third party. While completing this analysis you should also consider potential options for addressing applicable CORE Payment & Remittance Operating Rule requirements (e.g., remediate an in-house developed system, replace, or upgrade any COTS system, or work with third-party vendor).

Instructions:
1. In the second column of the worksheet, note if one of your system(s) is impacted by each rule and list the name of the impacted system(s).
    - **NOTE**: The impacted system(s) may include an in-house developed system, COTS system, or an outsourced solution from a third party. The "system" in certain cases may also be a manual process.
2. In the third column, identify potential options for addressing the rule requirements for each impacted system(s).
3. Use the worksheet findings to inform completion of the *Gap Analysis Worksheet* for any identified system impacted by the rule requirements. (Task D of the Key Analysis & Planning Tasks in Section 3 of this document).

Key Takeaway: Understand how many of your systems/products are impacted by each CORE Payment & Remittance Operating Rule and understand with which vendors you will need to coordinate.

CORE Systems Inventory & Impact Assessment Worksheet			
CORE Operating Rule Requirements	**Are One or More Systems/Processes Impacted?** *(Yes/No; Name of Impacted System/Process)*	**Is the System/Process In-House, COTS, or Outsourced to a Third Party?**	**Potential Options to Address Rule Requirements** *(e.g., remediate an in-house developed system, replace, or upgrade any COTS system, work with third party vendor to ensure they meet CORE Operating Rule requirements, or update manual processes)*
CORE Payment & Remittance Infrastructure Rules			
CORE Payment & Remittance (835) Infrastructure Rule (ability to support X12 005010X221A1 835 processing)			
CORE Payment & Remittance Data Content Rules			
CORE Payment & Remittance CARCs and RARCs Rule (aligning internal codes with CORE-required Code Combinations for CORE-defined Business Scenarios)			
CORE Payment & Remittance Reassociation (CCD+835) Rule (elapsed time between CCD+ and 835, minimum CCD+ data elements for successful reassociation, resolving late/missing transactions, etc.)			
CORE Payment & Remittance EFT Enrollment Data Rule (maximum data elements for manual and electronic EFT Enrollment)			
CORE Payment & Remittance ERA Enrollment Data Rule (maximum data elements for manual and electronic ERA enrollment)			

CORE Systems Inventory & Impact Assessment Worksheet			
CORE Operating Rule Requirements	**Are One or More Systems/Processes Impacted?** *(Yes/No; Name of Impacted System/Process)*	**Is the System/Process In-House, COTS, or Outsourced to a Third Party?**	**Potential Options to Address Rule Requirements** *(e.g., remediate an in-house developed system, replace, or upgrade any COTS system, work with third party vendor to ensure they meet CORE Operating Rule requirements, or update manual processes)*
CORE Connectivity Rules			
CORE Connectivity Rule vC2.0.0 (HTTPS Safe Harbor, with two envelope options: SOAP with WSDL and MIME Multi-part; two authentication modes: digital certification and username/password)			
CORE Connectivity vC4.0.0 (HTTPS Safe Harbor; continued support for SOAP and added support for REST; authorization: OAuth 2.0.; security: TLS 1.2)			

Appendix C: CORE Gap Analysis Worksheet

Purpose: After the *Systems Inventory & Impact Assessment*, the next task is for entities to determine the level of system(s) remediation necessary for adopting the business and technical requirements of the CORE Payment & Remittance Operating Rules using the *CORE Gap Analysis Worksheet*. Each rule requirement in the *Gap Analysis Worksheet* includes a section reference to the corresponding operating rule for more detail.

NOTES:

- For more detail on rule requirements refer to the actual CORE Payment and Remittance Operating Rule text which takes precedence over this worksheet.
- If your entity has identified more than one impacted system, you may need to complete a *Gap Analysis Worksheet* for each system.

Instructions:

1. The *Gap Analysis Worksheet* contains each CORE Payment & Remittance Operating Rule Requirement in the first column by CORE Payment & Remittance Operating Rule. In the second column, enter the system(s) impacted by the CORE Payment & Remittance Operating Rule Requirement. If there is no system impacted by the requirement, enter N/A.
    - **NOTE**: The impacted system(s) may include an in-house developed system, a COTS system, or an outsourced solution to a third party or agent.
2. In the third column, note if the system currently meets the CORE Payment & Remittance Operating Rule Requirement or not.
3. In the fourth column, briefly describe any gap between the CORE Payment & Remittance Operating Rule Requirement and the system under evaluation, if applicable. The high-level findings from the *Systems Inventory & Impact Assessment* will inform the input in this column.
4. In the fifth column, estimate the effort required to remediate the impacted system(s). This can include the type of skilled resource required, the number of such resources, and the potential hours required to fill the identified gap.
5. In the sixth column, identify and describe any impacted business process. These often include potential training and education of staff, clients, and other users of the system's new capabilities.
6. In the seventh column, estimate and describe the effort required to revise the impacted business process. This can include the type of skilled resources required, the number of such resources, and the potential hours required to fill the gap identified.
7. The results of the completed *Gap Analysis Worksheet* will allow for the development of a detailed project plan.

Key Takeaway: Understand the level of system(s) remediation necessary for adopting each CORE Payment & Remittance Operating Rule requirement.

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
CORE Payment & Remittance (835) Infrastructure Rule vPR.2.0							
	Health Care Claim Payment/Advice Connectivity Requirements (§4.1)						
1	A HIPAA-covered entity must be able to support the most recent published and CORE adopted version of the CORE Connectivity Rule.						
	Health Care Claim Payment/Advice Batch Acknowledgement Requirements (§4.2) [4]						
2	A receiver of a v5010 X12 835 transaction must return: a. A v5010 X12 999 Implementation Acknowledgement for each Functional Group of v5010 X12 835 transactions to indicate that the Functional Group was either accepted, accepted with errors, or rejected, and b. To specify for each included v5010 X12 835 transaction set that the transaction set was either accepted, accepted with errors, or rejected.						
3	A health plan must be able to accept and process a v5010 X12 999 for a Functional Group of v5010 X12 835 transactions.						
4	When a Functional Group of v5010 X12 835 transactions is either accepted with errors or rejected, the v5010 X12 999 Implementation Acknowledgement must report each error detected to the most specific level of detail supported by the v5010 X12 999 Implementation Acknowledgement.						

[4] See footnote on page 3 for detail on the Federal mandate and requirements pertaining to the use of Acknowledgements.

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	Dual Delivery of v5010 X12 835 and Proprietary Paper Claim Remittance Advices (§4.3)						
5	A health plan that currently issues proprietary paper claim remittance advices is required to continue to offer such paper remittance advices to each provider during that provider's initial implementation testing of the v5010 X12 835 for a minimum of 31 calendar days from the initiation of implementation. a. If the 31-calendar day period does not encompass a minimum of three payments to the provider by the health plan, the health plan is required to offer to continue to issue proprietary paper claim remittance advices for a minimum of three payments. b. At the conclusion of this time period, delivery of the proprietary paper claim remittance advices will be discontinued. At the provider's discretion, the provider may elect to not receive the proprietary paper claim remittance advices, to choose a shorter time period, or to discontinue receiving the proprietary paper claim remittance advices before the end of the specified timeframe by notifying the health plan of this decision. c. Upon mutual agreement between the provider and the health plan, the timeframe for delivery of the proprietary paper claim remittance advices may be extended by an agreed-to timeframe, at which time the health plan will						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	discontinue delivery of the proprietary paper claim remittance advices. d. If the provider determines it is unable to satisfactorily implement and process the health plan's electronic v5010 X12 835 following the end of the initial dual delivery timeframe and/or after an agreed-to extension, both the provider and health plan may mutually agree to continue delivery of the proprietary paper claim remittance advices.						
	Health Care Claim Payment/Advice Companion Guide (§4.4)						
6	An entity's Companion Guide covering the v5010 X12 835 must follow the format/flow as defined in the CORE Master Companion Guide Template for HIPAA Transactions.						
CORE Payment & Remittance CARCs and RARCs Rule vPR.1.0							
	Uniform Use of Claim Adjustment Reason Codes, Remittance Advice Remark Codes, Claim Adjustment Group Codes & NCPDP Reject Codes (§4.1.2)						
1	A health plan or its PBM agent must align its internal codes and corresponding business scenarios to the CORE-defined Claim Adjustment/Denial Business Scenarios specified in §4.1.1 and the CARC, RARC, CAGC and NCPDP Reject Code combinations specified in the *CORE-required Code Combinations for CORE-defined Business Scenarios.doc*.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	Use of CORE-required CARC/RARC/CAGC/NCPDP Reject Code Combinations (§4.1.3)						
2	A health plan or its PBM agent must support the maximum CORE-required CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC combinations in the v5010 X12 835, as specified in *CORE-required Code Combinations for CORE-defined Business Scenarios.doc*. a. No other CARC/RARC/CAGC or CARC/NCPDP Reject Codes/CAGC combinations are allowed for use in the CORE-defined Claim Adjustment/Denial Business Scenarios. b. When specific CORE-required CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC combinations are not applicable to meet the health plan's or its PBM agent's business requirements within the CORE-defined Business Scenarios, the health plan and its PBM agent are not required to use them. c. An adjusted *CORE-required Code Combinations for CORE-defined Business Scenarios.doc* will be published no less than three times annually to account for updates to the published code lists. d. Published new or modified codes per the codes committees can be used until the next version of the *CORE-required Code Combinations for CORE-defined Business Scenarios.doc* is						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	published; see the CORE Code Combinations Maintenance Process for more detail. e. A deactivated code must not be used.						
3	In the case where a health plan or its PBM agent wants to use an existing code combination that is not included in the maximum code combination set for a given CORE-defined Business Scenario, a new CARC/RARC code combination must be requested in accordance with the CORE process for updating the *CORE-required Code Combinations for CORE-defined Business Scenarios.doc*.						
	Basic Requirements for Receivers of the v5010 X12 835 (§4.2)						
4	When receiving a v5010 X12 835, the product extracting the data (e.g., a vendor's provider-facing system or solution) from the v5010 X12 835 for manual processing must make available to the end user: a. Text describing the CARC/RARC/CAGC and CARC/NCPDP Reject Codes *included in the remittance advice,* ensuring that the actual wording of the text displayed accurately represents the corresponding code description specified in the code lists without changing the meaning and intent of the description And b. Text describing the corresponding CORE-defined Claim Adjustment/Denial Business Scenario.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
5	The requirement to make available the end user text describing the corresponding CORE-defined Claim Adjustment/Denial Business Scenario does not apply to retail pharmacy.						
6	The requirement to make available the end user text describing the corresponding CORE-defined Claim Adjustment/Denial Business Scenario does not apply to an entity that is simply forwarding the v5010 X12 835 to another system for further processing.						
CORE Payment & Remittance Reassociation (CCD+835) Rule vPR.1.0							
	Receipt of the CORE-required Minimum CCD+ Data Required for Reassociation (§4.1)						
1	A health plan must proactively inform the healthcare provider during EFT (Healthcare EFT Standards) and ERA (v5010 X12 835) enrollment that it will need to contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements necessary for successful reassociation of the EFT payment with the ERA remittance advice.						
2	A healthcare provider must proactively contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements necessary for successful reassociation of the EFT payment with the ERA remittance advice.						
	Elapsed Time between Sending the v5010 X12 835 and the CCD+ Transactions (§4.2)						
3	A health plan must release for transmission to the healthcare provider the v5010 X12 835 corresponding to the Healthcare EFT Standards:						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	a. No sooner than three business days based on the time zone of the health plan prior to the CCD+ Effective Entry Date and b. No later than three business days after the CCD+ Effective Entry Date.						
4	A health plan must ensure that the CCD+ Effective Entry Date is a valid banking day and that the corresponding v5010 x12 835 BPR16 date is the same valid banking day.						
5	For retail pharmacy, the health plan may release for transmission the v5010 X12 835 any time prior to the CCD+ Effective Entry Date of the corresponding EFT; and no later than three days after the CCD+ Effective Entry Date (§4.2.1).						
	Elapsed Time Auditing Requirements (§4.2.2 of rule)						
6	A health plan must ensure the v5010 X12 835 and corresponding Healthcare EFT Standards meet the elapsed time requirements ninety percent (90%) of the time as measured within a calendar month.						
7	A health plan is required to have the capability to track and audit this elapsed time requirement.						
	Resolving Late/Missing EFT and ERA Transactions (§4.3)						
8	A health plan must establish written Late/Missing EFT and ERA Transactions Resolution Procedures defining the process a healthcare provider must use when researching and resolving a late or missing Healthcare EFT Standards payment and/or the corresponding late or missing v5010 X12 835.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
9	Late or missing is defined as a maximum elapsed time of four business days following the receipt of either the Healthcare EFT Standards or v5010 X12 835. For retail pharmacy, a late or missing v5010 835 is defined as a maximum elapsed time of four business days following the receipt of the CCD+.						
10	The Late/Missing EFT and ERA Resolution Procedures must be delivered to the healthcare provider during its EFT and ERA enrollment with the health plan.						
CORE Payment & Remittance EFT Enrollment Data Rule vPR.2.0							
	CORE-required Maximum EFT Enrollment Data Elements (§4.2)						
1	A health plan (or its agent or vendors offering EFT enrollment) is required to collect no more data elements than the maximum data elements defined in CORE-required Maximum EFT Enrollment Data Set Companion Document.						
2	Both the Individual Data Element name and its associated description must be used by a health plan (or its agent or vendors offering EFT enrollment) when collecting EFT enrollment data either electronically or via a manual paper-based process.						
3	The Individual Data Element Name and its associated description must not be modified.						
4	When a Data Element Group (DEG) is designated as required, all of the Individual Data Elements designated as required within the DEG must be collected by the health plan.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
5	Individual Data Elements designated as optional may be collected depending on the business needs of the health plan.						
6	When a DEG is designated as optional, the collection of the optional DEG is at the discretion of the health plan.						
7	When a health plan exercises its discretion to collect an optional DEG, any included Individual Data Element designated as required must be collected.						
8	When a health plan collects an optional Individual Data Element that is composed of one more optional Sub-elements, the optional Sub-element may be collected at the discretion of the health plan.						
9	When a health plan collects a required Individual Data Element that is composed of one or more optional Sub-elements, the optional Sub-element may be collected at the discretion of the health plan.						
10	Not collecting an Individual Data Element identified as optional does not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set.						
11	The collection of multiple occurrences of DEGs for another context does not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set.						
12	A health plan must develop and make available to the healthcare provider (or its agent) specific written instructions and guidance for the healthcare provider (or its agent) when providing and submitting the data elements in the CORE-required Maximum EFT Enrollment Data Set Companion Document.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	a. The health plan's specific instructions and guidance are not addressed in this rule.						
13	When an enrollment is being changed or cancelled, the health plan must make available to the provider instructions on the specific procedure to accomplish a change in their enrollment or to cancel their enrollment.						
	CORE Master Template for Collecting Manual Paper-Based Enrollment EFT Enrollment Data (§4.3.1)						
14	The name of the health plan (or its agent or the vendor offering EFT) and the purpose of the form will be on the top of the form, e.g., Health Plan X: Electronic Funds Transfer (EFT) Authorization Agreement.						
15	A health plan (or its agent or a vendor offering EFT) is required to use the format, flow, and data set including data element descriptions of the CORE-required Maximum EFT Enrollment Data Set as the CORE Master EFT Enrollment Submission Form when using a manual paper-based enrollment method.						
16	All CORE-required EFT Enrollment data elements must appear on the paper form in the same order as they appear in the CORE-required Maximum EFT Enrollment Data Set Companion Document.						
17	A health plan (or its agent) cannot revise or modify: a. The name of a CORE Master EFT Enrollment Data Element Name. b. The usage requirement of a CORE Master EFT Enrollment Data Element.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	c. The Data Element Group number of a CORE Master EFT Enrollment Data Element.						
18	Beyond the data elements and their flow, a health plan (or its agent) must: a. Develop and make available to the healthcare provider (or its agent) specific written instructions and guidance for the healthcare provider (or its agent) when completing and submitting the enrollment form, including when using paper. b. Provide a number to fax and/or a U.S. Postal Service or email address to send the completed form. c. Include contact information for the health plan, specifically a telephone number and/or email address to send questions. d. Include authorization language for the provider to read and consider. e. Include a section in the form that outlines how the provider can access online instructions for how the provider can determine the status of the EFT enrollment. f. Clearly label any appendix describing its purpose as it relates to the provider enrolling in EFT. g. Inform the provider that it must contact its financial institution to arrange for the delivery of						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	the CORE-required Minimum CCD+ Reassociation Data Elements needed for reassociation of the payment and the ERA. *See* CORE Payment & Remittance Reassociation (CCD+835) Rule.						
	CORE Master Template for Electronic Enrollment EFT Enrollment Data (§4.3.2)						
19	When electronically enrolling a healthcare provider in EFT, a health plan (or its agent) must use the CORE Master EFT Enrollment Data Element Name and Sub-element Name as specified in Table 4.2-1 without revision or modification.						
20	The flow, format, and data set including data element descriptions established by this rule must be followed.						
21	When using an XML-based electronic approach, the Data Element Name and Sub-element Name must be used exactly as represented in the table enclosed in angle brackets (i.e., < >) for the standard XML element name; and all spaces replaced with an underscore [_] character, e.g., <Provider_Address>.						
22	A health plan (or its agent or vendors offering EFT enrollment) will offer an electronic way for provider to complete and submit the EFT enrollment.						
	CORE Electronic Safe Harbor for EFT Enrollment to Occur Electronically (§4.4)						
23	Specifies that all health plans and their respective agents must implement and offer to any trading partner a secured electronic method and process for collecting the CORE-required Maximum EFT Enrollment Data Set.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	Instructions for Electronic Enrollment (§4.5)						
24	A health plan must develop and make available to the healthcare provider (or its agent) specific written instructions and guidance for the healthcare provider (or its agent) when providing and submitting the data elements in the CORE-required Maximum EFT Enrollment Data Set Companion Document.						
	Confirmation of Receipt of an Electronic Enrollment Submission (§4.6.1)						
25	When a provider or its agent clicks "submit", or a similar command button on an electronic enrollment form after completing all data fields, the system must return a submission receipt indicating to the provider or its agent that the completed enrollment form was successfully received, and information about the “next steps” for enrollment processing in 24 hours or less.						
26	This timeframe requirement must be met at least 90 percent of the time per calendar month.						
	Confirmation of Completed Processing of an Electronic Enrollment Submission (§4.6.2)						
27	When a health plan or its agent successfully processes an enrollment, disenrollment or enrollment change it must send an electronic notification to the provider or its agent to communicate that the request was completed in 2 weeks or less for provider enrollments.						
28	This timeframe requirement must be met at least 90 percent of the time per calendar month.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	Disclosure of Applicable EFT Fees (§4.7)						
29	A health plan or its agent must disclose any associated fees for receiving EFT payments that are incurred to the provider as part of the EFT enrollment process, when such fees are known.						
	Alternative Electronic Payments Opt-in and Opt-out (§4.8)						
30	A health plan or its agent must provide readily accessible guidance on how a provider can either opt in or opt out of non-EFT electronic payment methods (e.g., virtual credit card) or additional value-added services, if offered.						
	Time Frame for Rule Compliance (§4.5)						
31	Not later than the date that is six months after the compliance date specified in any Federal regulation adopting this rule, a health plan or its agent that uses a paper-based form to collect and submit the CORE-required Maximum EFT Enrollment Data Set must convert all its paper-based forms to comply with the data set specified in this rule.						
32	If a health plan or its agent does not use a paper-based manual method and process to collect the CORE-required Maximum EFT Enrollment Data Set as of the compliance date specified in any Federal regulation adopting this rule, it is not required by this rule to implement a paper-based manual process on or after the compliance date.						
33	It will be expected that all electronic EFT enrollment will meet this rule requirement as of the compliance date,						

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	and that the health plan (or its agent) will inform its providers that an electronic option is now available, if not previously available.						
CORE Payment & Remittance ERA Enrollment Data Rule vPR.2.0							
	CORE-required Maximum ERA Enrollment Data Elements (§4.2)						
1	A health plan (or its agent or vendors offering ERA enrollment) is required to collect no more data elements than the maximum data elements defined in the CORE-required Maximum ERA Enrollment Data Set Companion Document.						
2	Both the Individual Data Element name and its associated description must be used by a health plan (or its agent or vendors offering ERA enrollment) when collecting ERA enrollment data either electronically or via a manual paper-based process.						
3	The Individual Data Element Name and its associated description must not be modified.						
4	When a Data Element Group (DEG) is designated as required, all of the Individual Data Elements designated as required within the DEG must be collected by the health plan.						
5	Individual Data Elements designated as optional may be collected depending on the business needs of the health plan.						
6	When a DEG is designated as optional, the collection of the optional DEG is at the discretion of the health plan.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
7	When a health plan exercises its discretion to collect an optional DEG, any included Individual Data Element designated as required must be collected.						
8	When a health plan collects an optional Individual Data Element that is composed of one more optional Sub-elements, the optional Sub-element may be collected at the discretion of the health plan.						
9	When a health plan collects a required Individual Data Element that is composed of one or more optional Sub-elements, the optional Sub-element may be collected at the discretion of the health plan.						
10	Not collecting an Individual Data Element identified as optional does not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set.						
11	The collection of multiple occurrences of DEGs for another context does not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set.						
12	A health plan must develop and make available to the healthcare provider (or its agent) specific written instructions and guidance for the healthcare provider (or its agent) when providing and submitting the data elements in the CORE-required Maximum ERA Enrollment Data Set Companion Document. a. The health plan's specific instructions and guidance are not addressed in this rule.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
13	When an enrollment is being changed or cancelled, the health plan must make available to the provider instructions on the specific procedure to accomplish a change in their enrollment or to cancel their enrollment.						
	CORE Master Template for Collecting Manual Paper-Based Enrollment ERA Enrollment Data (§4.3.1)						
14	The name of the health plan (or its agent or the vendor offering ERA) and the purpose of the form will be on the top of the form, e.g., Health Plan X: Electronic Remittance Advice (ERA) Authorization Agreement.						
15	A health plan (or its agent or a vendor offering ERA) is required to use the format, flow, and data set including data element descriptions of the CORE-required Maximum ERA Enrollment Data Set as the CORE Master ERA Enrollment Submission Form when using a manual paper-based enrollment method.						
16	All CORE-required ERA Enrollment data elements must appear on the paper form in the same order as they appear in the CORE-required Maximum ERA Enrollment Data Set Companion Document						
17	A health plan (or its agent) cannot revise or modify: a. The name of a CORE Master ERA Enrollment Data Element Name. b. The usage requirement of a CORE Master ERA Enrollment Data Element. c. The Data Element Group number of a CORE Master ERA Enrollment Data Element.						
18	Beyond the data elements and their flow, a health plan (or its agent) must:						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	a. Develop and make available to the healthcare provider (or its agent) specific written instructions and guidance for the healthcare provider (or its agent) when completing and submitting the enrollment form, including when using paper. b. Provide a number to fax and/or a U.S. Postal Service or email address to send the completed form. c. Include contact information for the health plan, specifically a telephone number and/or email address to send questions. d. Include authorization language for the provider to read and consider. e. Include a section in the form that outlines how the provider can access online instructions for how the provider can determine the status of the ERA enrollment. f. Clearly label any appendix describing its purpose as it relates to the provider enrolling in ERA. g. Inform the provider that it must contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the ERA. *See* CORE Payment & Remittance Reassociation (CCD+835) Rule.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	CORE Master Template for Electronic Enrollment ERA Enrollment Data (§4.3.2)						
19	When electronically enrolling a healthcare provider in ERA, a health plan (or its agent) must use the CORE Master ERA Enrollment Data Element Name and Sub-element Name as specified in the CORE-required Maximum ERA Enrollment Data Set Companion Document without revision or modification.						
20	The flow, format and data set including data element descriptions established by this rule must be followed.						
21	When using an XML-based electronic approach, the Data Element Name and Sub-element Name must be used exactly as represented in the table enclosed in angle brackets (i.e., < >) for the standard XML element name; and all spaces replaced with an underscore [_] character, e.g., <Provider_Address>.						
22	A health plan (or its agent or vendors offering ERA enrollment) will offer an electronic way for provider to complete and submit the ERA enrollment.						
	CORE Electronic Safe Harbor for ERA Enrollment to Occur Electronically (§4.4)						
23	Specifies that all health plans and their respective agents must implement and offer to any trading partner a secured electronic method and process for collecting the CORE-required Maximum ERA Enrollment Data Set.						
	Instructions for Electronic Enrollment (§4.5)						
24	A health plan must develop and make available to the healthcare provider (or its agent) specific written instructions and guidance for the healthcare provider (or its agent) when providing and submitting the data						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	elements in the CORE-required Maximum ERA Enrollment Data Set Companion Document						
	Confirmation of Receipt of an Electronic Enrollment Submission (§4.6.1)						
25	When a provider or its agent clicks "submit", or a similar command button on an electronic enrollment form after completing all data fields, the system must return a submission receipt indicating to the provider or its agent that the completed enrollment form was successfully received, and information about the “next steps” for enrollment processing in 24 hours or less.						
26	This timeframe requirement must be met at least 90 percent of the time per calendar month.						
	Confirmation of Completed Processing of an Electronic Enrollment Submission (§4.6.2)						
27	When a health plan or its agent successfully processes an enrollment, disenrollment or enrollment change it must send an electronic notification to the provider or its agent to communicate that the request was completed in 2 weeks or less for provider enrollments.						
28	This timeframe requirement must be met at least 90 percent of the time per calendar month.						
	Time Frame for Rule Compliance (§4.5)						
29	Not later than the date that is six months after the compliance date in any Federal regulation adopting this rule, a health plan or its agent that uses a paper-based form to collect and submit the CORE-required Maximum ERA Enrollment Data Set must convert all its paper-based forms to comply with the data set specified in this rule.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
30	If a health plan or its agent does not use a paper-based manual method and process to collect the CORE-required Maximum ERA Enrollment Data Set as of the compliance date specified in any Federal regulation adopting this rule, it is not required by this rule to implement a paper-based manual process on or after the compliance date.						
31	It will be expected that at the time of certification all electronic ERA enrollment will meet this rule requirement as of the compliance date, and that the health plan (or its agent) will inform its providers that an electronic option is now available, if not previously available.						
CORE Connectivity Rule vC2.2.0							
	Requires a Health Plan and Health Plan Vendor to implement a server and to: (§4.1.1, §4.2, §4.3, §4.3.5.1, §4.3.5.2, §4.3.7, §6.3.1, §6.3.2)						
1	Implement Server capability to support both Message Envelope Standards and Message Exchanges specified in the rule for Real Time.						
2	Implement Server capability to support both Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered.						
3	Implement Server capability and enforce one of two specified Submitter Authentication Standards for both Real Time and/or Batch.						
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.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
5	Have the capability to receive and process large Batch transaction files if batch is supported.						
6	Publish detailed specifications in a Connectivity Companion Guide on its public web site as required by the appropriate Companion Guide.						
	If a Health Plan and Health Plan Vendor elects to optionally implement a client, it is required to: (§4.1.1, §4.2, §6.3.1, §6.3.2)						
7	Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified in the rule for Real Time.						
8	Implement Client capability to support Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered.						
9	Implement Client capability to support Submitter Authentication Standards for both Real Time and/or Batch.						
	Requires a Clearinghouse and Other Intermediaries to implement a server and to: (§4.1.1, §4.2, §4.3.5.1, §4.3.5.2, §4.3.7, §6.3.1)						
10	Implement Server capability to support both Message Envelope Standards and Message Exchanges specified in the rule for Real Time.						
11	Implement Server capability to support both Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered.						
12	Implement Server capability and enforce one of two specified Submitter Authentication Standards for both Real Time and/or Batch.						
13	Have a capacity plan such that it can receive and process a large number of single concurrent real-time						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	transactions via an equivalent number of concurrent connections.						
14	Have the capability to receive and process large Batch transaction files if batch is supported.						
15	Publish detailed specifications in a Connectivity Companion Guide on its public web site as required by the appropriate Companion Guide.						
	Requires a Clearinghouse and Other Intermediaries to implement a client and to: (§4.1.2, §4.2, §6.3.1, §6.3.2)						
16	Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified in the rule for Real Time.						
17	Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered.						
18	Implement Client capability to support both specified Submitter Authentication Standards for both Real Time and/or Batch.						
	Requires a Provider and Provider Vendor to implement a client and to: (§4.1.2, §4.2, §6.3.1)						
19	Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified in the rule for Real Time.						
20	Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered.						
21	Implement Client capability to support both specified Submitter Authentication Standards for both Real Time and/or Batch.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	If a Provider and Provider Vendor elects to optionally implement a server, it is required to: (§4.1.3, §4.2, §6.3.1)						
22	Implement Server capability to support both Message Envelope Standards and Message Exchanges specified in the rule for Real Time.						
23	Implement Server capability to support one of two Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered.						
24	Implement Server capability and enforce one of two specified Submitter Authentication Standards for both Real Time and/or Batch.						
	Requires all Message Receivers to: (§4.3.4.1)						
25	Track the times of any received inbound messages.						
26	Respond with the outbound message for the received inbound message.						
27	Include the date and time the message was sent in HTTP+MIME or SOAP+WSDL Message Header tags.						
	Specifies: (§4.2.1 §4.2.1.8, §4.2.2, §4.2.2.1, §4.2.2.2, §4.2.2.1.1, §4.3.1, §4.3.2, §4.3.3, §4.4)						
28	Message Enveloping specifications for HTTP MIME Multipart (Envelope Standard A).						
29	HTTP MIME Multipart Payload attachment handling.						
30	Message Enveloping specifications for SOAP+WSDL (Envelope Standard B).						
31	XML Schema specification for SOAP.						
32	Web Services Definition Language (WSDL) specification.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
33	SOAP Payload attachment handling.						
34	Request and response handling for real time, batch, and batch response pickup.						
35	Submitter authentication and authorization handling.						
36	Error handling for both Envelope Messaging Standards.						
37	Envelope metadata fields, including descriptions, intended use syntax and value-sets applicable to both Enveloping Messaging Standards.						
CORE SOAP Connectivity Rule vC4.0.0							
	Message Envelope Requirement (§4.1)						
1	Requires the use of SOAP+WSDL.						
	Submitter Authentication Requirement (§4.1.1)						
2	Requires the use of X.509 Client Authentication (mutual authentication) over TLS 1.2 or higher.						
	Submitter Authorization Requirements (§4.1.2)						
3	Requires support for OAuth 2.0 Client Authorization over TLS 1.2 or higher						
	Real Time and Batch Payload Attachment Handling (§4.1.4)						
4	Payload must be sent as an MTOM encapsulated object.						
	Required Transport Method (§4.2.1)						
5	HIPAA-covered entities or their agents must implement HTTP/S Version 1.1 over the public internet.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
6	Receivers must perform the role of an HTTP/S server; Senders must perform the role of an HTTP/S client.						
7	All information exchanged between the client and server is encrypted by a session-level private key negotiated at connection time.						
	Real Time Requests (§4.2.3)						
8	Real Time requests must include a single inquiry or submission as specified in the transaction's corresponding CORE Infrastructure Rule.						
	Batch Submission (§4.2.4)						
9	Batch requests are sent in the same way as Real Time requests.						
10	Response must be only the standard HTTP message indicating whether the request was accepted or rejected.						
11	Message receivers must not respond to a batch submission with an ASC X12 response such as a 5010 X12 999 in the HTTP response to the batch request, even if their systems' capabilities allow such a response.						
12	All X12 responses must be available for pick up by the message sender (client) in accordance with the respective CORE Infrastructure Rule for the transaction.						
	Batch Response Pickup (§4.2.5)						
13	Batch responses must be picked up after the message receiver has had a chance to process a Batch submission in the timeframes specified in the transaction's corresponding CORE Infrastructure Rule.						

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	Error Handling (§4.2.6)						
14	The appropriate HTTP error or status codes and SOAP Faults as applicable to the error/status situation must be used.						
	Tracking of Date and Time and Payload ID (§4.2.8)						
15	Servers are required to track the times of any received inbound messages, and respond with the outbound message for that Payload ID.						
16	Clients must include the date and time the message was sent in the CORE metadata element Time Stamp.						
	Capacity Plan (§4.2.9.1, §4.2.9.2)						
17	A HIPAA-covered entity or its agent's messaging system must 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 which must be received, processed, and the appropriate response provided within response time requirements specified in the transaction's corresponding CORE Operating Rule.						
18	A HIPAA-covered entity or its agent's messaging system must have the capability to receive and process large Batch transaction files which must be received, processed, and the appropriate response provided within the time specified in the applicable CORE Operating Rule.						
	Response Time, Time Out Parameters, and Re-transmission (§4.2.10)						
19	If the HTTP Post Reply Message is not received within the 60 second response period, the client system should						

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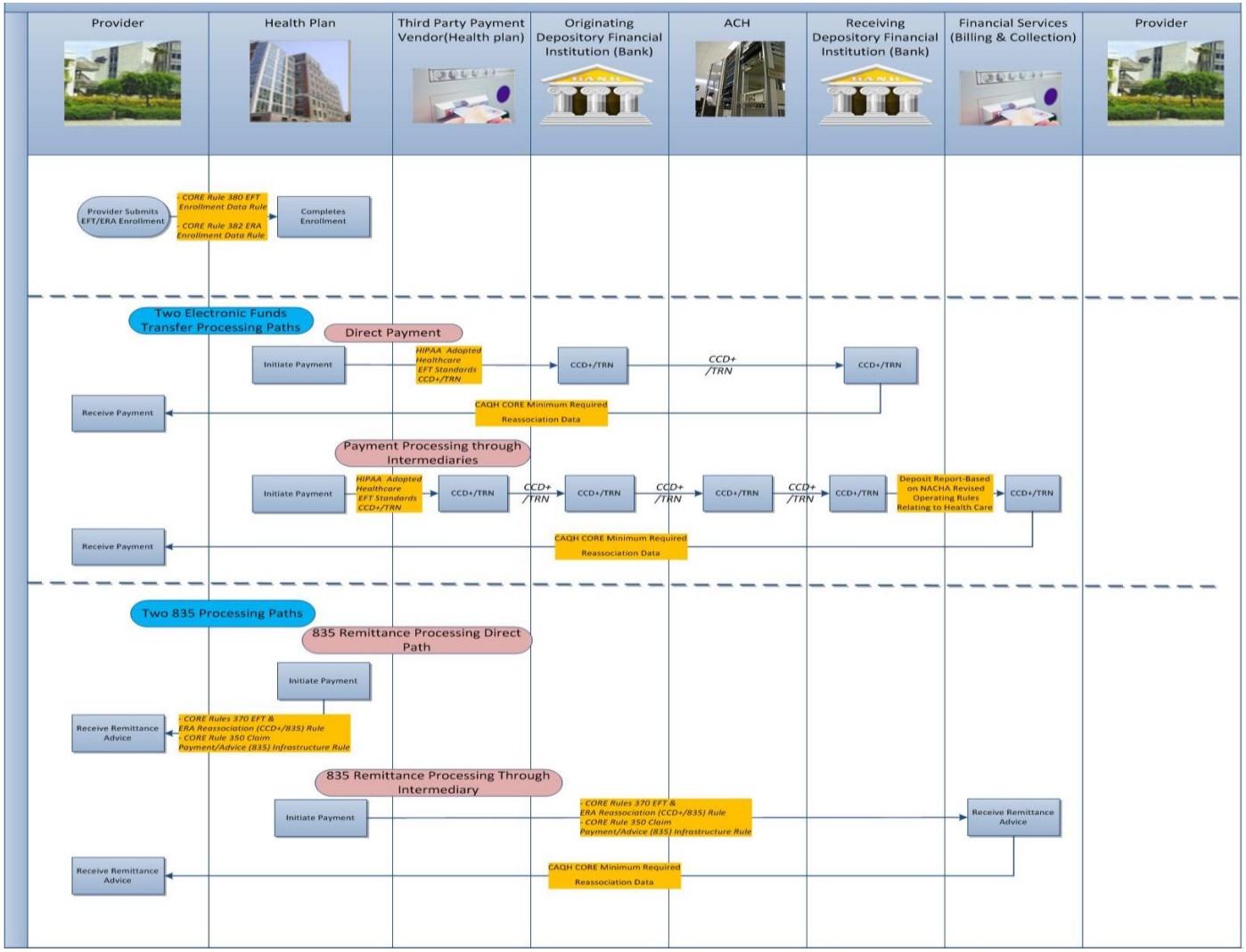
	send a duplicate transaction no sooner than 90 seconds after the original attempt was sent.						
20	Client system should submit no more than 5 duplicate transactions within the next 15 minutes if no response is received after the second attempt.						
21	If the additional attempts result in the same timeout termination, the client system should notify the submitter to contact the receiver directly to determine if system availability problems exist or if there are known internet traffic constraints causing the delay.						
	Publication of Entity-Specific Connectivity Companion Document (§4.3)						
22	Servers must publish detailed specifications in a Connectivity Companion Document on the entity's public web site.						
	Envelope Metadata (§4.4.2)						
23	The Envelope Metadata specified in Table 4.4.2 pertains to the Message Envelope SOAP+WSDL. With the exception of *ErrorCode* and *ErrorMessage* fields, which are only sent in the response, the CORE required envelope metadata for the request and response are required to be identical.						
	Processing Mode (§4.4.3.1)						
24	A HIPAA-covered entity or its agent must support the transaction processing mode requirements specified in the *COREProcessingModePayloadTypeTables.docx* companion document when exchanging transactions in conformance with this CORE Connectivity Rule vC4.0.0.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
25	The Processing Mode requirements specified also apply when a HIPAA-covered entity or its agent are exchanging the transactions addressed by this rule using any other connectivity method as permitted by the CORE Safe Harbor.						
	Enumeration of Payload Type Fields (§4.4.3.2)						
26	A HIPAA-covered entity or its agent must support the requirements for identifying the Payload (*PayloadType)* carried within the content of the Message Envelope as specified in the *COREProcessingModePayloadTypeTables.docx* companion document to this CORE Connectivity Rule v4.0.0						
CORE REST Connectivity Rule vC4.0.0							
	API Interface Format Requirement (§5.1.1)						
1	HIPAA-covered entities and their agent must use JavaScript Object Notation (JSON) for REST Interfaces.						
	Authentication Requirement (§5.1.2)						
2	Requires the use of X.509 Client Authentication (mutual authentication) over TLS 1.2 or higher.						
	Submitter Authorization Requirements (§4.1.2)						
3	Requires support for OAuth 2.0 Client Authorization over TLS 1.2 or higher.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	Transport Method (§5.2.1)						
4	HIPAA-covered entities and their agents must be able to implement HTTP/S Version 1.1 over the public internet.						
	Request and Response Handling (§5.2.2)						
5	Request and response handling for both Synchronous Real-time and Asynchronous Batch Process.						
	Error Handling (§5.2.6)						
6	Message receiver must notify the message sender if the request was successfully handled during the processing of HTTP headers and processing of the Payload.						
	Tracking of Date and Time and Payload (§5.2.8)						
7	Servers are required to track the times of any received inbound messages and respond with the outbound message for that Payload.						
8	Clients must include the date and time the message was last modified.						
	Capacity Plan (§5.2.9., §5.2.11)						
9	A HIPAA-covered entity or its agent's messaging system must have a capacity plan such that it can receive and process a large number of single concurrent Synchronous Real Time transactions via an equivalent number of concurrent connections which must be received, processed, and the appropriate response provided within response time requirements specified in the transaction's corresponding CORE Operating Rule.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
10	A HIPAA-covered entity or its agent's messaging system must have the capability to receive and process large Batch transaction files which must be received, processed, and the appropriate response provided within the time specified in the applicable CORE Operating Rule.						
	Specifications for REST API Uniform Resource Identifiers (URI) Paths (§5.3.1, §5.3.2)						
11	Servers are required to communicate the version of the CORE Connectivity Rule implemented and version of the REST API through the URI Path, per Table 5.3.1.						
12	Requires entities to use standard naming conventions for REST API endpoints to streamline and support uniform REST implementations.						
	REST HTTP Request Method Requirements (§5.4)						
13	Requires entities to use of HTTP Methods listed in Table 5.4 to indicate the desired action to be performed for a given resource.						
	REST HTTP Metadata, Descriptions, Intended Use and Values (§5.5)						
14	Entities are required to use the metadata specified in Table 5.5 for HTTP Requests and HTTP Responses for REST Exchanges.						
	Publication of Entity-Specific Connectivity Companion Document (§5.7)						
15	Servers must publish detailed specifications in a Connectivity Companion Document on the entity's website.						

Appendix D: Dollars and Data Flow Diagrams[5]



[5] The diagrams make reference to the *NACHA Operating Rules*, which include requirements around Health Care Payments via ACH (amendment approved 10/31/2012 and effective 09/20/2013).