Phase II CAQH CORE 259: Eligibility and Benefits 270/271 AAA Error Code Reporting Rule

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1 BACKGROUND

Providers need to have consistent and specific patient identification validation error reporting from health plans in the HIPAA-adopted ASC X12 005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271) Technical Report Type 3 (TR3) implementation guide (hereafter v5010 270/271, v5010 270, v5010 271) response in order to obtain a robust v5010 271 response so that appropriate follow-up action can be taken to obtain correct information.

§1.4.7.1(7) of the v5010 270/271 TR3 states that: "The information source is also required to return information from any of the following segments supplied in the 270 request that was used to determine the 271 response."

The Phase II CORE Identifiers Subgroup evaluated and considered several approaches for attempting to achieve the goals noted above. Due to the multiple and inconsistent use of AAA error codes by health plans and a variety of search and match approaches used for patient identification, the Subgroup reached consensus on developing a Phase II CORE Rule for specifying a standard and consistent method for reporting AAA errors without specifying the search process utilized by the health plan.

In developing this approach, the Subgroup decided to use the full set of AAA error codes available in v4010A1 271 in order to provide as much specificity as possible within the 271 standard on the reasons for the patient identification error(s). The Subgroup also consulted the v5010 270/271 closely as part of its analysis so that this rule would complement rather than conflict with requirements for error reporting.

2 ISSUE TO BE ADDRESSED AND BUSINESS REQUIREMENT JUSTIFICATION

Healthcare providers and health plans have a requirement to uniquely identify patients (aka subscribers, members, beneficiaries) for the purpose of ascertaining the eligibility of the patient for health plan benefits. At a high level, this identification requirement consists of accurately matching:

- Individuals with records and information that relate to them and to no one else; and
- Disparate records and information held in various organizations' computer systems about the same individuals.

For health plans, this identification requirement currently is met by uniquely delineating the individuals whereby each person (or a subscriber and dependents) is assigned an identifier by the health plan covering the individual, i.e., a subscriber, member or beneficiary ID. This ID is combined with other demographic data about the individual (e.g., first name, last name, date of birth, gender, etc.) and then used in healthcare transactions, such as eligibility inquiries, claims submissions, etc.

Healthcare providers obtain this unique identifier from patients, combine it with other demographic data, and then subsequently use it when conducting electronic transactions with health plans, such as insurance verification and claims submissions. The health plans (or information sources) then use this combination of ID and demographic data to attempt to uniquely locate the individual within their systems. However, oftentimes, the ID may not be valid and correct, the other demographic data submitted by the healthcare provider does not match similar demographic data held by the health plans' systems, or some of the data elements required by the health plan are missing; therefore such transactions are then rejected or denied.

The v5010 270 transaction submitted by healthcare providers may contain some or all of the four data elements in the v5010 270/271 and agreed to in the trading partner agreements. §§1.4.8 and 1.4.8.1 of the v5010 270/271 TR3 define a "maximum data set that an information source may require and identifies further elements the information source may use if they are provided. Section 1.4.8.2 defines four alternate search options that an Information Source is required to support in addition to the Primary Search Option. If an Information Source is unable to identify a unique individual in their system (more than one individual matches the information from the Required Alternate Search Option), the Information Source is required to reject the transaction and identify in the 2100C or 2100D AAA segment the additional information from the Primary Search Option that is needed to identify a unique individual in the Information Source's system."

Among the key findings of the 2006 CORE Patient ID Study (see table below), the following were identified regarding error rates and the disparate use of the AAA error codes:

- Providers and health plan respondents have relatively similar rates of valid 271 responses (78-83%). Clearinghouse respondents have a lower rate of valid 271 responses (70%) but a much higher level of rejections for non-eligibility related reasons, such as system timeout, and system availability issues.
- More generic AAA error codes generally have the highest volume of errors for the v5010 270/271 transactions (e.g., Patient not found, Subscriber/Insured not found).[1]

These findings suggest:

- Improved specificity and standardized use of the AAA codes would give providers better feedback to understand what information is missing or incorrect in order to obtain a valid match.

The following table includes data from the 2006 CORE Patient ID Study about the valid response rate and the utilization of patient-ID related AAA error codes. The table includes data from providers, clearinghouses and health plans. The data show that more specific AAA error codes are rarely used in the current environment.

270/271 ELIGIBILITY INQUIRY RESPONSE - SUMMARY				
Initial Eligibility Inquiry Response DESCRIPTIONS	**AAA Code**	**Providers**	**Health Plans**	**Clearinghouses**
An Inquiry results in a valid response on the 1st pass	**None**	**82.5%**	**77.9%**	**69.5%**
Invalid/Missing Date of Birth	58	0.1%	0.1%	0.3%
Invalid/Missing Patient ID	64	0.4%	0.6%	0.5%
Invalid/Missing Patient Name	65	0.1%	0.1%	0.2%
Invalid/Missing Patient Gender Code	66	0.0%	0.0%	0.0%
Patient Not Found	67	9.2%	1.1%	11.2%
Duplicate Patient ID Number	68	0.0%	0.0%	0.1%
Pt Birth Date Does Not Match Patient DOB in Database	71	0.1%	3.1%	0.4%
Invalid/Missing Subscriber/Insured ID	72	0.2%	7.8%	0.6%
Invalid/Missing Subscriber/Insured Name	73	0.0%	1.8%	0.0%
Invalid/Missing Subscriber/Insured Gender Code	74	0.0%	0.3%	0.0%
Subscriber/Insured Not Found	75	1.8%	5.3%	9.3%
Duplicate Subscriber/Insured ID Number	76	0.0%	0.0%	0.5%
Subscriber Found, Patient Not Found	77	0.0%	0.6%	0.1%
Subscriber/Insured Not in Group/Plan Identified	78	0.0%	0.0%	0.0%
Other Pt Identification Related Rejection Issues		3.8%	0.0%	0.0%
Rejects due to ***NON ELIGIBILITY RELATED REASONS (e.g., system timeout, provider authorization issues)***		1.7%	1.3%	7.2%
TOTALS		**100.0%**	**100.0%**	**100.0%**
Number of Respondents		**7**	**9**	**3**

3 SCOPE

3.1 What the Rule Applies To

This Phase II CORE rule applies only to certain data elements used to identify a person in loops and data segments in the v5010 270/271 TR3 as specified in §3.4 of this rule.

This Phase II CORE rule defines a standard way to report errors that cause a health plan (or information source) not to be able to respond with a v5010 271 showing eligibility information for the requested patient or subscriber. The goal is to use a unique error code wherever possible for a given error condition so that the re-use of the same error code is minimized. Where this is not possible, the goal (when re-using an error code) is to return a unique combination of one or more AAA segments along with one or more of the submitted patient identifying data elements such that the provider will be able to determine as precisely as possible what data elements are in error and take the appropriate corrective action.

[1] One large national health plan had a significant volume of AAA errors for invalid (not missing) subscriber ID, which resulted in a relatively high overall error rate for this AAA code across all health plans.

3.2 When the Rule Applies

This rule applies only when a health plan (or information source) is processing the data elements identifying an individual in a v5010 270 received from a submitter

and

- the health plan (or information source) performs pre-query evaluation against one or more of the HIPAA-maximum required data elements[2] identifying an individual in a v5010 270 received from a submitter

or

- the health plan (or information source) performs post-query evaluation against one or more of the HIPAA-maximum required data elements identifying an individual in a v5010 270 from a submitter.

In the context of this Phase II CORE rule the following definitions will apply:

- Pre-query evaluation is the logic of one or more checks of the following done by a health plan's (or information source's) system prior to a database look-up to determine if
  - the data elements it requires to identify an individual are present in the v5010 270

or

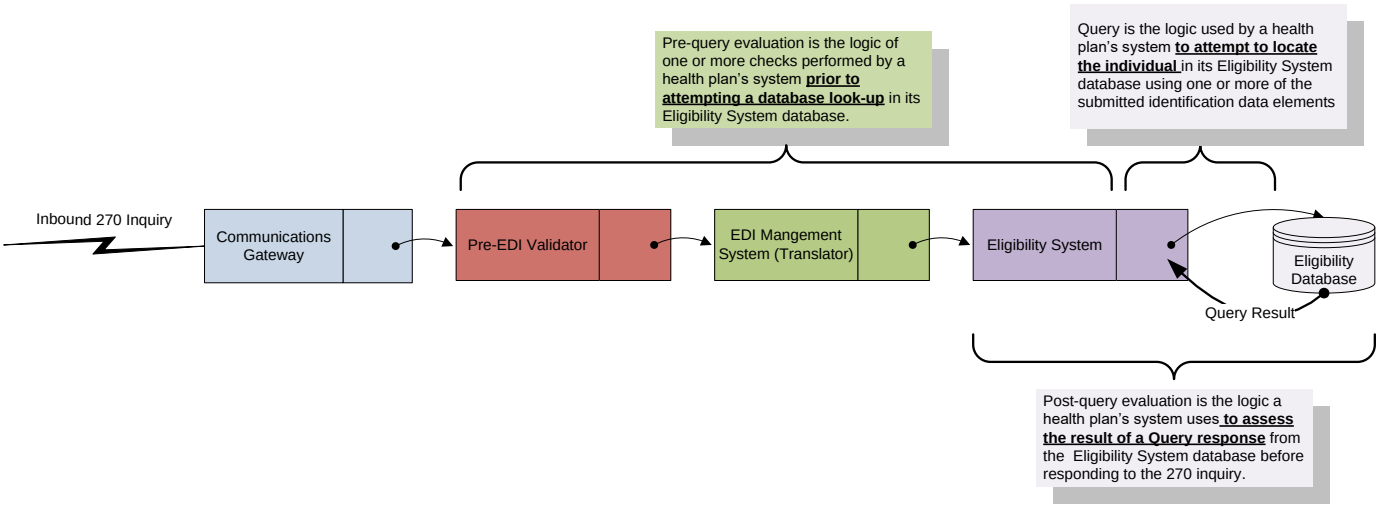
  - the data elements it requires to identify an individual satisfy formatting requirements as defined in §4.3.2 of this rule

or

  - the date-of-birth (DOB) for either the subscriber or dependent is a valid date as defined in §4.3.2 of this rule.
- **Query** is the logic used by a health plan's (or information source's) system to attempt to locate the individual in its eligibility system using one or more of the submitted identification data elements
- **Post-query** evaluation is the logic a health plan's (or information source's) eligibility system uses to assess the results of a Query attempt before responding to the v5010 270.

Figure 1 below is a graphical representation of a conceptual system information flow showing where such pre-query, query and post-query evaluations may take place. This diagram does not represent all systems, but is a conceptual approach solely to illustrate these concepts.

Figure 1 – Conceptual Information Flow



[2] HIPAA-adopted v5010 270/271 TR3 §1.3.8 through §1.4.8.1 specifies the following: "If the patient is the subscriber, the maximum data elements that can be required by an information source to identify a patient in loop 2100C are: Patient's Member ID, Patient's First Name, Patient's Last Name, Patient's Date of Birth. If the patient is a dependent of a subscriber, the maximum data elements that can be required by an information source to identify a patient in loop 2100C and 2100D are: Loop 2100C Subscriber's Member ID, Loop 2100D Patient's First Name, Patient's Last Name, Patient's Date of Birth."

3.3 What the Rule Does Not Require

This Phase II CORE rule does not require a health plan (or information source):

- to use any specific search and match criteria or logic
- to use any specific combination of submitted identification data elements
- to perform a pre-query evaluation
- to perform DOB validation
- to reject the v5010 270 upon detecting an error condition addressed by this rule, but only requires the health plan to return the AAA record when the health plan does reject the v5010 270.

3.4 Applicable Data Elements & Loops

This rule covers the following specified data element and loops in the v5010 270/271 transactions:

Loop ID and Name
Loop 2100C Subscriber Name
Data Element Segment Position, Number & Name
NM103-1035 Last Name
NM104-1036 First Name
NM108-66 ID Code Qualifier
NM109-67 ID Code
DMG02-1251 Subscriber Date of Birth
AAA01-1073 Valid Request Indicator
AAA03-901 Reject Reason Code
AAA04-889 Follow-up Action Code
Loop ID and Name
Loop 2100D Dependent Name
Data Element Segment Position, Number & Name
NM103-1035 Last Name
NM104-1036 First Name
DMG02-1251 Dependent Date of Birth
AAA01-1073 Valid Request Indicator
AAA03-901 Reject Reason Code
AAA04-889 Follow-up Action Code

3.5 Assumptions

- The v5010 270 and v5010 271 are compliant with v5010 270/271 TR3.
- The submitter of the v5010 270 knows which data elements were submitted in the v5010 270 (i.e., member identifier, first name, last name, date of birth).
- A last or first name is considered invalid only when it does not match a last or first name in the health plan's (or information source's) eligibility system.

3.6 Abbreviations Used in this Rule

- MID = member identifier
- FN = first name
- LN = last name
- DOB = date of birth

3.7 Outside the of Scope of this Rule

This rule does not specify whether or not a health plan (or information source) must use the full last or first name or may use only a portion of the last or first name when performing a Pre-Query, Query, or Post-Query process. (Refer to Phase II CORE 258: Normalizing Patient Last Name Rule for use of special characters and letter case in subscriber/patient names.)

4 RULE

4.1 Basic Requirements for Health Plans and Information Sources

A health plan (or information source) is required

- to return a AAA segment for each error condition (as defined in the "Error Condition Description" column of the Error Reporting Codes & Requirements Table in §4.5) that it detects as specified in §4.3 – 4.5

and

- to return code "N" in the AAA01 Valid Request Indicator data element

and

- to return the specified Reject Reason Code in AAA03 as specified in §4.3 – 4.5 for the specific error condition described

and

- to return code "C" in the AAA04 Follow-up Action Code data element

and

- to return data elements submitted and used as specified in §4.5.

This may result in multiple AAA segments being returned in the v5010 271 response such as an AAA segment specifying an error in the LN data element and another AAA segment specifying an error in the MID data element in the same NM1 segment. Examples of such AAA segments include (error conditions and required error codes are specified in subsequent sections of this rule):

AAA*N73*C~**	Indicates LN missing & required or LN does not match LN in eligibility system
AAA*N73*C~**	Indicates FN missing & required or FN does not match FN in eligibility system
AAA*N72*C~**	Indicates MID missing & required or MID does not match MID in eligibility system

4.2 Basic Requirements for Receivers of the v5010 271

The receiver of a v5010 271 (defined in the context of this Phase II CORE rule as the system originating the v5010 270) is required

- to detect all combinations of error conditions from the AAA segments in the v5010 271 as defined in the "Error Condition Description" column of the Error Reporting Codes & Requirements Table in §4.5

and

- to detect all data elements to which this rule applies as returned by the health plan in the v5010 271

and

- to display to the end user text that uniquely describes the specific error condition(s) and data elements returned by the health plan in the v5010 271

and

- ensure that the actual wording of the text displayed accurately represents the AAA03 error code and the corresponding "Error Condition Description" specified in the Error Reporting Codes & Requirements Table in §4.3 – 4.5 without changing the meaning and intent of the error condition description.

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

4.3 Pre-Query Error Conditions and Reporting Requirements

Pre-query errors may occur when a health plan (or information source) performs various evaluations against the data elements in the v5010 270 used to identify an individual. There are two types of pre-query evaluations that may be performed as specified in §4.3.1 and §4.3.2.

A health plan (or information source) is not required by this rule to perform any pre-query evaluations.

When a health plan (or information source) performs a pre-query evaluation, it must return a AAA segment for each error condition detected along with the data elements submitted and used as specified in §4.3.1 and §4.3.2.

4.3.1 Missing & Required Data Element

This error condition may occur when a health plan (or information source) checks to determine that one or more of the data elements it requires to attempt a database look-up in its eligibility system are present in the submitted v5010 270.

When a health plan (or information source) checks for missing and required data elements and errors are found, the health plan (or information source) is required to return a v5010 271 as specified in §4.5 of this rule.

This rule does not require a health plan (or information source) to check for missing and required data elements.

The maximum data elements that may be required by a health plan (or information source) are specified in §1.4.8 Search Options of the v5010 270/271 TR3.

4.3.2 Invalid MID or DOB

An invalid MID error condition may occur when a health plan (or information source) has specific requirements for the minimum or maximum length or datatype (e.g., all numeric) of a member identifier. This rule does not require a health plan (or information source) to validate a MID for any formatting requirements.

The MID is invalid if it does not meet either the length, formatting or data type requirements of the health plan. When a health plan (or information source) checks the format of the MID and the MID is invalid, the health plan (or information source) must return a v5010 271 as specified in §4.5 of this rule.

An invalid DOB error condition may occur when a health plan (or information source) validates a DOB. This rule does not require a health plan (or information source) to validate a DOB.

A DOB is invalid when it does not represent a valid date as determined by the health plan (or information source).

When a health plan (or information source) validates a DOB and errors are found, the health plan (or information source) is required to return a v5010 271 as specified in §4.5 of this rule.

4.3.3 Pre-Query Error Reporting

When a pre-query error is detected the health plan (or information source) must

- return a AAA segment for each error detected using the appropriate Reject Reason Code for each Pre-Query Error Condition listed in §4.5 of this rule

and

- return the data elements indicated in §4.5 of this rule.

4.4 Post-Query Error Conditions and Reporting Requirements

Post-query errors may occur when a health plan (or information source) attempts a database look-up in its eligibility system and is not able to locate a unique record. The following types of post-query errors that may occur include:

- Look-up attempted, no record found
- Look-up attempted, single record found
- Look-up attempted, multiple records found

The error conditions and error codes reporting requirements tables specified in §4.5 of this rule are designed to apply regardless of a health plan's (or information source's) specific search and match logic. As such, the codes are applicable to any health plan's (or information source's) search and match logic.

A health plan (or information source) is not required by this Phase II CORE rule to use any specific combination of submitted individual identification data elements nor any specific search and match logic.

When a health plan (or information source) detects any of the specified error conditions, it must

- return a AAA segment for each error detected using the appropriate Reject Reason Code for each Post-Query Error Condition as specified in §4.5 of this rule

and

- return the data elements as specified in §4.5 of this rule.

4.5 Error Reporting Codes & Requirements Table

The Error Reporting Codes and Requirements Table below describes each error condition and the corresponding AAA03 error code that must be used to identify the error in the v5010 271. Errors may occur in either the Subscriber Loop or the Dependent Loop or both. The error code that must be used for each defined error condition is marked with an X. The data elements submitted in the v5010 270 that must be returned if used are also specified. Multiple error conditions are possible.

Table 4.5-1 Error Reporting Codes & Requirements Table

Error Reporting Codes & Requirements Table												
		Subscriber Loop						Dependent Loop				
Error Condition #	Error Condition Description	Invalid/Missing Date-of-Birth	Patient Birth Date Does Not Match That for the Patient	Invalid/Missing Subscriber/Insured ID	Invalid/Missing Subscriber/Insured Name	Duplicate Subscriber/Insured	Data Elements Returned in 271 Response (See Note 1)	Invalid/Missing Date-of-Birth	Invalid/Missing Patient Name	Patient Birth Date Does Not Match That for the Patient	Data Elements Returned in 271 Response (See Note 1)	
		58	71	72	73	76		58	65	71		
Pre-Query - No Look-up Attempted **Missing & Required Data**												
1	Health plan (or information source) requires MID MID was not submitted in the v5010 270 Health plan (or information source) does not attempt look-up			X			None					
2	Health plan requires LN LN was not submitted in the v5010 270 Health plan does not attempt look-up				X		None		X			None
3	Health plan (or information source) requires FN FN was not submitted in the v5010 270 Health plan (or information source) does not attempt look-up				X		None		X			None
4	Health plan (or information source) requires DOB DOB was not submitted in the v5010 270	X					None	X				None

Error Reporting Codes & Requirements Table											
		Subscriber Loop						Dependent Loop			
Error Condition #	**Error Condition Description**	**Invalid/Missing Date-of-Birth**	**Patient Birth Date Does Not Match That for the Patient**	**Invalid/Missing Subscriber/Insured ID**	**Invalid/Missing Subscriber/Insured Name**	**Duplicate Subscriber/Insured**	**Data Elements Returned in 271 Response (See Note 1)**	**Invalid/Missing Date-of-Birth**	**Invalid/Missing Patient Name**	**Patient Birth Date Does Not Match That for the Patient in the Database**	**Data Elements Returned in 271 Response (See Note 1)**
		58	**71**	**72**	**73**	**76**		**58**	**65**	**71**	
	Health plan (or information source) does not attempt look-up										
Pre-Query – No Look-up Attempted **Formatting Errors**											
5	MID submitted in the v5010 270 does not satisfy health plan (or information source) formatting requirements Health plan (or information source) does not attempt look-up			X			MID submitted				
6	DOB submitted is not valid Health plan (or information source) does not attempt look-up	X					Subscriber DOB submitted	X			DOB submitted at either Subscriber or Dependent Level or both depending on which DOB is in error
Post-Query – Look-up Attempted **No Record Found**											
7	MID submitted in the v5010 270 in Subscriber loop is not found in eligibility system when health plan (or information source) uses MID to search			X			Subscriber MID submitted Other data elements submitted & used and any AAA error codes associated with these data elements				

Error Reporting Codes & Requirements Table												
		Subscriber Loop						Dependent Loop				
Error Condition #	Error Condition Description	Invalid/Missing Date-of-Birth	Patient Birth Date Does Not Match That for the Patient	Invalid/Missing Subscriber/Insured ID	Invalid/Missing Subscriber/Insured Name	Duplicate Subscriber/Insured	Data Elements Returned in 271 Response (See Note 1)	Invalid/Missing Date-of-Birth	Invalid/Missing Patient Name	Patient Birth Date Does Not Match That for the Patient	Data Elements Returned in 271 Response (See Note 1)
		58	71	72	73	76		58	65	71	
8	LN submitted in the v5010 270 in Subscriber loop is not found in eligibility system when health plan (or information source) uses LN to search				X		Subscriber LN submitted Other data elements submitted & used and any AAA error codes associated with these data elements				
Post-Query – Look-up Attempted Single Record Found												
9	MID submitted in the v5010 270 in Subscriber loop does not match MID in eligibility system when health plan (or information source) uses LN to search and a single record is returned			X			Subscriber MID submitted Subscriber LN submitted Other data elements submitted & used and any AAA error codes associated with these data elements				
10	LN submitted in the v5010 270 in Subscriber or Dependent loop does not match LN in eligibility system when health plan (or information source) uses MID to search and a single record is returned				X		Subscriber MID submitted Subscriber LN submitted Other data elements submitted & used		X		None
11	FN submitted in the v5010 270 in either Subscriber or Dependent loop does not match FN in eligibility				X		Subscriber FN submitted Other data elements submitted & used and any AAA error codes		X		Dependent FN submitted Other data elements submitted & used and

Error Reporting Codes & Requirements Table											
		Subscriber Loop						Dependent Loop			
Error Condition #	Error Condition Description	Invalid/Missing Date-of-Birth	Patient Birth Date Does Not Match That for the Patient	Invalid/Missing Subscriber/Insured ID	Invalid/Missing Subscriber/Insured Name	Duplicate Subscriber/Insured	Data Elements Returned in 271 Response (See Note 1)	Invalid/Missing Date-of-Birth	Invalid/Missing Patient Name	Patient Birth Date Does Not Match That for the Patient	Data Elements Returned in 271 Response (See Note 1)
		58	71	72	73	76		58	65	71	
	system when health plan (or information source) uses either MID or LN to search and a single record is returned						associated with these data elements				any AAA error codes associated with these data elements
12	DOB submitted in the v5010 270 in either Subscriber or Dependent loop does not match DOB in eligibility system when health plan (or information source) uses either MID or LN to search and a single record is returned		X				Subscriber DOB submitted Other data elements submitted & used and any AAA error codes associated with these data elements			X	Dependent DOB submitted Other data elements submitted & used and any AAA error codes associated with these data elements
13	LN and/or FN submitted in the v5010 270 in Dependent loop does not match LN and/or FN in eligibility system when health plan (or information source) uses MID to search and a single record is returned *Note: This may be an unlikely condition that could occur, e.g., a MID only submitted in Subscriber loop and Dependent LN submitted*								X		Subscriber MID submitted Other data elements submitted & used and any AAA error codes associated with these data elements

Error Reporting Codes & Requirements Table											
		Subscriber Loop						Dependent Loop			
Error Condition #	Error Condition Description	Invalid/Missing Date-of-Birth	Patient Birth Date Does Not Match That for the Patient	Invalid/Missing Subscriber/Insured ID	Invalid/Missing Subscriber/Insured Name	Duplicate Subscriber/Insured	Data Elements Returned in 271 Response (See Note 1)	Invalid/Missing Date-of-Birth	Invalid/Missing Patient Name	Patient Birth Date Does Not Match That for the Patient in the Database	Data Elements Returned in 271 Response (See Note 1)
		58	71	72	73	76		58	65	71	
Post-Query Look-up Multiple Records Found											
14	Multiple records returned when only a MID submitted in the v5010 270 in Subscriber loop (MID search)					X	Subscriber MID submitted Other data elements submitted & used and any AAA error codes associated with these data elements				
15	Multiple records returned for LN when only LN/FN was submitted in the v5010 270 in Subscriber loop (name search)				X		Subscriber LN submitted Other data elements submitted & used and any AAA error codes associated with these data elements				
16	LN submitted in the v5010 270 in Subscriber loop does not match LN in eligibility system when only LN/MID was submitted and health plan (or information source) uses MID to search and multiple records are returned				X		Subscriber LN submitted Subscriber MID submitted Other data elements submitted & used and any AAA error codes associated with these data elements				
17	FN submitted in the v5010 270 in Subscriber loop does not match FN in eligibility system when only				X		Subscriber FN submitted Other data elements submitted & used and any AAA error codes				

Error Reporting Codes & Requirements Table											
		Subscriber Loop						Dependent Loop			
Error Condition #	Error Condition Description	Invalid/Missing Date-of-Birth	Patient Birth Date Does Not Match That for the Patient	Invalid/Missing Subscriber/Insured ID	Invalid/Missing Subscriber/Insured Name	Duplicate Subscriber/Insured	Data Elements Returned in 271 Response (See Note 1)	Invalid/Missing Date-of-Birth	Invalid/Missing Patient Name	Patient Birth Date Does Not Match That for the Patient in the Database	Data Elements Returned in 271 Response (See Note 1)
		58	71	72	73	76		58	65	71	
	FN/ LN/MID was submitted and health plan (or information source) uses either MID or LN to search and multiple records are returned						associated with these data elements				

5 CONFORMANCE REQUIREMENTS

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

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