CAQH CORE Benefit Enrollment (834) Infrastructure Rule

Version BE.2.0

April 2022

CAQH Committee on Operating Rules for Information Exchange (CORE)
CAQH CORE Benefit Enrollment (834) Infrastructure Rule vBE.2.0

Revision History for CAQH CORE Benefit Enrollment (834) Infrastructure Rule

Version	Revision	Description	Date
4.0.0	Major	Phase IV CAQH CORE 834 Benefit Enrollment Rule balloted and approved via CAQH CORE Voting Process.	September 2015
BE.1.0	Minor	• Non-substantive adjustments to support re-organization of operating rules into rule sets organized by business transaction (e.g., Eligibility & Benefits, Claim Status, etc.) rather than phase (e.g., Phase I, II, etc.) as approved by the CAQH CORE Board in 2019. • Operating rule naming, versioning and numbering methodologies updated to align with business transaction-based rule sets.	May 2020
BE.2.0	Major	• Substantive updates to system availability requirements to align with current business needs. • Update Connectivity reference to align with the most recent published and CAQH CORE adopted version of the CAQH CORE Connectivity Rule. • Additional non-substantive adjustments for clarity.	April 2022

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1 Background Summary

The CAQH CORE Benefit Enrollment (834) Infrastructure Rule addresses the benefit enrollment and maintenance transaction to allow the industry to leverage its investment in the CAQH CORE Claims Status (276/277), Eligibility & Benefits (270/271) and Payment & Remittance (835) Infrastructure Operating Rules and apply them to conducting the X12 005010X220 Benefit and Enrollment Maintenance (834) transaction (hereafter referenced as X12 v5010 834) as well as the X12 005010X231 Implementation Acknowledgment for Health Care Insurance (999) transaction and all associated errata (hereafter referred to as X12 v5010 999). Benefits to the industry from applying the CAQH CORE infrastructure rules to the X12 v5010 834 include:

- Increased consistency and automation across entities
- Reduced administrative costs
- More efficient processes
- Reduced staff time for phone inquiries
- Enhanced revenue cycle management

The inclusion of this CAQH CORE Benefit Enrollment (834) Infrastructure Rule for the X12 v5010 834 continues to facilitate the industry's momentum to increase access to the HIPAA-mandated administrative transactions, and will encourage all HIPAA-covered entities, business associates, intermediaries, and vendors to build on and extend the infrastructure they have established for other business transactions.

1.1 Affordable Care Act Mandates

This CAQH CORE Rule is part of a set of rules that addresses requirements in Section 1104 of the Affordable Care Act (ACA). Section 1104 contains an industry mandate for the use of operating rules to support implementation of the HIPAA standards. Using successful, yet voluntary, national industry efforts as a guide, Section 1104 defines operating rules as "the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications." As such, operating rules build upon existing healthcare transaction standards. The ACA outlines three sets of healthcare industry operating rules to be approved by the Department of Health and Human Services (HHS) and then implemented by the industry.

The third set of ACA-mandated operating rules addresses the health care claims or equivalent encounter information transactions, enrollment and disenrollment in a health plan, health plan premium payments, claims attachments, and referral certification and authorization.[1] The ACA requires HHS to adopt a set of operating rules for these five transactions by July 2014.[2] In a letter dated 09/12/12 to the Chairperson of the National Committee on Vital and Health Statistics (NCVHS),[3] the Secretary of HHS designated CAQH CORE as the operating rule authoring entity for the remaining five HIPAA-mandated electronic transactions.

Section 1104 of the ACA also adds the health claims attachment transaction to the list of electronic healthcare transactions for which the HHS Secretary must adopt a standard under HIPAA. The ACA requires the health claims attachment transaction standard to be adopted by 01/01/14, in a manner ensuring that it is effective by 01/01/16.[4]

NOTE: As of April 2022, HHS had not adopted a standard for health claims attachments and an effective date for these operating rules is not included in the ACA.

[1] The first set of operating rules under ACA Section 1104 applies to eligibility and claim status transactions; these operating rules were effective 01/01/13. The second set of operating rules applies to EFT and ERA; these operating rules were effective 01/01/14.
[2] This date is statutory language and statutory language can be changed only by Congress.
[3] 09/12/12 HHS Letter from the Secretary to the Chairperson of NCVHS.

[4] This date is statutory language and statutory language can be changed only by Congress.

2 Issue to Be Addressed and Business Requirement Justification

When the HIPAA transactions were first mandated for use in October 2000[5], many health plan systems were not capable of processing the X12 v4010 834 transaction in Real Time, thus only Batch transactions were accepted. If Real Time transactions were accepted, the responses would not be returned in Real Time. Even with the transition to v5010 in 2011, the use of multiple connectivity methods and file formats still occurs depending upon the relationship between the health plan issuer and its trading partners. Results of straw polling conducted during development of this rule in 2014/2015 by the CAQH CORE Benefit Enrollment and Maintenance/Premium Payment Subgroup indicate the continued use of various file formats based on health plan issuer preference including manual processes.

By promoting consistent connectivity methods and the use of the HIPAA mandated transaction standard between health plan issuers and their trading partners, manual processes for benefit enrollment and maintenance can be reduced and electronic transaction usage increased. Defining acceptable use of response times, appropriate Batch and Real Time acknowledgements, system availability, and requiring entities that publish a Companion Guide do so in a common standard format to ensure that trading partners are informed of the nuances required for successful transaction processing will allow the industry to more easily adopt the X12 v5010 834 transaction.

The CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule is designed to bring consistency and to improve the timely flow of the eligibility transactions. These infrastructure rules requirements include:

- Real Time exchange of eligibility transactions within 20 seconds or less
- The consistent use of the X12 v5010 999[6] for both Real Time and Batch exchanges
- 90 percent system availability of a HIPAA-covered health plan's eligibility processing system components over a calendar week
- Use of the public internet for connectivity
- Use of a best practices Companion Guide template for format and flow of Companion Guides for entities that issue them

The CAQH CORE Claim Status and CAQH CORE Payment and Remittance Infrastructure Rules were applied to the exchange of the HIPAA-mandated X12 005010X212 Health Care Claim Status Request and Response (276/277) transactions and the HIPAA-mandated X12 005010X221A1 Health Care Claim Payment/Advice (835) transaction. These infrastructure rules include robust, prescriptive, and comprehensive connectivity requirements.

During the development of the CAQH CORE Benefit Enrollment (834) Infrastructure Rule, CAQH CORE used discussion, research, and straw poll results to determine which infrastructure requirements should be applied to the exchange of the X12 v5010 834 transaction. The table below lists the infrastructure requirements incorporated into this rule in §4.

[5] The first set of HIPAA-mandated transaction standards were adopted in the August 2000 HHS Final Rule, *Health Insurance Reform: Standards for Electronic Transactions*, with an effective date of October 16, 2000. A subsequent *Final Rule* published in January 2009 with an effective date of January 1, 2010, adopted the X12 005010X220 Benefit and Enrollment Maintenance (834) as the standard for the enrollment and disenrollment in a health plan.

[6] The use of the X12 TA1 Interchange Acknowledgement is not specifically addressed by the CAQH CORE Operating Rules. The A1 errata to Appendix C.1 of the X12 999 provides industry guidance for the use of the TA1.

Infrastructure Requirements for the X12 v5010X220 834 Transaction	
CAQH CORE Infrastructure Requirement Description	**Apply to CAQH CORE Benefit Enrollment Infrastructure Rule for the X12 v5010X220 834**
Processing Mode*	**Y**
Connectivity	**Y**
System Availability	**Y**
Real Time Processing Mode Response Time	**Y**
Batch Processing Mode Response Time	**Y**
Real Time Acknowledgements	**Y**
Batch Acknowledgements	**Y**
Companion Guide	**Y**
*__Note__: The CAQH CORE Premium Payment (820) Infrastructure Rule explicitly clarifies processing mode requirements. In previous rule sets this requirement was not as explicit as needed resulting in questions from implementers. The CAQH CORE Connectivity Rule specifies the processing mode(s) that must be supported for each applicable transaction.	

This CAQH CORE Benefit Enrollment (834) Infrastructure Rule defines the specific requirements that HIPAA-covered health plans or their agents[7] must satisfy. As with all CAQH CORE Operating Rules, these requirements are intended as a base or minimum set of requirements, and it is expected that many entities will go beyond these requirements as they work towards the goal of administrative interoperability. This CAQH CORE Benefit Enrollment (834) Infrastructure Rule requires that HIPAA-covered health plans or their agents make appropriate use of the standard acknowledgements, support the CAQH CORE Connectivity requirements, and use the CAQH CORE Companion Guide Template when publishing their X12 v5010 834 Companion Guide.

By applying these CAQH CORE infrastructure requirements to the conduct of the X12 v5010 834 transactions, this CAQH CORE Benefit Enrollment (834) Infrastructure Rule helps provide the information that is necessary to electronically process a benefit enrollment or maintenance submission uniformly and consistently and thus reduce the cost of today's proprietary transaction processes.

It is understood that applying the CAQH CORE infrastructure requirements to the exchange of the X12 v5010 834 transaction does not address the industry's transaction data content needs but rather establishes an electronic "highway".

3 Scope

3.1 What the Rule Applies To

This CAQH CORE Benefit Enrollment (834) Infrastructure Rule applies to the conduct of the HIPAA-mandated X12 v5010 834 transaction.

3.2 When the Rule Applies

This CAQH CORE Benefit Enrollment (834) Infrastructure Rule applies when a HIPAA-covered health plan or its agent uses, conducts, or processes the X12 v5010 834 transaction.

3.3 What the Rule Does Not Require

This rule does not require any entity to conduct, use, or process the X12 v5010 834 transaction if it currently does not do so or is not required by Federal or state regulation to do so.

3.4 Outside the Scope of This Rule

This rule does not address any data content requirements of the X12 v5010 834 transaction. This CAQH

[7] One who agrees and is authorized to act on behalf of another, a principal, to legally bind an individual in particular business transactions with third parties pursuant to an agency relationship. Source: West's Encyclopedia of American Law, edition 2. Copyright 2008 The Gale Group, Inc. All rights reserved.

CORE Benefit Enrollment (834) Infrastructure Rule applicable to benefit enrollment and maintenance is related to improving access to the transaction and **not to** addressing content requirements.

This rule does not address requirements for the use of the X12 v5010 834 transaction by the ACA Federal or state Health Information Exchanges (HIX).

3.5 Maintenance of This Rule

Should implementation of this rule be required via Federal regulation, any substantive updates to the rule (i.e., change to rule requirements) will be made in alignment with Federal processes for updating versions of the operating rules.

3.6 How the Rule Relates to Eligibility & Benefits, Claim Status, and Payment & Remittance Advice

The CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule focused on improving Real Time electronic eligibility and benefits verification as eligibility is the first transaction in the claims process. The CAQH CORE Eligibility & Benefits (270/271) Data Content Rule focused on extending the value of electronic eligibility by adding additional data content requirements that deliver more robust patient financial liability information, including remaining deductibles, and adding more service type codes that must be supported. Building on this, CAQH CORE also determined that a rule set should be created to address infrastructure rules around the claim status transaction to allow providers to check electronically, in Real Time, the status of a claim, without manual intervention, or to confirm receipt of claims, and thus created the CAQH CORE Claim Status (276/277) Infrastructure Rule. The Payment & Remittance (835) Infrastructure Rule includes rules around the health care claim payment/advice transaction to allow the industry to leverage its investment in the eligibility and benefits and claim status transactions.

This CAQH CORE Benefit Enrollment (834) Infrastructure Rule adds to the CAQH CORE infrastructure rule requirements by specifying the use of the X12 v5010 999 and the CAQH CORE infrastructure requirements when conducting the X12 v5010 834 transaction.

As with other CAQH CORE Operating Rules, general CAQH CORE policies also apply to CAQH CORE Benefit Enrollment Operating Rules and will be outlined in the CAQH CORE Benefit Enrollment Operating Rule Set.

This rule supports the CAQH CORE Guiding Principles that CAQH CORE Operating Rules will not be based on the least common denominator but rather will encourage feasible progress, and that CAQH CORE Operating Rules are a floor and not a ceiling, i.e., entities can go beyond the CAQH CORE Benefit Enrollment Operating Rule Set.

3.7 Assumptions

A goal of this rule is to adhere to the principles of electronic data interchange (EDI) in assuring that transactions sent are accurately received and to facilitate correction of errors for electronically submitted benefit enrollment and maintenance transactions.

The following assumptions apply to this rule:

- A successful communication connection has been established
- This rule is a component of the larger set of CAQH CORE Operating Rules; as such, all the CAQH CORE Guiding Principles apply to this rule and all other rules
- This rule is not a comprehensive companion document addressing any content requirements of the X12 v5010 834 or the X12 v5010 999 transactions
- Compliance with all CAQH CORE Operating Rules is a minimum requirement; any entity is free to offer more than what is required in the rule

3.8 Abbreviations and Definitions Used in This Rule

Batch (Batch Mode, Batch Processing Mode): Batch Mode is when the initial (first) communications session is established and maintained open and active only for the time required to transfer a Batch file of one or more transactions. A separate (second) communications session is later established and maintained

open and active for the time required to acknowledge that the initial file was successfully received and/or to retrieve transaction responses.

Batch Mode/Batch Processing Mode is also considered to be an asynchronous processing mode, whereby the associated messages are chronologically and procedurally decoupled. In a request-response interaction, the client agent can process the response at some indeterminate point in the future when its existence is discovered. Mechanisms to implement this capability may include: polling, notification by receipt of another message, receipt of related responses (as when the request receiver "pushes" the corresponding responses back to the requestor), etc. Batch Mode/Batch Processing Mode is from the perspective of both the request initiator and the request responder. If a Batch (asynchronous) request is sent via intermediaries, then such intermediaries may, or may not, use Batch Processing Mode to further process the request.
Processing Mode: Refers to when the payload of the connectivity message envelope is processed by the receiving system, i.e., in Real Time or in Batch mode.

Real Time (Real Time Mode, Real Time Processing Mode): Real Time Mode is when an entity is required to send a transaction and receive a related response within a single communications session, which is established and maintained open and active until the required response is received by the entity initiating that session.
Communication is complete when the session is closed. Real Time Mode/Real Time Processing Mode is also considered to be a synchronous processing mode. Real Time Mode/Real Time Processing Mode is from the perspective of both the request initiator and the request responder.

Safe Harbor: A “Safe Harbor” is generally defined as a statutory or regulatory provision that provides protection from a penalty or liability.

In many IT-related initiatives, a safe harbor describes a set of standards/guidelines that allow for an “adequate” level of assurance when business partners are transacting business electronically.

The CAQH CORE Connectivity Safe Harbor requires the implementation of the CAQH CORE Connectivity Rule so that application vendors, providers, and health plans (or their agents) can be assured the CAQH CORE Connectivity Rule will be supported by any trading partner. All entities must demonstrate the ability to implement connectivity as described in the most recent published and CAQH CORE adopted version of the CAQH CORE Connectivity Rule (hereafter referred to as CAQH CORE Connectivity Rule).

4. Rule Requirements

4.1 Benefit Enrollment and Maintenance Processing Mode Requirements

A HIPAA-covered health plan or its agent must implement the server requirements for Batch Processing Mode for the X12 v5010 834 transaction as specified in the CAQH CORE Connectivity Rule. Optionally, a HIPAA-covered health plan or its agent may elect to implement the server requirements for Real Time Processing Mode for the X12 v5010 834 transaction as specified in the CAQH CORE Connectivity Rule.

A HIPAA-covered health plan or its agent may also elect to implement the client requirements as specified in the CAQH CORE Connectivity Rule in addition to implementing the server requirements. When a HIPAA-covered health plan or its agent elects to implement the client requirements as specified in the CAQH CORE Connectivity Rule it must comply with all requirements specified in Sections 4.2, 4.3, 4.4, 4.5, 4.6, 5 and all respective Subsections.

The CAQH CORE Connectivity Rule Real Time Processing Mode requirements are applicable when Real Time Processing Mode is offered for these transactions. The CAQH CORE Connectivity Rule Batch Processing Mode requirements are applicable when Batch Processing Mode is offered for these transactions.

A HIPAA-covered health plan or its agent conducting the X12 v5010 834 transaction is required to conform to the processing mode requirements specified in this section regardless of any other connectivity modes and methods used between trading partners.

4.2 Benefit Enrollment and Maintenance Connectivity Requirements

A HIPAA-covered entity or its agent must be able to support the CAQH CORE Connectivity Rule.

This connectivity rule addresses usage patterns for Real Time and Batch Processing Modes, the exchange of security identifiers, and communications-level errors and acknowledgements. It does not attempt to define the specific content of the message payload exchanges beyond declaring the formats that must be used between entities and that security information must be sent outside of the message envelope payload.

All HIPAA-covered entities must demonstrate the ability to implement connectivity as described in CAQH CORE Connectivity Rule. The CAQH CORE Connectivity Rule is designed to provide a “Safe Harbor” that application vendors, providers and health plans or other entities can be assured will be supported by any trading partner. Supported means that the entity is capable and ready at the time of the request by a trading partner to exchange data using the CAQH CORE Connectivity Rule. These requirements are not intended to require trading partners to remove existing connections that do not match the rule, nor are they intended to require that all trading partners must use this method for all new connections. CAQH CORE expects that in some technical circumstances, trading partners may agree to use different communication mechanism(s) and/or security requirements than those described by these requirements.

4.3 Benefit Enrollment and Maintenance System Availability

Many health plan issuers and their trading partners have a need to conduct benefit enrollment and maintenance transactions outside of the typical business day and business hours. Additionally, health plan issuers and their trading partners are now allocating staff resources to performing administrative and financial back-office activities on weekends and evenings. As a result, health plan issuers and their trading partners have a business need to be able to conduct enrollment and disenrollment transactions at any time.

On the other hand, health plan issuers have a business need to periodically take their benefit enrollment and maintenance processing and other systems offline in order to perform required system maintenance. This typically results in some systems not being available for timely processing of X12 v5010 834 and X12 v5010 999 transactions on certain nights and weekends. This rule requirement addresses these conflicting needs.

4.3.1 System Availability Requirements

4.3.3.1 Weekly System Availability Requirement

System availability must be no less than 90 percent per calendar week for both Real Time and Batch Processing Modes. System is defined as all necessary components required to process an X12 v5010 834 transaction, and an X12 v5010 999 transaction. Calendar week is defined as 12:01 a.m. Sunday to 12:00 a.m. the following Sunday. This will allow for a HIPAA-covered health plan or its agent to schedule system updates to take place within a maximum of 17 hours per calendar week for regularly scheduled downtime.

4.3.3.2 Quarterly System Availability Requirement

A HIPAA-covered health plan or its agent may choose to use an additional 24 hours of scheduled system downtime per calendar quarter. System is defined as all necessary components required to process a 5010 834 transaction and an X12 v5010 999 transaction. This will allow a HIPAA-covered health plan or its agent to schedule additional downtime for substantive system migration. This additional allowance in a system downtime is in excess of the allowable weekly system downtime specified in Section 4.3.3.1.

4.3.2 Reporting Requirements

4.3.2.1 Scheduled Downtime

A HIPAA-covered health plan or its agent must publish its regularly scheduled system downtime in an appropriate manner (e.g., on websites or in companion guides) such that the HIPAA-covered health plan's trading partners can determine the health plan’s system availability so that staffing levels can be effectively managed.

4.3.2.2 Non-Routine Downtime

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

4.3.2.3 Unscheduled Downtime

For unscheduled/emergency downtime (e.g., system crash), a HIPAA-covered health plan or its agent

are required to provide information within one hour of realizing downtime will be needed.

4.3.2.4 No Response Required

No response is required during scheduled, non-routine, or unscheduled downtime(s).

4.3.2.5 Holiday Schedule

Each HIPAA-covered health plan or its agent will establish its own holiday schedule and publish it in accordance with the rule requirements above.

4.4 Benefit Enrollment and Maintenance Real Time Processing Mode Response Time Requirements

Maximum response time for the receipt of an X12 v5010 999 transaction from the time of submission of an X12 v5010 834 must be 20 seconds when processing in Real Time Processing Mode.

Each HIPAA-covered entity or its agent must support this *maximum* response time requirement to ensure that at least 90 percent of all required responses are returned within the specified maximum response time as measured within a calendar month.

Each HIPAA-covered entity or its agent must capture, log, audit, match, and report the date (YYYYMMDD), time (HHMMSS) and control numbers from its own internal systems and the corresponding data received from its trading partners.

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

Each HIPAA-covered entity or its agent must support these response time requirements in this section and other CAQH CORE Operating Rules regardless of the connectivity mode and methods used between trading partners.

The goal of this requirement is to adhere to the principles of EDI in assuring that transactions sent are accurately received and to facilitate correction of errors in Functional Groups of X12 v5010 834 transactions.

This requirement assumes a successful communication connection has been established.

4.5 Benefit Enrollment and Maintenance Real Time Processing Mode Acknowledgement Requirements

A HIPAA-covered health plan or its agent must return an X12 v5010 999 transaction to indicate that a Functional Group(s) or Transaction Set(s) is accepted, accepted with errors, or rejected and must report each error detected to the most specific level of detail supported by the X12 v5010 999 transaction.

4.6 Benefit Enrollment and Maintenance Batch Processing Mode Response Time Requirements

Maximum response time for availability of X12 v5010 999 transaction when processing an X12 v5010 834 transaction submitted in Batch Processing Mode by 9:00 pm Eastern Time of a business day by a health plan sponsor or its agent must be no later than 7:00 am Eastern Time the third business day following submission.

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

Each HIPAA-covered entity or its agent must support this *maximum* response time requirement to ensure that at least 90 percent of all required responses are returned within the specified maximum response time as measured within a calendar month.

Each HIPAA-covered entity or its agent must capture, log, audit, match, and report the date (YYYYMMDD), time (HHMMSS) and control numbers from its own internal systems and the corresponding data received from its trading partners.

Each HIPAA-covered entity or its agent must support these response time requirements in this section and other CAQH CORE Operating Rules regardless of the connectivity mode and methods used between trading

partners.

The goal of this requirement is to adhere to the principles of EDI in assuring that transactions sent are accurately received and to facilitate correction of errors in Functional Groups of X12 v5010 834 transactions.

This requirement assumes a successful communication connection has been established.

4.7 Benefit Enrollment and Maintenance Batch Processing Mode Acknowledgement Requirements

A HIPAA-covered health plan or its agent must return an X12 v5010 999 transaction for each Functional Group of X12 v5010 834 transactions:

- To indicate that the Functional Group(s) was either accepted, accepted with errors, or rejected

And

- To specify for each included X12 v5010 834 that the Transaction Set was either accepted, accepted with errors, or rejected

The HIPAA-covered health plan or its agent must not return the X12 v5010 999 transaction during the initial communications session in which the X12 v5010 834 transaction is submitted.

When a Functional Group of X12 v5010 834 of transactions is either accepted with errors or rejected, the X12 v5010 999 transaction must report each error detected to the most specific level of detail supported by the X12 v5010 999 transaction.

4.8 Elapsed Time for Enrollment System Processing of Received Benefit Enrollment Data

A HIPAA-covered health plan or its agent must process the benefit enrollment and maintenance data by its enrollment application system within five business days following the successful receipt and validation of the data. In the context of this rule

- *Successful Receipt* means that the X12 v5010 834 transaction has not been rejected by the health plan or its agent's EDI management system

And

- *Validation* means that any data inconsistencies detected in an accepted X12 v5010 834 transaction which would prevent accurate posting of that data to the health plan or its agent's internal enrollment application system have been resolved

4.9 Benefit Enrollment and Maintenance Companion Guide

A HIPAA-covered health plan or its agent has the option of creating a "companion guide" that describes the specifics of how it will implement the HIPAA transactions. The companion guide is in addition to and supplements the X12 TR3 Implementation Guide.

Currently HIPAA-covered health plans or their agents have independently created companion guides that vary in format and structure. Such variance can be confusing to trading partners who must review numerous companion guides along with the X12 TR3 Implementation Guides. To address this issue, CAQH CORE developed the CAQH CORE Companion Guide Template for health plans or their agents. Using this template, health plans or their agents can ensure that the structure of their companion guide is similar to other health plan's documents, making it easier for its trading partners to find information quickly as they consult each health plan's document on these important industry EDI transactions.

Developed with input from multiple health plans, system vendors, provider representatives, and health care/HIPAA industry experts, this template organizes information into several simple sections – General Information (Sections 1-9) and Transaction-Specific Information (Section 10) – accompanied by an appendix. Note that the Companion Guide template is presented in the form of an example from the viewpoint of a fictitious Acme Health Plan.

Although CAQH CORE believes that a standard template/common structure is desirable, it recognizes that different health plans may have different requirements. The CAQH CORE Companion Guide template gives health plans the flexibility to tailor the document to meet their particular needs.

4.9.1 Benefit Enrollment and Maintenance Companion Guide Requirements

If a HIPAA-covered entity or its agent publishes a companion guide covering the X12 v5010 834 transaction, the companion guide must follow the format/flow as defined in the CAQH CORE Companion Guide Template.

NOTE: This rule does not require any entity to modify any other existing companion guides that cover other HIPAA-mandated transaction implementation guides.

5 Conformance Requirements

Conformance with this CAQH CORE Operating Rule can be voluntarily demonstrated and certified through successful completion of the Benefit Enrollment CAQH CORE Certification Test Suite with a third party CAQH CORE-authorized Testing Vendor, followed by the entity's successful application for a CORE Certification Seal. A CORE Certification Seal demonstrates that an entity has successfully tested for conformity with all of the CAQH CORE Benefit Enrollment Operating Rules, and the entity or its product has fulfilled all relevant conformance requirements.

Only the Department of Health and Human Services (HHS) can decide whether a particular HIPAA-covered entity's system is **compliant** or **noncompliant** with the HIPAA Administrative Simplification requirements (which include HIPAA-adopted CAQH CORE Operating Rules). HHS may adjudicate on a HIPAA-covered entity's compliance and assess civil money penalties or penalty fees for noncompliance under the following HIPAA Administrative Simplification mandates:

- HIPAA regulations mandate that the Secretary "will impose a civil money penalty upon a covered entity or business associate if the Secretary determines that the covered entity or business associate has violated an administrative simplification provision." (47 CFR 160.402)
- Under the ACA, HIPAA mandates a certification process for HIPAA-covered health plans only, under which HIPAA-covered health plans are required to file a statement with HHS certifying that their data and information systems are in compliance with applicable standards and associated operating rules. (Social Security Act, Title XI, Section 1173(h)) HIPAA also mandates that a HIPAA-covered health plan must "ensure that any entities that provide services pursuant to a contact with such health plan shall comply with any applicable certification and compliance requirements." (Social Security Act, Title XI, Section 1173(h)(3))
- Under the ACA, HIPAA also mandates that HHS is to "conduct periodic audits to ensure that health plans…are in compliance with any standards and operating rules." (Social Security Act, Title XI, Section 1173(h))

6 Appendix

6.1 Appendix 1: Reference

- X12 005010X231 Implementation Acknowledgement for Health Care Insurance (999) Technical Report Type 3 and associated errata
- X12 005010X220 Benefit Enrollment and Maintenance (834) Technical Report Type 3 Implementation Guide and associated errata