



**CAQH CORE Health Care Claim (837)  
Infrastructure Rule  
Version HC.2.0 April 2022**

**CAQH Committee on Operating Rules for Information Exchange (CORE)  
Health Care Claim (837) Infrastructure Rule vHC.2.0**

**Revision History for CAQH CORE Health Care Claim (837) Infrastructure Rule**

<b>Version</b>	<b>Revision</b>	<b>Description</b>	<b>Date</b>
4.0.0	Major	Phase IV CAQH CORE Health Care Claim (837) Infrastructure Rule balloted and approved via CAQH CORE Voting Process.	September 2015
HC.1.0	Minor	<ul style="list-style-type: none"> <li>• Non-substantive adjustments to support re-organization of operating rules into rule sets organized by business transaction (e.g., Eligibility &amp; Benefits, Claim Status, etc.) rather than phase (e.g., Phase I, II, etc.) as approved by the CAQH CORE Board in 2019.</li> <li>• Operating rule naming, versioning and numbering methodologies updated to align with business transaction-based rule sets.</li> </ul>	May 2020
HC.2.0	Major	<ul style="list-style-type: none"> <li>• Substantive updates to system availability requirements to align with current business needs.</li> <li>• Update Connectivity reference to align with the most recent published and CAQH CORE adopted version of the CAQH CORE Connectivity Rule.</li> <li>• Additional non-substantive adjustments for clarity.</li> </ul>	April 2022

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## **1 Background Summary**

The CAQH CORE Health Care Claim (837) Infrastructure Rule addresses the health care claim 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 005010X222 Health Care Claim (837) Professional, X12 005010X223 Health Care Claim (837) Institutional, and X12 005010X224 Health Care Claim (837) Dental transactions and their respective errata (collectively hereafter X12 v5010 837 Claim) including the use of acknowledgements for electronic claims by specifying the use of the following standard electronic acknowledgments when conducting the X12 v5010 837 Claim:

- The X12 005010X231 Implementation Acknowledgement for Health Care Insurance (999) Technical Report Type 3 (TR3) and associated errata (hereafter X12 v5010 999)
- The X12 005010X214 Health Care Claim Acknowledgement (277) Technical Report Type 3 (TR3) and associated errata (hereafter X12 v5010 277CA).

Benefits to the industry from applying the CAQH CORE infrastructure rules to health care claims include:

- Less staff time spent on phone calls and websites
- Increased ability to conduct targeted follow-up
- More accurate and efficient processing of claims

The inclusion of this CAQH CORE Health Care Claim (837) Infrastructure Rule for the X12 v5010 837 Claim 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 address the health care claims or equivalent encounter information transaction, enrollment and disenrollment in a health plan, health plan premium payments, claims attachments, and referral certification and authorization.<sup>1</sup> The ACA requires HHS to adopt a set of operating rules for these five transactions by July 2014.<sup>2</sup> In a letter dated 09/12/12 to the Chairperson of the National Committee on Vital and Health Statistics (NCVHS),<sup>3</sup> 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

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<sup>1</sup> 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.

<sup>2</sup> This date is statutory language and statutory language can be changed only by Congress.

<sup>3</sup> 09/12/12 HHS [Letter from the Secretary](#) to the Chairperson of NCVHS.

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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.<sup>4</sup>

**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.

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

By promoting consistent connectivity methods between providers, health plans, vendors, and clearinghouses, manual processes for claims processing can be reduced and electronic transaction usage increased. Defining acceptable acknowledgement 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 837 Claim 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 requirements include:

- Real Time exchange of eligibility transactions within 20 seconds or less
- The consistent use of the X12 v5010 999 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 (276/277) and the CAQH CORE Payment & Remittance (835) 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 included more robust, prescriptive, and comprehensive connectivity requirements. During the rule development process, CAQH CORE used discussion, research, and straw poll results to determine which infrastructure requirements should be applied to the exchange of the X12 v5010 837 Claim transaction. Listed below is an overview of the infrastructure requirements incorporated into this rule in §4.

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<sup>4</sup> These dates are statutory language and statutory language can be changed only by Congress.

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<b>Infrastructure Requirements for the X12 v5010 837 Claim Transaction</b>	
<b>CAQH CORE Infrastructure Requirement Description</b>	<b>Apply to CAQH CORE Health Care Claim (837) Infrastructure Rule for the X12 v5010 837 Claim</b>
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
<p><b>*Note:</b> The CAQH CORE Health Care Claim (837) Infrastructure Rule explicitly clarifies processing mode requirements. In previous rule sets this requirement was not as explicit as needed resulting in questions from implementers. CAQH CORE Connectivity Rule specifies the processing mode(s) that must be supported for each applicable transaction.</p>	

This CAQH CORE Health Care Claim (837) Infrastructure Rule defines the specific requirements that HIPAA-covered health plans or their agents<sup>5</sup> and HIPAA-covered providers or their agents 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 Health Care Claim (837) Infrastructure Rule requires that HIPAA-covered health plans or their agents make appropriate use of the claim acknowledgements, support the CAQH CORE connectivity requirements, and use the CAQH CORE Master Companion Guide Template when publishing their X12 v5010 837 Claim Companion Guide.

By applying these CAQH CORE infrastructure requirements to the conduct of the X12 v5010 837 Claim transaction, this CAQH CORE Health Care Claim (837) Infrastructure Rule helps provide claim information electronically and thus reduce the current cost of today’s manual transaction processes.

It is understood that applying the CAQH CORE infrastructure requirements to the exchange of the X12 v5010 837 Claim transaction does not address the industry’s transaction data content needs but rather establishes an electronic “highway.”

**2.1. Claim Acknowledgements**

This CAQH CORE Health Care Claim (837) Infrastructure Rule contains specific requirements for claim acknowledgements. Providers have a critical business need to know as quickly as possible whether the HIPAA-covered health plan received the claim and then whether the claim was rejected or received into the HIPAA-covered health plan’s adjudication system. Often, the claim is rejected early in the information exchange path by intermediaries between the provider and HIPAA-covered health plan. Alternatively, the claim can be received by the HIPAA-covered health plan but not enter the HIPAA-covered health plan’s adjudication system. In either case, the provider does not know with certainty that the claim was received by the HIPAA-covered health plan.

These issues represent not just a single problem to be resolved, but a chain of related but different problems that impact both the claim and the ability of the provider to determine the status of the claim, which requires different solutions along the chain of information exchanges.<sup>6</sup> The information exchange can vary from a simple provider- direct-to-health plan exchange to a much more complex exchange from the provider through one or multiple clearinghouses or other intermediaries to the health plan. At each

<sup>5</sup> 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.

<sup>6</sup> Currently, the information exchanges can be either an X12 Interchange of an X12 v5010 837 Claim, an X12 TA1 Interchange Acknowledgment, an X12 v5010 999 Implementation Acknowledgment, an = X12 v5010 277 Claim Acknowledgment, or a proprietary report format.

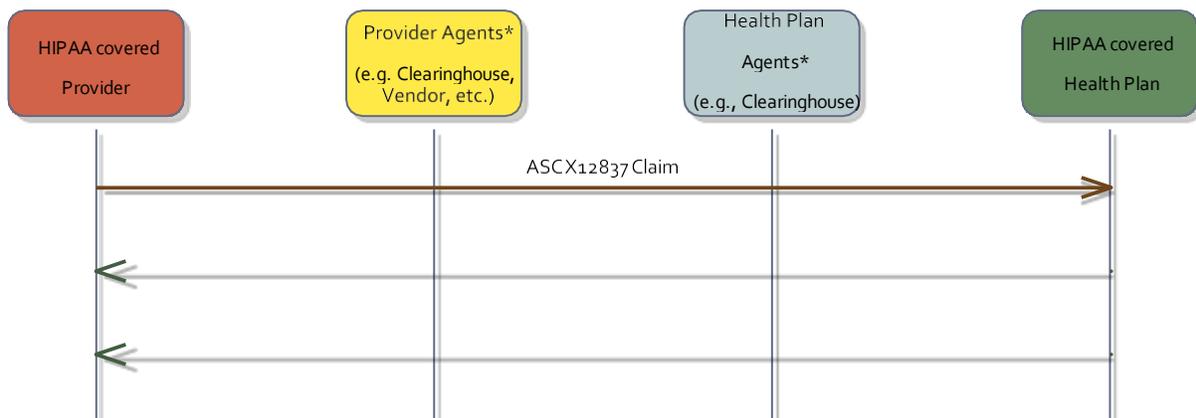
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point (node) on this information exchange path the information goes through several processes during which a variety of validations and editing are performed. Some of these validation/editing processes may include:

- Claim scrubbing on behalf of the provider
- Receiving a standard interchange and forwarding it to HIPAA-covered health plan or the HIPAA-covered health plan's clearinghouse
- Opening the interchange and applying a HIPAA-covered health plan's business edits on behalf of the HIPAA-covered health plan
- Opening the interchange and reformatting into a proprietary file format for the HIPAA-covered health plan
- Opening a proprietary file and reformatting it into the standard interchange for forwarding to the HIPAA-covered health plan

Figure 1 below is a visual representation of the problem space and information exchanges that are the focus of this rule. Analysis of Figure 1 indicates that the problem space can be generally described as *"Providers need to know whether or not the claim is received and then whether it makes it successfully into the payer's adjudication system."* This problem space can be defined to encompass the point of submission of a claim by a provider to the point that the claim is accepted into a health plan's adjudication system. This problem space includes both the direct submission of a claim to the health plan and the use of one or more intermediaries (e.g., clearinghouses, repricers, etc.) between the provider and the health plan.

**Figure 1: Problem Space and Information Exchanges**



- This Sequence Diagram depicts only the direction of the transaction being exchanged and the order (sequence) in which the exchanges take place
- Exchanges may be accomplished in either Real Time or Batch Processing mode
- The elapsed time of the exchange of a transaction between the two HIPAA covered entities and their respective agents is not shown
- This Sequence Diagram does not include any aspect of a Real Time Adjudication process

\*Note: Services and other activities performed by an agent are considered to be performed on behalf of the HIPAA covered entity in the role of a Business Associate.

An X12 v5010 837 Claim Transaction Set undergoes several processing steps before being allowed into the payer's adjudication system, e.g.:

- Verification that the Interchange, Functional Group, and Transactions conform to the X12 standard and implementation specification
- Verification that the claim passes all payer-specific business edits and is allowed to enter into adjudication

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Currently, when an X12 v5010 837 Claim Transaction Set (or a single claim within a Transaction Set, i.e., unit of work) fails to pass X12 validation, X12 TR3 validation, or payer-specific business edits there is no single industry-wide mechanism to report such rejections to the provider in a standard and consistent format. Lack of a standard report mechanism using standardized data, codes, error messages, etc., hinders the provider's ability to reasonably process myriad reports received and manage their revenue cycle of claim-to-cash effectively and efficiently.

Methods currently employed inconsistently across the industry include:

- X12 v5010 997 Functional Acknowledgment (reports only X12 standards syntax compliance and is not recommended by the X12N Insurance Subcommittee to be used in health care)
- X12 v5010 999 Implementation Acknowledgment (reports ASC X12C TR3 compliance errors and is recommended by the X12N Insurance Subcommittee to be used in health care)
- X12 v5010 277 Claim Acknowledgment (reports ONLY payer-specific business and ASC X12N v5010 837 Claim Technical Report Type 3 semantic editing results)
- Proprietary clearinghouse-specific or payer-specific report

**NOTE:** The various X12 standard acknowledgements identified have not been addressed or mandated by HIPAA at the present time.

CAQH CORE achieved substantial industry-wide consensus via its 2013 Industry Surveys that a CAQH CORE Health Care Claim (837) Infrastructure Rule should address the use of the X12 standard acknowledgements specified in §3.2 below for the conduct of the HIPAA-mandated X12 v5010 837 Claim transaction. CAQH CORE also agreed the requirements pertaining to acknowledgements in this CAQH CORE Health Care Claim (837) Infrastructure Rule be applicable only to:

- HIPAA-covered health plans or their agents receiving an X12 Interchange of X12 v5010 837 Claim transactions
- And
- Receivers (defined in this CAQH CORE Operating Rule as HIPAA-covered providers or their agents) of any or all of the specified acknowledgements.

### **2.2. Real Time Adjudication**

Real Time Claim Adjudication (RTA) relies on HIPAA-covered providers, HIPAA-covered health plans or all of their respective agents involved in the process to build Real Time connections to exchange claim transactions and respective acknowledgments, e.g., a rejection or confirmation that the claim has been successfully adjudicated and reimbursement will be forthcoming. An RTA process may include only the adjudication of a claim in Real Time with the actual claim payment processed at a later date. Alternatively, an RTA process may include both the adjudication of a claim and the actual payment of the claim. Whether claim payment is included in a HIPAA-covered health plan's RTA process is determined by each HIPAA-covered health plan.

Critical success factors for RTA include well-defined internal processes and governing policies of the respective providers and HIPAA-covered health plans (specific agreements regarding which claims for which beneficiaries can be submitted) as well as inter-enterprise standardization at the edge, i.e., the "rules-of-the-road." Such rules- of-the-road must address the unique and specific aspects for the Real Time exchange of claims and appropriate responses in a consistent, reliable manner that may be similar to but are uniquely different than simply applying to RTA the various CAQH CORE infrastructure requirements addressed in this CAQH CORE Health Care Claim (837) Infrastructure Rule. Simply because an X12 v5010 837 Claim is submitted in Real Time does not then mean that the claim will be adjudicated in Real Time, either with or without Real Time claim payment.

NOTE: This CAQH CORE Health Care Claim (837) Infrastructure Rule does not address any requirements for RTA but does address certain requirements for when an X12 v5010 837 Claim is submitted in Real Time without any adjudication. See Section 3.2.

## **3 Scope**

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**3.1. What the Rule Applies To**

This CAQH CORE Health Care Claim (837) Infrastructure Rule applies to the conduct of:

- X12 Interchanges containing Functional Groups of any HIPAA-mandated X12 v5010 837 Claim transaction
- X12 Interchanges containing Functional Groups of any X12 v5010 277CA Claim Acknowledgement transaction
- X12 Interchanges containing Functional Groups of any X12 v5010 999 Implementation Acknowledgement transaction

**3.2. When the Rule Applies**

This CAQH CORE Health Care Claim (837) Infrastructure Rule applies when:

- A HIPAA-covered health plan or its agent processes an X12 Interchange containing one or more Functional Groups of one or more HIPAA-mandated X12 v5010 837 Claim transactions submitted in Batch Processing Mode

Or

- A HIPAA-covered health plan or its agent processes an X12 Interchange containing one or more Functional Groups of one or more HIPAA-mandated X12 v5010 837 Claim transactions submitted in Real Time Processing Mode without Real Time adjudication

Or

- A HIPAA-covered entity receives:
  - An X12 v5010 999 Implementation Acknowledgment of an X12 Functional Group(s) of X12 v5010 837 Claim transactions, or
  - An X12 v5010 277CA transaction.

This rule **does not** apply:

- When the HIPAA-covered provider and the HIPAA-covered health plan are engaged in the conduct of Real Time Claim Adjudication (RTA)
- To the HIPAA-covered health plan-to-health plan or repricer exchange or routing of HIPAA-mandated X12 v5010 837 Claim transactions

**3.3. What the Rule Does Not Require**

This rule does not require any entity to:

- Support the Real Time submission of X12 v5010 837 Claim transactions (See Sections 4.1 and 4.4.1)
- Adjudicate in Real Time a claim or encounter submitted in Real Time
- Engage in the conduct of Real Time Claim Adjudication
- Integrate its current claims processing system components into its current eligibility or claim status processing system if they are not currently integrated

**3.4. Outside the Scope of This Rule**

The data content of any version of the following transactions is not addressed in this rule:

- X12 v5010 277CA transaction
- X12 v5010 837 Claim transaction
- X12 v5010 999 transaction
- X12 v5010 TA1 Interchange Acknowledgement transaction
- X12 v5010 835 transaction

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**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 operating rule versions.

**3.6. How the Rule Relates to Other CAQH CORE Rule Sets**

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 and operating rules.

This CAQH CORE Health Care Claim Infrastructure Rule leverages the previously mentioned CAQH CORE Infrastructure Rule requirements by specifying the use of the X12 v5010 999 transaction and the X12 v5010 277CA transaction and other CAQH CORE infrastructure requirements when conducting any X12 v5010 837 Claim transaction.

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 Health Care Claims Operating Rules.

**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 health care claims.

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 Health Care Claims Operating Rules; as such, all of the CAQH CORE Guiding Principles apply to this rule and all other CAQH CORE Operating Rules
- This rule is not a comprehensive companion document addressing any content requirements of any X12 v5010 837 Claim transaction, the X12 v5010 999 transaction, or the X12 v5010 277CA transaction
- Compliance with all CAQH CORE Operating Rules is a minimum requirement; any HIPAA-covered 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-

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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.<sup>7</sup>

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, HIPAA-covered providers, HIPAA-covered health plans or their respective 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. Health Care Claim/Encounter Reporting Processing Mode Requirements**

A HIPAA-covered health plan or its agent must implement the server requirements for Batch Processing Mode for the X12 v5010 837 Claim transaction as specified in the CAQH CORE Connectivity Rule. Optionally, a HIPAA-covered health plan or its agent may elect to also implement the server requirements for Real Time Processing Modes as specified in the CAQH CORE Connectivity Rule. 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 837 Claim 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. Health Care Claim Connectivity Requirements**

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<sup>7</sup> Merriam-Webster's Dictionary of Law. Merriam-Webster, Inc., 28 May 2007. <[Dictionary.com http://dictionary.reference.com/browse/safeharbor](http://dictionary.reference.com/browse/safeharbor)>

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A HIPAA-covered entity or its agent must be able to support the most recent published and CAQH CORE adopted version of the CAQH CORE Connectivity Rule.

This CAQH CORE 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 the CAQH CORE Connectivity Rule. The CAQH CORE Connectivity Rule is designed to provide a “Safe Harbor” that application vendors, HIPAA-covered providers and HIPAA-covered health plans (or other their agents) 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.

The requirement to support the CAQH CORE Connectivity Rule does not apply to retail pharmacy. For retail pharmacy the entity should refer to the National Council for Prescription Drug Programs (NCPDP) at [www.ncdp.org](http://www.ncdp.org). NCPDP and CAQH CORE support a shared goal of continued alignment for connectivity across retail pharmacy and medical.

### ***4.3. Health Care Claim/Encounter Reporting System Availability***

Many healthcare providers have a need to submit health care claims and encounter reporting outside of the typical business day and business hours. Additionally, many institutional providers are now allocating staff resources to performing administrative and financial back-office activities on weekends and evenings. As a result, providers have a business need to be able to conduct health care claim and encounter reporting transactions at any time.

On the other hand, HIPAA-covered health plans have a business need to periodically take their claims 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 837 Claim, X12 v5010 999, and X12 v5010 277CA transactions on certain nights and weekends. This rule requirement addresses these conflicting needs.

#### ***4.3.1. System Availability Requirements***

##### ***4.3.1.1. 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 837 Claim transaction, an X12 v5010 999 transaction, and an X12 v5010 277CA 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.

##### ***4.3.1.2. 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 an X12 v5010 837 Claim transaction, an X12 v5010 999 transaction, and an X12 v5010X 277CA transaction. This will allow a HIPAA-covered health plan or its agent to schedule additional downtime for substantive system migration in excess of the allowable weekly system downtime specified in Section 4.3.1.1.

#### ***4.3.2. Reporting Requirements***

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**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. Basic Requirements for a HIPAA-covered Health Plan or its Agent Receiving Electronic Claims/Encounter Reporting**

**4.4.1. Use of the 999 Implementation Acknowledgement and 277 Claim Acknowledgement**

This rule section addresses the requirements for a HIPAA-covered health plan or its agent when it receives an X12 Interchange containing one or more Functional Groups of any X12 v5010 837 Claim transaction submitted either in Batch Processing Mode or in Real Time Processing Mode without Real Time Adjudication.

The requirements in this section do not apply to the conduct of a Real Time Adjudication (RTA) process in which a health care claim (X12 v5010 837 Claim) is submitted to a HIPAA-covered health plan or its agent in Real Time and the HIPAA-covered health plan or its agent adjudicates that claim in Real Time during the same communications session and returns a single response to the submitter.

**4.4.1.1. Functional Group and Transaction Set and Claim Acknowledgement**

**4.4.1.1.1. Requirements when any X12 v5010 837 Claim Transaction is Submitted in Batch Processing Mode**

When any Functional Group of any X12 v5010 837 Claim Transaction Set is accepted, accepted with errors, or rejected the HIPAA-covered health plan or its agent must return an X12 v5010 999 transaction. The X12 v5010 999 transaction must report each error detected to the most specific level of detail supported by the X12 v5010 999 transaction.

A HIPAA-covered health plan or its agent must acknowledge each claim received in any Functional Group of any X12 v5010 837 Claim Transaction Set using the X12 v5010 277CA transaction only when X12 v5010 837 Claim Transaction Set is not rejected.

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NOTE: §1.4 Business Usage of the X12 277CA<sup>8</sup> transaction states that the “277 is the only notification of pre-adjudication claim status” and that “claims failing the pre-adjudication editing process are not forwarded to the claims adjudication system.”

**4.4.1.1.2. Requirements when any X12N v5010 837 Claim Transaction is Submitted in Real Time Processing Mode without Adjudication**

When any Functional Group of any X12 v5010 837 Claim Transaction Set is rejected the HIPAA-covered health plan or its agent must return an X12 v5010 999 transaction. The X12 v5010 999 transaction must report each error detected to the most specific level of detail supported by the X12 v5010 999 transaction.

An X12 v5010 999 transaction must not be returned when the Functional Group of any X12 v5010 837 Claim Transaction Set is not rejected.

A HIPAA-covered health plan or its agent must acknowledge each claim received in any Functional Group of any X12 v5010 837 Claim Transaction Set using the X12 v5010 277CA transaction only when X12 v5010 837 Claim Transaction Set is accepted.

**4.4.2. Response Time Requirements for Availability of Acknowledgements Addressed in this CAQH CORE Operating Rule**

Maximum elapsed time for the availability of an X12 v5010 999 transaction or X12 v5010 277CA transaction to any X12 v5010 837 Claim transaction that is submitted by a provider, or on a provider's behalf by a clearinghouse/switch, by 9:00 pm Eastern Time of a business day must be no later than 7:00 am Eastern Time the second 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.

**Basic Requirements for Receivers of Acknowledgments**

The receiver (defined in the context of this CAQH CORE Operating Rule as the HIPAA-covered provider or its agent) of an X12 v5010 999 transaction and an X12 v5010 277CA transaction is required:

- To process any X12 v5010 999 transaction within one business day of its receipt
- And
- To process any X12 v5010 277CA transaction within one business day of its receipt
- And
- To recognize all error conditions that can be specified using all standard acknowledgements named in this rule

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<sup>8</sup> ASC X12 005010X214 Health Care Claim Acknowledgement (277) Technical Report Type 3 Implementation Guide and associated errata.

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And

- To pass all such error conditions to the end user as appropriate

Or

- To display to the end user text that uniquely describes the specific error condition(s), ensuring that the actual wording of the text displayed accurately represents the error code and the corresponding error description specified in the related X12 acknowledgement specification without changing the meaning and intent of the error condition description.

The actual wording of the text displayed is at the discretion of the HIPAA-covered provider or its agent.

#### ***4.5. Health Care Claim 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.

Historically, 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/providers who must review numerous companion guides along with the X12 TR3 Implementation Guides. To address this issue, CAQH CORE developed the CAQH CORE Master Companion Guide Template for health plans or their agents. Using this template, health plans and their agents can ensure that the structure of their companion guide is similar to other health plan’s documents, making it easier for providers 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 HIPAA-covered health plans may have different requirements. The CAQH CORE Master Companion Guide template gives health plans the flexibility to tailor the document to meet their particular needs.

The requirements specified in this section do not currently apply to retail pharmacy.

##### ***4.5.1. Health Care Claim Companion Guide Requirements***

If a HIPAA-covered entity or its agent publishes a companion guide covering the X12 v5010 837 Claim transaction, then the companion guide must follow the format/flow as defined in the CAQH CORE Master Companion Guide Template for HIPAA Transactions. A HIPAA-covered entity or its agent’s companion guide covering the X12 v5010 837 Claim transaction must include the entity’s requirements for coordination of benefits in Section 7 and Section 10 as appropriate.

**NOTE:** This rule does not require any HIPAA-covered 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 demonstrated and certified through successful completion of the Health Care Claims CAQH CORE 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 Health Care Claims Operating Rules, and the entity or its product has fulfilled all relevant conformance requirements.

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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: References**

- X12 005010X231 Implementation Acknowledgement for Health Care Insurance (999) Technical Report Type 3 Implementation Guide and associated errata
- X12 005010X222 Health Care Claim (837) Professional Technical Report Type 3 Implementation Guide and associated errata
- X12 005010X223 Health Care Claim (837) Institutional Technical Report Type 3 Implementation Guide and associated errata
- X12 005010X224 Health Care Claim (837) Dental Technical Report Type 3 Implementation Guide and associated errata
- X12 005010X214 Health Care Claim Acknowledgement (277) Technical Report Type 3 Implementation Guide and associated errata