Analysis & Planning Guide for Implementing the CAQH CORE Eligibility & Benefits Operating Rules

May 2022

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1. Introduction: Analysis & Planning for CAQH CORE Rule Adoption

This CAQH CORE Analysis & Planning Guide provides a resource for entities preparing to adopt the CAQH CORE Eligibility & Benefits Operating Rules.[1] A solid understanding of the CAQH CORE Operating Rules combined with an effective planning effort is the basis for a successful implementation project.

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

- Understand the applicability of the CAQH CORE Eligibility & Benefits Operating Rule requirements to your organization's systems that conduct eligibility & benefits transactions (e.g., need for internal testing, project management, eligibility, and benefits resources, etc.)
- Identify and inventory all impacted external and internal systems and outsourced vendors that process eligibility & benefits transactions
- Conduct a detailed rule requirements gap analysis to identify system(s) that may require remediation in order to conform to the CAQH CORE Eligibility & Benefits Operating Rule requirements and to identify business process which may be impacted by the CAQH CORE Eligibility & Benefits Operating Rules.

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

- Stakeholder & Business Type Evaluation: Use to determine your stakeholder type(s) and understand the role of your intermediaries that conduct the eligibility and benefits transaction
- Systems Inventory & Impact Assessment Worksheet: Use to conduct a high-level inventory of all external and internal systems that conduct the eligibility & benefits transactions and are impacted by the CAQH CORE Eligibility & Benefits Operating Rules.
- Gap Analysis Worksheet: Use to determine the level of system(s) remediation necessary for adopting the business requirements of the CAQH CORE Eligibility & Benefits Operating Rules

NOTES:

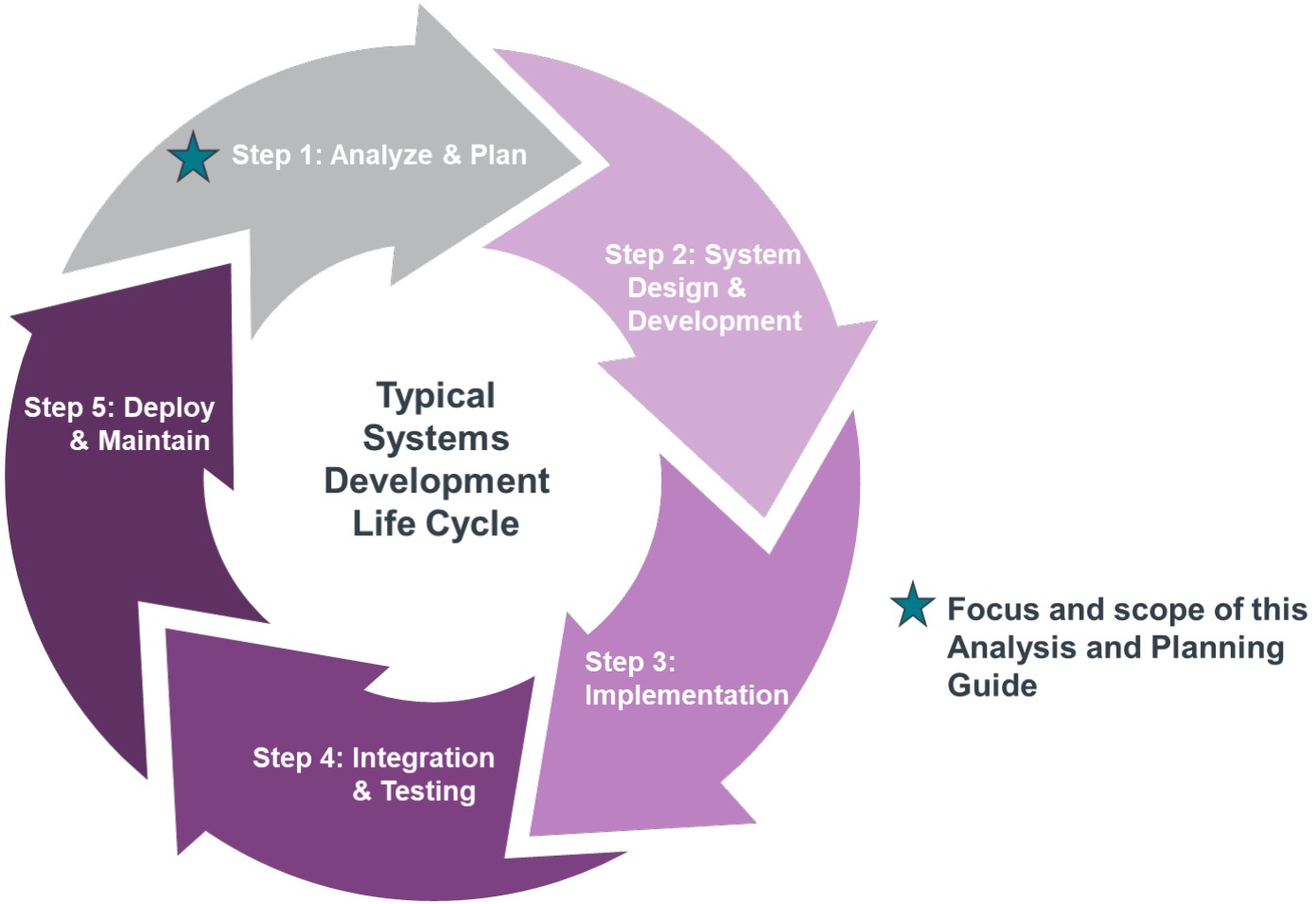
- This document is for educational purposes only; in the case of a question between this document and CAQH CORE Operating Rule text and/or Federal regulations, the latter take precedence.
- This Analysis & Planning Guide is scoped to *general* adoption of the CAQH CORE Eligibility & Benefits Operating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

2. Systems Development Life Cycle

The diagram below illustrates a typical systems development life cycle (SDLC) for developing or remediating information systems, SDLC includes five key steps, beginning with analysis and planning through deployment and ongoing maintenance. This Analysis & Planning Guide is scoped to assist you in the first step of an SDLC for the adoption of the CAQH CORE Operating Rules given Step 1 sets the stage for all other steps.

[1] **NOTE:** The HHS Final Rule for operating rules for the eligibility & benefits transaction adopts all the CAQH CORE Operating Rules for the Eligibility & Benefits **except** those requirements pertaining to the use of Acknowledgements. ACA amends HIPAA, therefore, *all HIPAA covered entities* must be in compliance with operating rules by their effective dates.

Typical Systems Development Life Cycle



3. Analysis & Planning for the CAQH CORE Operating Rules: Key Tasks

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

Analysis and Planning: Key Tasks	
Task	**Activity**
Task A - Complete Staff Education and Training on the CAQH CORE Operating Rules	• Thoroughly review and understand the CAQH CORE Eligibility & Benefits Operating Rules • Conduct general education and awareness of the CAQH CORE Eligibility & Benefits Operating Rules for the impacted areas in your organization (see Section 4 of this document for additional resources available to educate staff on the CAQH CORE Eligibility & Benefits Operating Rules)
Task B -Determine Your Organization's Stakeholder & Business Type(s) (Stakeholder & Business Type Evaluation) *CAQH CORE Operating Rule requirements are tied to applicable stakeholder type(s): provider, health plan, clearinghouse, and vendor*	• Determine your stakeholder and business type(s) to understand which CAQH CORE Eligibility & Benefits Operating Rules apply to your organization • Understand the role of intermediaries that conduct eligibility and benefits transactions • Consider the following based on your stakeholder type(s):
	• If your organization is a health plan: – The majority of the CAQH CORE Eligibility & Benefits Operating Rule requirements will apply to your systems. – Health plans that outsource to a clearinghouse or other intermediary to process the eligibility transactions from providers on their behalf may have some unique implementation considerations. Depending on the scenario between the health plan and its clearinghouse/intermediary, the health plan may not need to implement some rule requirements directly and the clearinghouse/intermediary will need to implement them on behalf of the health plan.
	• If your organization is a provider: – You likely are outsourcing some of the CAQH CORE Eligibility & Benefits Operating Rule requirements to a clearinghouse or your software vendor. Provider organizations using a clearinghouse or software vendor to send and receive eligibility transactions with health plans may have some unique implementation considerations since the clearinghouse/software vendor is performing some functions on behalf of the provider.
	• If your organization is a clearinghouse: – You are responsible for implementing CAQH CORE Eligibility & Benefits Operating Rule requirements applicable to you as a clearinghouse. – Additionally, if a health plan and/or provider outsources certain functions to you to perform on their behalf, you are responsible for implementing all CAQH CORE Eligibility & Benefits Operating Rule requirements which have been outsourced to you. In this instance, your organization will need to work with your business partners to determine applicable rule requirements.

Analysis and Planning: Key Tasks	
Task	**Activity**
	• If your organization is a software or services vendor: – You are responsible for implementing many of the CAQH CORE Eligibility & Benefits Operating Rule requirements into your services or software. – Note, if your services or software are provider-facing you will have a unique set of requirements to implement that are different than a health plan-facing vendor's services or software.
Task C - Conduct a Systems Inventory (Systems Inventory & Impact Assessment Worksheet)	*Relative to your stakeholder type(s):* • Identify and inventory all impacted external and internal systems and outsourced vendors that process the v5010 270/271 transaction • Determine which functions for each identified impacted system/outsourced vendor are in-house developed and maintained, commercial off the shelf (COTS) system, or outsourced to a third party • Determine potential options for addressing the CAQH CORE Eligibility & Benefits Operating Rule requirements applicable to your stakeholder type(s) (e.g., remediate an in-house developed system, replace, or upgrade any COTS system, or work with third party vendor to ensure they meet CAQH CORE Eligibility & Benefits Operating Rule requirements)
Task D - Conduct Detailed Rule Requirements Gap Analysis (Gap Analysis Worksheet)	• Identify the impacted systems (identified via the *Systems Inventory & Impact Assessment Worksheet*) responsible for satisfying each requirement of the CAQH CORE Eligibility & Benefits Operating Rules • Determine and document any gaps between the existing system's capability and each rule requirement • Identify and document any business process which may also be impacted by each CAQH CORE Eligibility & Benefits Operating Rule requirement and to what extent the process is impacted
Task E - Develop a Detailed Project Plan	• A detailed project plan typically outlines steps for completion of the following key activities as Steps 2-5 of the System Development Life Cycle: – Determine required resources to complete the project (i.e., estimate resources, time, system release schedules, and money) – Develop a detailed Functional Requirements Document – Create a detailed Systems Design Document describing, in detail, the required functions and capabilities necessary to implement the CAQH CORE Eligibility & Benefits Operating Rules – Implement necessary system(s) enhancements – Test impacted systems to ensure conformance to the requirements set in the Functional Requirements Document – Deploy (i.e., implement system(s) into production environment) – Conduct trading partners implementation testing

Analysis and Planning: Key Tasks	
Task	**Activity**
	• Consider CORE Certification as part of your project plan[2] – CAQH CORE offers CORE Certification to the four stakeholder types that create, transmit or use eligibility and benefits data: health plans, providers, software/services vendors, and clearinghouses. – Key benefits to completing CORE Certification include: ▪ Certification testing provides an on-line mechanism for a stakeholder to test its systems ability to exchange eligibility and benefits data with its trading partners using the CAQH CORE Eligibility & Benefits Operating Rules. ▪ Demonstrates via a recognized industry "Seal" your organization's adoption of the CAQH CORE Operating Rules to the industry ▪ Encourages trading partners to work together on transaction data content, infrastructure and connectivity needs ▪ Promotes maximum ROI when all stakeholders in the information exchange are known to conform with the CAQH CORE Eligibility & Benefits Operating Rules. • More information on the CORE Certification process is available on the CAQH website HERE.

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

4. Additional Resources

Beyond the information provided in this CAQH CORE Analysis & Planning Guide, the CAQH website provides additional resources for entities preparing to implement the CAQH CORE Operating Rules:

- CAQH CORE Eligibility & Benefits Operating Rules
- PowerPoint Overview of the CAQH CORE Eligibility & Benefits Operating Rules
- Past CAQH CORE Education Sessions for further clarification on rule requirements
- CAQH CORE FAQs address typical questions regarding the CAQH CORE Eligibility & Benefits Operating Rules
    - If question not listed as an FAQ, email question to core@caqh.org
- CORE Certification Master Test Suites (initially developed for CORE Certification but same concepts, e.g., role of trading partners, apply for general adoption of the CAQH CORE Operating Rules)
    - Eligibility & Benefits CAQH CORE Certification Test Suite
- HHS Final Rule for Adoption of Operating Rules for Eligibility & Benefits for a Health Plan
- CMS FAQs (FAQs related to Federally mandated operating rules are #10958-10971)

5. Notes for Implementers

Entities seeking to implement the CAQH CORE Eligibility & Benefits Operating Rules are encouraged to note the following:

- The CAQH CORE Eligibility & Benefits Operating Rules assume that any HIPAA-covered entity implementing the operating rules is compliant with the most recently mandated version of HIPAA; HIPAA compliance is not defined by CAQH CORE.
- The CAQH CORE Operating Rule requirements are tied to the applicable stakeholder type(s). The applicability of a specific CAQH CORE Eligibility & Benefits Operating Rule requirement may vary according to trading partner relationship, contracted services, and other arrangements. If you have specific questions concerning applicability, please contact CAQH CORE Staff.
- CAQH CORE staff is available to assist with questions about understanding the requirements of the CAQH CORE Operating Rules in regard to your stakeholder type(s); gap analysis and systems remediation are the responsibility of the implementing entities.

6. Appendix

Appendix A: CAQH CORE Stakeholder & Business Type Evaluation

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

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

- Provider direct-to-health plan connection:
  - Health plan implements all requirements of the CAQH CORE Eligibility & Benefits Operating Rules
- Single/dual clearinghouse-to-health plan connection:
  - Health plan outsources infrastructure and connectivity functions to a clearinghouse[3]
  - Health plan-facing clearinghouse acts as a proxy for health plan's CAQH CORE conformance for the contracted services
- Provider-to-clearinghouse/vendor connection:
  - Provider outsources eligibility and benefits request submission function to clearinghouse/vendor
  - Provider-facing clearinghouse or vendor solution acts as a proxy for provider's CAQH CORE conformance for the contracted services

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

[3] In some cases, a clearinghouse may offer full outsourcing services for eligibility and benefit verification functions, inclusive of data hosting.

Stakeholder & Business Type Evaluation		
Question	**Points for Consideration**	**Your Response**
1. What is your stakeholder type(s) (e.g., health plan, provider vendor, clearinghouse)?	The CAQH CORE Eligibility & Benefits Operating Rules define four stakeholder types that implement the operating rules: health plan, clearinghouse, provider, and vendor; the applicability of specific CAQH CORE Eligibility & Benefits Operating Rule requirements vary according to stakeholder type.	
2. What role and responsibilities does my organization have for implementing the CAQH CORE Operating Rules, given our stakeholder type(s)?	The CAQH CORE Eligibility & Benefits Operating Rules outline the specific roles and responsibilities for each stakeholder type, review CAQH CORE Eligibility & Benefits Operating Rules text for more detail.	
3. Does my organization rely on trading partners (e.g., vendors or clearinghouses) to assist with processing the eligibility and benefits transaction?	The applicability of a specific CAQH CORE Eligibility & Benefits Operating Rule requirement may vary according to trading partner relationship, contracted services, and other arrangements. If your organization relies on a software vendor or a clearinghouse to meet any of the CAQH CORE Eligibility & Benefits Operating Rule requirements, you will need to coordinate with that entity as part of your pre-implementation planning and outline applicability of each requirement to the vendor or clearinghouse. See Section 4 of this document for additional resources that provide guidance on working with trading partners.	

Appendix B: CAQH CORE Systems Inventory & Impact Assessment Worksheet
Purpose: After you complete the *Stakeholder & Business Type Evaluation,* your next step is to complete the *CAQH CORE Systems Inventory & Impact Assessment Worksheet* which enables you to identify and inventory all impacted systems that process eligibility and benefits transaction.

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

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

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

CAQH CORE Systems Inventory & Impact Assessment Worksheet			
CAQH CORE Operating Rule Requirements	**Is One or More Systems Impacted?** *(Yes/No; Name of Impacted System)*	**Is the System In-house, COTS, or Outsourced to a Third Party?**	**Potential Options to Address Rule Requirements** *(e.g. remediate an in-house developed system, replace or upgrade any COTS system, or work with third party vendor to ensure they meet CAQH CORE Operating Rule requirements)*
CAQH CORE Eligibility & Benefits Data Content Rules			
CAQH CORE Eligibility & Benefits (270/271) Data Content Rule vEB.2.0			
CAQH CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule vEB.1.0			
CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule			
CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule vEB.2.0			
CAQH CORE Connectivity Rules			
CAQH CORE Connectivity Rule vC1.1.0 (HTTPS Safe Harbor)			
CAQH CORE Connectivity Rule vC2.2.0 (HTTPS Safe Harbor, with two envelope options: SOAP with WSDL and MIME Multi-part; two authentication modes: digital certification and username/password)			
CAQH CORE Connectivity Rule vC4.0.0 (HTTPS Safe Harbor; continued support for SOAP, and added support for REST; authorization: OAuth 2.0.; security: TLS 1.2)			

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

NOTES:

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

Instructions:

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

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

Rule Req. #	CAQH CORE Operating Rule Requirement	System Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
CAQH CORE Eligibility and Benefits (270/271) Data Content Rule vEB.2.0							
Electronic Delivery of Patient Financial Information Rule Requirements							
	CORE requirements for v5010 271 Eligibility & Benefits Inquiry Response: (§1.3.2.1, §1.3.2.5)						
1	When the individual is located in the system, the health plan must return: The health plan name (if one exists within the health plan's or information source's system) in EB05-1204 Plan Coverage Description. Neither the health plan or information source is required to obtain such a health plan name from outside its own organization The patient financial responsibility for co-insurance, co-payment and deductibles.						
	To specify the co-insurance responsibility: (§1.3.2.8)						
2	Use code "A" Co-Insurance in EB01-1390 Eligibility or Benefit Information data element and use EB08-954 Percent data element for each reported type of service.						
3	If the patient financial responsibility amounts differ for in and out of network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as appropriate						
4	The health plan (or information source) may, at its discretion, elect not to return co-insurance information for the following services specified in EB03-1365: 1 – Medical Care; 30 – Health Plan Benefit Coverage; 35– Dental Care; 88 – Pharmacy; AL – Vision (Optometry); MH – Mental Health. This optional reporting does not preempt the health plan's (or information source's) requirement to report patient co-payment responsibility for the remaining 7 CORE required service types (33 – Chiropractic, 48 – Hospital Inpatient, 50 – Hospital Outpatient, 86 – Emergency Services, 98 – Professional						

Rule Req. #	CAQH CORE Operating Rule Requirement	System Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	(Physician) Visit– Office), 47 – Hospital, UC – Urgent Care that must be reported in a generic request for eligibility (Service Type Code 30) or a service type not supported by the health plan.						
	To specify the co-payment responsibility: (§1.3.2.7)						
5	Use code "B" Co-Payment in EB01-1390 Eligibility or Benefit Information data element and use EB07-782 Monetary Amount element for each reported type of service.						
6	If the patient financial responsibility amounts differ for in and out of network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as appropriate.						
7	The health plan (or information source) may, at its discretion, elect not to return co-payment information for the following services specified in EB03-1365: 1 – Medical Care; 30 – Health Plan Benefit Coverage; 35– Dental Care; 88 – Pharmacy; AL – Vision (Optometry), MH – Mental Health. This optional reporting does not preempt the health plan's (or information source's) requirement to report patient co-payment responsibility for the remaining 7 CORE required service types (33– Chiropractic, 48 – Hospital Inpatient, 50 – Hospital Outpatient, 86 – Emergency Services, 98 – Professional (Physician) Visit– Office), 47 – Hospital, UC – Urgent Care that must be reported in a generic request for eligibility (Service Type Code 30) or a service type not supported by the health plan.						
	To specify the deductible responsibility: (§1.3.2.6)						

Rule Req. #	CAQH CORE Operating Rule Requirement	System Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
8	Use code "C" Deductible in EB01-1390 Eligibility or Benefit Information data element and use EB07-782 Monetary Amount to indicate the dollar amount of the deductible for the type of service specified in EB03-1365 service type code.						
9	If the patient financial responsibility amounts differ for in and out of network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as appropriate.						
10	If the deductible amount varies by the benefit coverage level specified in EB02-1207 Coverage Level Code, place the appropriate code in EB02 and use additional occurrences of the EB Eligibility or Benefit Information segment as necessary for each benefit coverage level for each type of service, e.g., individual or family coverage.						
11	The health plan (or information source) may, at its discretion, elect not to return deductible information for the following services specified in EB03 -1365: 1 – Medical Care; 30 – Health Plan Benefit Coverage; 35– Dental Care; 88 – Pharmacy; AL – Vision (Optometry), MH – Mental Health. This optional reporting does not preempt the health plan's (or information source's) requirement to report patient deductible responsibility for the remaining 7 CORE required service types (33 – Chiropractic, 48 – Hospital Inpatient, 50 – Hospital Outpatient, 86 – Emergency Services, 98 – Professional (Physician) Visit – Office), 47 – Hospital, UC – Urgent Care that must be reported in a generic request for eligibility (Service Type Code 30) or a service type not supported by the health plan.						
	Eligibility dates: (§1.3.2.2)						

Rule Req. #	CAQH CORE Operating Rule Requirement	System Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
12	The X12 270 eligibility inquiry may request a benefit coverage date 12 months in the past or up to the end of the current month. If the inquiry is outside of this date range and the health plan (or information source) does not support eligibility inquiries outside of this date range, the v5010 X12 271 response must include the AAA segment with code "62" Date of Service Not Within Allowable Inquiry Period in the AAA03-901 Reject Reason Code data element.						
	Requires a Health Plan (or Information Source) to: (§1.3.2.6 - §1.3.2.8, §1.3.2.6.1, §1.3.2.6.2, §1.3.2.6.3, §1.3.2.9, §1.3.2.10, §1.3.2.11, §1.3.2.12, §1.3.2.13						
13	Respond to an explicit inquiry for a CORE-required service type with patient financial responsibility.						
14	Specify when a service type covered by this rule is a covered benefit only for in-network providers and not a covered benefit for out-of-network providers.						
15	Specify the Health Plan base deductible amount only on the EB segment where EB03=30-Health Benefit Plan Coverage).						
16	Specify the Health Plan remaining deductible amount that is the patient's financial responsibility only on the EB segment where EB03=30-Health Benefit Plan Coverage.						
17	Return the benefit-specific (service type) remaining deductible amount for each benefit (service type) only when the amount is different than for the health plan.						
18	Return the benefit-specific (service type) base deductible amount for each benefit (service type) only when the amount is different than for the health plan.						

Rule Req. #	CAQH CORE Operating Rule Requirement	System Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
19	Return patient liability information (co-pay, co-insurance, and deductible information) for a CORE-required explicit v5010 X12 270 inquiry.						
20	Return both family and individual Health Plan base and remaining deductible amounts as applicable to the health plan coverage.						
21	Not return base and remaining deductible amounts for a specific benefit (service type) when the amount is not different than for the health plan.						
22	Return deductible amounts only in U.S. amounts.						
23	Return the date(s) for the Health Plan base deductible only if different than the Health Plan Coverage date.						
24	Return the date(s) for a Benefit-specific base deductible only if different than the Health Plan Coverage date.						
25	Return CMS External Place of Service Codes for Professional Claims Code 02 or 10 in Segment III within Data Element III02 (INDUSTRY CODE) to indicate what service or benefit is available for telemedicine.						
26	Return maximum benefit limitations and remaining benefits for each maximum benefit limitation for the 10 CORE-required remaining coverage benefit service types specified in §5.1 using two EB segment occurrences.						
27	Indicate if authorization or certification is required using EB11 with codes N or Y per plan provisions when authorization or certification requirements can be determined by the health plan for each service type.						
	Prohibits a Health Plan (or Information Source) from: (§1.3.2.6.1 and §1.3.2.6.2)						

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28	Redundantly returning the Health Plan base and remaining deductible amounts on any EB segment where EB03≠30-Health Benefit Plan Coverage when these amounts are not different for that specific service type.						
	Allows a Health Plan (or Information Source) to: (§1.3.2.5)						
29	Return patient liability information (co-pay, co-insurance, and deductible information) at its discretion for 9 specified Service Type Codes.						
	Specifies that: (§1.3.2.6.2 and §1.3.2.6.4, §1.3.2.3)						
30	Only Code 29-Remaining can be used in EB06 data element to specify the remaining deductible amount.						
31	51 service type codes that must be supported for an explicit inquiry.						
	Requires a Receiver of the V5010 271 Response to: (§1.3.1)						
32	Detect and extract all data elements to which the rule applies.						
33	Display to the end user text that appropriately describes these data elements.						
Procedure Codes							
	Requires Submitters (Providers, Provider Vendors and Information Receivers) to: (§1.4.1)						
1	Detect and extract all data elements to which this rule applies as returned by the health plan and its agent in the v5010 271.						
	Requires a Health Plan (or Information Source) to: (§1.4.2, §1.4.2.1, §1.4.2.2, §1.4.2.3, §1.4.2.4, §1.4.2.5, §1.4.2.6, §1.4.2.7, §1.4.2.8, §1.4.2.9, §1.4.2.10)						

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2	Comply with all requirements when returning the v5010 271 when the individual is located in the health plan's (or information source's) system.						
3	Return the health plan name when an individual is located in health plan's and its agent's system (if one exists within the health plan's or information source's system) in EB05-1204 Plan Coverage Description.						
4	Return AAA segment with code "62" Date of Service Not Within Allowable Inquiry Period in the AAA03-901 Reject Reason Code data element if the inquiry is outside of this date range and the health plan (or information source) does not support eligibility inquiries outside of this date range.						
5	Support an explicit v5010 270 for each procedure code (CPT or HCPCS) received that can be placed by the health plan into one or more of the categories of service as specified in Table 1.4.2.3 returning a v5010 271 as specified in §1.4.2.4 through §1.4.2.10.						
6	Indicate the non-covered status for out-of-network providers for each service type using EB12-1073 Yes/No – in Plan Network.						
7	Return the patient financial responsibility for base and remaining deductible, co-insurance and co-payment as specified in §1.4.2.6 through §1.4.2.8. for each procedure code returned.						
8	Return the dollar amount of the base and remaining deductible for all procedure codes required by §1.4.2.3. The deductible amount returned must be in U.S. dollars only.						
9	Return the Benefit-specific base deductible as defined in §1.2.7 that is the patient financial responsibility, including both						

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	individual and family deductibles (when applicable) in Loops 2110C/2110D only when the status of the health plan coverage and the status of the specific benefit as required in §1.4.2.4.						
10	Return the Benefit-specific remaining deductible, that is patient financial responsibility, including both individual and family deductibles (when applicable) in Loops 2110C/2110D only when the status of the health plan coverage and the status of the specific benefit as required in §1.3.2.4 is equal to one of the active coverage codes 1 through 5 and EB03≠30–Health Benefit Plan Coverage.						
11	Return the patient financial responsibility for co- payment for each Procedure Code returned.						
12	Return the patient financial responsibility for co- insurance for each Procedure Code returned.						
13	Return a date specifying the begin date for the base Procedure Code-specific deductible only in Loops 2110C/2110D where EB01= active coverage code 1 through 5 and EB03≠30–Health Plan Benefit Coverage and EB01=C−Deductible when the Procedure Code-specific Base Deductible date is not the same date as the Health Plan Coverage Dates for the Individual.						
14	Indicate if authorization or certification is required using EB11 with codes N or Y per plan provisions when authorization or certification requirements can be determined by the health plan for each procedure code when a Procedure Code covered by this rule is a covered benefit.						
Telemedicine Benefits							
	Requires a Health Plan (or Information Source) to: (§1.3.2.11, §1.3.2.12, §1.3.2.12.1, §1.3.2.12.2, §1.3.2.12.3, §1.3.2.13)						

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1	Use the Centers for Medicare and Medicaid Services External Place of Service Codes for Professional Claims Code 02 (Telehealth Provided Other than in Patient's Home) or 10 (Telehealth Provided in Patient's Home), in Segment III3 (SUBSCRIBER/DEPENDENT ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION), within Data Element III02 (INDUSTRY CODE) to indicate what service or benefit is available for telemedicine when a service type code is covered for telemedicine.						
2	Return maximum benefit limitations and return remaining benefits for each maximum benefit limitation for the 10 CORE-required remaining coverage benefit service types specified in §5.1 using two EB segment occurrences.						
3	Return maximum benefit limitations in an EB segment.						
4	Return the related remaining benefit limitation in an EB segment.						
5	Return the next eligible date for a benefit when a service type has a date limitation, when applicable, using the EB and DTP Segment.						
6	Indicate if authorization or certification is required using EB11 with codes N or Y per plan provisions when authorization or certification requirements can be determined by the health plan for each service type as follows when a service type code covered by this rule is a covered benefit.						
Tiered Benefits							
	Requires a Health Plan (or Information Source) to: (§1.5.1, §1.5.2)						
1	Include data in EB Loops 2110C/2110D for each applicable tiered benefit when the v5010 270 includes a CORE-required						

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	service type or procedure code. Each EB loop must also include an MSG segment identifying the benefit tier and the MSG segment content must begin with "MSG*BenefitTier…" when the v5010 270 includes a CORE-required service type or procedure code, as specified in §1.3.2 and §1.4.2, and it is determined to be a tiered benefit for the patient identified.						
2	Return the tiered network status of in-network, out-of-network, or exclusive/preferred for the inquiring provider AND Benefit information only for the patient tier that applies to the inquiring provider if determination can be made when the health plan and its agent can appropriately identify the provider specified in Loop 2100B NM1/REF/PRV segments.						
Normalizing Patient Last Name							
	Requires a Health Plan (or Information Source) to: (§2.3.2.1, §2.3.2.3)						
1	Normalize the last name submitted on the v5010 X12 270 before using submitted last name.						
2	Normalize internally-stored last name before using internally-stored last name.						
3	Return the v5010 X12 271 response with AAA segment using appropriate error code(s) when normalized names are not successfully matched or validated.						
4	Return the un-normalized internally-stored last name when it does not match the un-normalized submitted last name in the NM103-1035 data element and return the INS segment as specified in Table 4.3.1.						
5	Return the v5010 X12 271 response when normalized names are successfully matched or validated.						
	Requires a Receiver of the v5010 X12 271 Response to: (§2.3.4)						

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6	Detect all data elements addressed by the rule as returned in the v5010 X12 271 response.						
7	Display to the end user text uniquely describing the specific error condition(s) and data elements returned in the v5010 X12 271.						
8	Ensure that displayed text accurately represents the Follow Up Action without changing meaning and intent of the Follow Up Action.						
	Recommendations for Submitters of the v5010 X12 270: (§2.3.1.1, §2.3.1.2)						
9	Submit a person's name suffix in the NM107-1039 data element when submitter's system enables capture and storage of a name suffix in a separate data field.						
10	Separate a person's name suffix from the last name using either a space, comma, or forward slash when the submitter's system does not enable the capture and storage of a name suffix in a separate data field.						
11	Attempt to identify and parse the last name data element to extract any name suffix and to submit the suffix in the NM107-1039 data element.						
AAA Error Code Reporting							
	Requires a Health Plan (or Information Source) to: (§3.3.1, §3.3.5, §3.3.3.1, §3.3.3.2, §3.3.3.4)						
1	Return a AAA segment for each error condition detected.						
2	Return code "N" in the AAA01 Valid Request Indicator data element.						
3	Return the specified Rejection Reason Code in AAA03 as specified for the error condition detected.						

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4	Return code "C" in the AAA04 Follow-up Action Code data element.						
5	Return submitted data elements used.						
6	Return a AAA segment for each error condition detected along with submitted data elements used when conducting a pre-query evaluation.						
7	Return a AAA segment for each missing and required data element when conducting a pre-query evaluation.						
8	Return a AAA segment for an invalid MID when conducting a pre-query evaluation.						
9	Return a AAA segment for an invalid DOB when conducting a pre-query evaluation.						
10	Return a AAA segment for each error condition detected along with submitted data elements used when conducting a post-query evaluation.						
	Requires a Receiver of the v5010 X12 271 to: (§3.3.2, §3.3.5)						
11	Detect all combinations of error conditions from the AAA segments in the v5010 X12 271 response.						
12	Detect all data elements addressed by the rule as returned in the v5010 X12 271 response.						
13	Display to the end user text uniquely describing the specific error condition(s) and data elements returned in the v5010 X12 271.						
14	Ensure that displayed text accurately represents the AAA03 error code and corresponding Error Condition Description without changing meaning and intent of the Error Condition Description.						

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	Defines: (§3.2.2)						
15	Pre-query evaluation of patient identification elements.						
16	Post-query evaluation of patient identification elements.						
17	Query using one or more of submitted patient identification data elements.						
CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule vEB.2.0							
Batch Acknowledgments[4] *(§3.2.1, §3.2.2)*							
1	A v5010 X12 999 is returned to indicate either acceptance of the batch or rejection of a Functional Group (including the enclosed Transaction Set) error resulting in the rejection of the entire Functional Group.						
2	A v5010 X12 999 must ALWAYS be returned if there are no errors in the Functional Group and enclosed Transaction Set.						
3	A v5010 X12 271 eligibility response transaction must ALWAYS be returned for an Interchange, Functional Group and Transaction Set that complies with X12 TR3 implementation guide requirements.						
4	A v5010 X12 271 eligibility response transaction may contain either the appropriate AAA Validation Request segment(s) or the data segments containing the requested eligibility and benefit status details.						
5	A v5010 X12 999 must not be returned during the initial communications session in which the X12 270 batch is submitted.						

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

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Real-time Acknowledgments[5] (§2.2.1, §2.2.2)							
1	A v5010 X12 999 is returned ONLY to indicate a Functional Group (including the enclosed Transaction Set) error resulting in the rejection of the entire Functional Group.						
2	A v5010 X12 999 must NOT be returned if there are no errors in the Functional Group and enclosed Transaction Set.						
3	A v5010 X12 271 eligibility response transaction must ALWAYS be returned for an Interchange, Functional Group and Transaction Set that complies with X12 TR3 implementation guide requirements.						
4	A v5010 X12 271 eligibility response transaction may contain either the appropriate AAA Validation Request segment(s) or the data segments containing the requested eligibility and benefit status details.						
Companion Guide (§7.2)							
1	All entities' Companion Guides covering the v5010 270/271 eligibility inquiry and response transactions must follow the format/flow as defined in the CORE Master Companion Guide Template for HIPAA Transactions. This rule does not require any entity to modify any other existing companion guides that cover other HIPAA-adopted transaction implementation guides.						
Batch Response Time (§5.2.1, §5.2.2, §5.2.3)							

[5] Ibid.

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1	Maximum response time when processing in batch mode for the receipt of a v5010 X12 271 response to a v5010 X12 270 inquiry 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 returned by 7:00 am Eastern time the following business day. 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 health plan or information source.						
2	v5010 X12 999 responses must be available to the submitter within one hour of receipt of the batch: to the provider in the case of a batch of v5010 X12 270 inquiries and to the health plan (or information source) in the case of a batch of v5010 X12 271 responses.						
3	Conformance with this maximum response time rule shall be considered achieved if 90 percent of all required are returned within the specified maximum response time as measured within a calendar month.						
4	Each entity must demonstrate its conformance with this maximum response time rule by demonstrating its ability to capture, log, audit, match and report the date (YYYYMMDD), time (HHMMSS) and control numbers from its own internal systems and the corresponding data received from its trading partners.						
Real-time Response (§4.1.1, §4.2)							
1	Maximum response time when processing in real time mode for the receipt of a v5010 X12 271 (or in the case of an error, a v5010 X12 999 response from the time of submission of a						

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	v5010 270 inquiry must be 20 seconds (or less). v5010 X12 999 response errors must be returned within the same response timeframe.						
2	Conformance with this maximum response time rule shall be considered achieved if 90 percent of all required responses are returned within the specified maximum response time as measured within a calendar month.						
3	Each entity must demonstrate its conformance with this maximum response time rule by demonstrating its ability to capture, log, audit, match and report the date (YYYYMMDD), time (HHMMSS) and control numbers from its own internal systems and the corresponding data received from its trading partners.						
System Availability							
	System Requirements (§6.2.1.1)						
1	System availability must be no less than 90 percent per calendar week for both real-time and batch processing modes. This will allow for health plan, (or other information source) clearinghouse/switch or other intermediary system updates to take place within a maximum of 17 hours per calendar week for regularly scheduled downtime.						
	Reporting Requirements (§6.2.2.1, §6.2.2.2, §6.2.2.3)						
2	Health plans (or information sources), clearinghouses/switches or other intermediaries must publish their regularly scheduled system downtime in an appropriate manner (e.g., on websites or in the CAQH CORE Companion Guide) such that the healthcare provider can determine the health plan's system availability so that staffing levels can be effectively managed						

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3	For non-routine downtime (e.g., system upgrade), an information source must publish the schedule of non-routine downtime at least one week in advance.						
4	For unscheduled/emergency downtime (e.g., system crash), an information source will be required to provide information within one hour of realizing downtime will be needed.						
	Other Requirements (§6.2.2.4, §6.2.3)						
5	No response is required during scheduled downtime(s).						
6	Each health plan, (or other information source) clearinghouse/switch or other intermediary will establish its own holiday schedule and publish it.						
CAQH CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule vEB.1.0							
	Identification of Subscriber/Dependent Attribution: (§4.2)						
2	A health plan and its agent must return explicit attribution status and effective dates of attribution in the X12 271 for each of the CORE service type codes required by the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule submitted in a X12 270 Request. A health plan and its agent must develop and make available to the healthcare provider specific written instructions and guidance for the healthcare provider on its implementation of this operating rule and the following definitions of attribution and attribution status: • Attribution Status – Yes • Attribution Status – No • Attribution Status – Partial • Attribution Status – Not Applicable						
	Attribution Basic Requirements for Receivers of the x12 271 Response: (§4.3)						

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3	When receiving an X12 271 Response, a product extracting the data (e.g., a vendor's provider-facing system or solution) from the X12 271 Response for manual processing must make available to the end user: • Exact text describing the message in the Loop 2110C/Loop 2110D MSG01 Segment included in the X12 271 Response, ensuring that the actual wording of the text displayed accurately represents the corresponding message including exact text in Attribution Status column: Attribution Status Definitions, without changing the meaning and intent of the description (i.e., Attribution Status: Yes; Attribution Status: No; Attribution Status: Partial; or Attribution Status: Not Applicable). This requirement does not apply to an entity that is simply forwarding the X12 271 Response to another system for further processing.						
CAQH CORE Connectivity Rule vC1.1.0							
	Real Time Requests: (§2.2)						
1	Must include a single inquiry or submission, e.g., one eligibility inquiry to one information source for one patient.						
	Batch Requests: (§2.3)						
2	Are sent in the same way as real time requests.						
	Batch Submissions: (§2.3)						

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3	Response must be only the standard HTTP message indicating whether the request was accepted or rejected (see below for error reporting.						
4	Message receivers must not respond to a batch submission with an X12 response such as a v5010 X12 999 in the HTTP response to the batch request, even if their systems' capabilities allow such a response.						
	Batch Responses: (§2.3.1)						
5	Should be picked up after the message receiver has had a chance to process a batch submission.						
	Required Data Elements: (§2.4.1)						
6	Certain business data elements: authorization information, a payload identifier, and date and time stamps, must be included in the HTTP message body outside of the X12 data.						
7	Information Sources must publish their detailed specification for the message format in their publicly available Companion Guide.						
8	In order to comply with the Batch Response Time and Real Time Response Time Requirements message receivers will be required to track the times of any received inbound messages, and respond with the outbound message for that payload ID.						
9	Message senders must include the date and time the message was sent in the HTTP Message Header tags.						
	Date and Time Requirements: (§2.4.2)						
10	Date must be sent and logged using 8 digits (YYYYMMDD).						

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11	Time must be sent and logged using a minimum of 6 digits (HHMMSS).						
	Security: (§2.5)						
12	The HTTP/S protocol, all information exchanged between the sender and receiver is encrypted by a session-level private key negotiated at connection time.						
	User ID and Password: (§2.5.1)						
13	Entities will employ User ID and Password as the default minimum criteria authentication mechanism.						
14	Issuance, maintenance, and control of password requirements may vary by implementer and should be issued in accordance with the organizations' HIPAA Security Compliance policies.						
15	The User ID and Password authentication must be encrypted by the HTTP/S protocol but passed outside of the X12 payload information as described in the HTTP Message format section.						
16	The receiver may require the message sender to register the IP address for the host or subnet originating the transaction and may refuse to process transactions whose source is not registered or does not correspond to the ID used.						
17	Due to programming requirements of POSTing over HTTP/S, use of a digital certificate is required to establish communications. Entities will make available information on how to obtain the receiver's root public certificate.						
18	No additional security for file transmissions, such as the separate encryption of the X12 payload data, is required in this CAQH CORE Operating Rule for connectivity. By mutual consent, organizations can implement additional encryption,						

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	but HTTP/S provides sufficient security to protect healthcare data as it travels the Internet.						
	Response Time, Time Out Parameters, and Re-transmission: (§2.6)						
19	If the HTTP Post Reply Message is not received within the 60 second response period, the provider's system should send a duplicate transaction no sooner than 90 seconds after the original attempt was sent.						
20	If no response is received after the second attempt, the provider's system should submit no more than 5 duplicate transactions within the next 15 minutes.						
21	If the additional attempts result in the same timeout termination, the provider's system should notify the provider to contact the health plan or information source directly to determine if system availability problems exist or if there are known Internet traffic constraints causing the delay.						
	Authorization Errors: (§2.7.1)						
22	At the message acknowledgement level, a message receiver must send back a response with a status code of HTTP 202 Accepted once the message has been received. This does not imply that the X12 content has been validated or approved.						
	Batch Submission Acknowledgements: (§2.7.2)						
23	At the message acknowledgement level, a message receiver must send back a response with a status code of HTTP 202 Accepted once the message has been received. This does not imply that the X12 content has been validated or approved.						
	Real Time Response or Response to Batch Response Pickup: (§2.7.3)						

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24	When a message receiver is responding to a real time request or a batch response pickup request, assuming that the message authorization passed, the receiver must respond with an HTTP 200 Ok status code and the X12 data content as specified by the Batch Acknowledgement and Real Time Acknowledgement requirements.						
	Server Errors: (§2.7.4)						
25	It is possible that the HTTP server is not able to process a real time or batch request. In this case, the message receiver must respond with a standard HTTP 5xx series error such as HTTP 500 Internal Server Error or HTTP 503 Service Unavailable.						
26	If a sender receives a response with this error code, they will need to resubmit the request at a later time, because this indicates that the message receiver will never process this message.						
CAQH CORE Connectivity Rule vC2.2.0							
	Requires a Health Plan and Health Plan Vendor to implement a server and to: (§4.1.1, §4.2, §4.3.5.1, §4.3.5.2, §4.3.7, §6.3.1, §6.3.2)						
1	Implement Server capability to support both Message Envelope Standards and Message Exchanges specified in the rule for Real Time.						
2	Implement Server capability to support both Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered.						
3	Implement Server capability and enforce one of two specified Submitter Authentication Standards for both Real Time and/or Batch.						

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4	Have a capacity plan such that it can receive and process a large number of single concurrent real-time transactions via an equivalent number of concurrent connections.						
5	Have the capability to receive and process large batch transaction files if batch is supported.						
6	Publish detailed specifications in a Connectivity Companion Guide on its public web site as required by the appropriate Companion Guide.						
	If a Health Plan and Health Plan Vendor elects to optionally implement a client, it is required to: (§4.1.1, §4.2, §6.3.1, §6.3.2)						
7	Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified in the rule for Real Time.						
8	Implement Client capability to support Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered.						
9	Implement Client capability to support Submitter Authentication Standards for both Real Time and/or Batch.						
	Requires a Clearinghouse and Other Intermediaries to implement a server and to: (§4.1.1, §4.2, §4.3.5.1, §4.3.5.2, §4.3.7, §6.3.1, §6.3.2)						
10	Implement Server capability to support both Message Envelope Standards and Message Exchanges specified in the rule for Real Time.						
11	Implement Server capability to support both Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered.						
12	Implement Server capability and enforce one of two specified Submitter Authentication Standards for both Real Time and/or Batch.						

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13	Have a capacity plan such that it can receive and process a large number of single concurrent real-time transactions via an equivalent number of concurrent connections.						
14	Have the capability to receive and process large batch transaction files if batch is supported.						
15	Publish detailed specifications in a Connectivity Companion Guide on its public web site as required by the appropriate Companion Guide.						
	Requires a Clearinghouse and Other Intermediaries to implement a client and to: (§4.1.2, §4.2, §6.3.1, §6.3.2)						
16	Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified in the rule for Real Time.						
17	Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered.						
18	Implement Client capability to support both specified Submitter Authentication Standards for both Real Time and/or Batch.						
	Requires a Provider and Provider Vendor to implement a client and to: (§4.1.2, §4.2, §6.3.1, §6.3.2						
19	Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified in the rule for Real Time.						
20	Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered.						
21	Implement Client capability to support both specified Submitter Authentication Standards for both Real Time and/or Batch.						

Rule Req. #	CAQH CORE Operating Rule Requirement	System Impacted *(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)*	System Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	If a Provider and Provider Vendor elects to optionally implement a server, it is required to: (§4.1.3, §4.2, §6.3.1, §6.3.2)						
22	Implement Server capability to support both Message Envelope Standards and Message Exchanges specified in the rule for Real Time.						
23	Implement Server capability to support one of two Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered.						
24	Implement Server capability and enforce one of two both specified Submitter Authentication Standards for both Real Time and/or Batch.						
	Requires all Message Receivers to: (§4.3.4.1)						
25	Track the times of any received inbound messages						
26	Respond with the outbound message for the received inbound message.						
27	Include the date and time the message was sent in HTTP+MIME or SOAP+WSDL Message Header tags.						
	Specifies: (§4.2.1, §4.2.1.8, §4.2.2, §4.2.2.1, §4.2.2.2, §4.2.2.11, §4.3.1, §4.3.2, §4.3.3, §4.4)						
28	Message Enveloping specifications for HTTP MIME Multipart (Envelope Standard A).						
29	HTTP MIME Multipart payload attachment handling.						
30	Message Enveloping specifications for SOAP+WSDL (Envelope Standard B).						
31	XML Schema specification for SOAP.						
32	Web Services Definition Language (WSDL) specification.						
33	SOAP payload attachment handling						

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34	Request and response handling for real time, batch, and batch response pickup.						
35	Submitter authentication and authorization handling.						
36	Error handling for both Envelope Messaging Standards.						
37	Envelope metadata fields, including descriptions, intended use syntax and value-sets applicable to both Enveloping Messaging Standards.						
CAQH CORE SOAP Connectivity Rule vC4.0.0							
	Message Envelope Requirement (§4.1)						
1	Requires the use of SOAP+WSDL.						
	Submitter Authentication Requirement (§4.1.1)						
2	Requires the use of X.509 Client Authentication (mutual authentication) over TLS 1.2 or higher.						
	Submitter Authorization Requirements (§4.1.2)						
3	Requires support for OAuth 2.0 Client Authorization over TLS 1.2 or higher						
	Real Time and Batch Payload Attachment Handling (§4.1.4)						
4	Payload must be sent as an MTOM encapsulated object.						
	Required Transport Method (§4.2.1)						
5	HIPAA-covered entities or their agents must implement HTTP/S Version 1.1 over the public Internet.						
6	Receivers must perform the role of an HTTP/S server; Senders must perform the role of an HTTP/S client.						
7	All information exchanged between the client and server is encrypted by a session-level private key negotiated at						

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	connection time.						
	Real Time Requests (§4.2.3)						
8	Real Time requests must include a single inquiry or submission as specified in the transaction's corresponding CAQH CORE Infrastructure Rule.						
	Batch Submission (§4.2.4)						
9	Batch requests are sent in the same way as Real Time requests.						
10	Response must be only the standard HTTP message indicating whether the request was accepted or rejected.						
11	Message receivers must not respond to a batch submission with an ASC X12 response such as a 5010 X12 999 in the HTTP response to the batch request, even if their systems' capabilities allow such a response.						
12	All ASC X12 responses must be available for pick up by the message sender (client) in accordance with the respective CAQH CORE Infrastructure Rule for the transaction.						
	Batch Response Pickup (§4.2.5)						
13	Batch responses must be picked up after the message receiver has had a chance to process a Batch submission in the timeframes specified in the transaction's corresponding CAQH CORE Infrastructure Rule.						
	Error Handling (§4.2.6)						
14	The appropriate HTTP error or status codes and SOAP Faults as applicable to the error/status situation must be used.						
	Tracking of Date and Time and Payload ID (§4.2.8)						
15	Servers are required to track the times of any received inbound messages, and respond with the outbound message						

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	for that Payload ID.						
16	Clients must include the date and time the message was sent in the CORE metadata element Time Stamp.						
	Capacity Plan (§4.2.9.1, §4.2.9.2)						
17	A HIPAA-covered entity or its agent's messaging system must have a capacity plan such that it can receive and process a large number of single concurrent Real Time transactions via an equivalent number of concurrent connections which must be received, processed and the appropriate response provided within response time requirements specified in the transaction's corresponding CAQH CORE Operating Rule.						
18	A HIPAA-covered entity or its agent's messaging system must have the capability to receive and process large Batch transaction files which must be received, processed and the appropriate response provided within the time specified in the applicable CAQH CORE Operating Rule.						
	Response Time, Time Out Parameters, and Re-transmission (§4.2.10)						
19	If the HTTP Post Reply Message is not received within the 60 second response period, the client system should send a duplicate transaction no sooner than 90 seconds after the original attempt was sent.						
20	Client system should submit no more than 5 duplicate transactions within the next 15 minutes if no response is received after the second attempt.						
21	If the additional attempts result in the same timeout termination, the client system should notify the submitter to contact the receiver directly to determine if system availability problems exist or if there are known Internet traffic constraints causing the delay.						

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	Publication of Entity-Specific Connectivity Companion Document (§4.3)						
22	Servers must publish detailed specifications in a Connectivity Companion Document on the entity's public web site.						
	Envelope Metadata (§4.4.2)						
23	The Envelope Metadata specified in Table 4.4.2 pertains to the Message Envelope SOAP+WSDL. With the exception of *ErrorCode* and *ErrorMessage* fields, which are only sent in the response, the CAQH CORE required envelope metadata for the request and response are required to be identical.						
	Processing Mode (§4.4.3.1)						
24	A HIPAA-covered entity or its agent must support the transaction processing mode requirements specified in the *COREProcessingModePayloadTypeTables.docx* companion document when exchanging transactions in conformance with this CAQH CORE Connectivity Rule vC4.0.0.						
25	The Processing Mode requirements specified also apply when a HIPAA-covered entity or its agent are exchanging the transactions addressed by this rule using any other connectivity method as permitted by the CAQH CORE Safe Harbor.						
	Enumeration of Payload Type Fields (§4.4.3.2)						
26	A HIPAA-covered entity or its agent must support the requirements for identifying the payload (*PayloadType)* carried within the content of the Message Envelope as specified in the *COREProcessingModePayloadTypeTables.docx* companion document to this CAQH CORE Connectivity Rule v4.0.0						
	CAQH CORE REST Connectivity Rule vC4.0.0						
	API Interface Format Requirement (§5.1.1)						

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1	HIPAA-covered entities and their agent must use JavaScript Object Notation (JSON) for REST Interfaces.						
	Authentication Requirement (§5.1.2)						
2	Requires the use of X.509 Client Authentication (mutual authentication) over TLS 1.2 or higher.						
	Submitter Authorization Requirements (§4.1.2)						
3	Requires support for OAuth 2.0 Client Authorization over TLS 1.2 or higher						
	Transport Method (§5.2.1)						
4	HIPAA-covered entities and their agents must be able to implement HTTP/S Version 1.1 over the public internet.						
	Request and Response Handling (§5.2.2)						
5	Request and response handling for both Synchronous Real-time and Asynchronous Batch Process.						
	Error Handling (§5.2.6)						
6	Message receiver must notify the message sender if the request was successfully handled during the processing of HTTP headers and processing of the payload.						
	Tracking of Date and Time and Payload (§5.2.8)						
7	Servers are required to track the times of any received inbound messages and respond with the outbound message for that Payload.						
8	Clients must include the date and time the message was last modified.						

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	Capacity Plan (§5.2.9., §5.2.11)						
9	A HIPAA-covered entity or its agent's messaging system must have a capacity plan such that it can receive and process a large number of single concurrent Synchronous Real Time transactions via an equivalent number of concurrent connections which must be received, processed and the appropriate response provided within response time requirements specified in the transaction's corresponding CAQH CORE Operating Rule.						
10	A HIPAA-covered entity or its agent's messaging system must have the capability to receive and process large Batch transaction files which must be received, processed and the appropriate response provided within the time specified in the applicable CAQH CORE Operating Rule.						
	Specifications for REST API Uniform Resource Identifiers (URI) Paths (*§5.3.1, §5.3.2)*						
11	Servers are required to communicate the version of the CAQH CORE Connectivity Rule implemented and version of the REST API through the URI Path, per Table 5.3.1.						
12	Requires entities to use standard naming conventions for REST API endpoints to streamline and support uniform REST implementations.						
	REST HTTP Request Method Requirements (*§5.4)*						
13	Requires entities to use of HTTP Methods listed in Table 5.4 to indicate the desired action to be performed for a given resource.						
	REST HTTP Metadata, Descriptions, Intended Use and Values (§5.5)						

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14	Entities are required to use the metadata specified in Table 5.5 for HTTP Requests and HTTP Responses for REST Exchanges.						
	Publication of Entity-Specific Connectivity Companion Document (§5.7)						
15	Servers must publish detailed specifications in a Connectivity Companion Document on the entity's website.						