Eligibility & Benefits CAQH CORE Certification Test Suite
Version EB1.0
May 2020

Revision History for Eligibility & Benefits CAQH CORE Certification Test Suite

Version	Revision	Description	Date
1.0.0	Major	Phase I CORE Certification Test Suite balloted and approved by the CAQH CORE Voting Process.	July 2008
2.0.0	Major	Phase II CORE Certification Test Suite balloted and approved by the CAQH CORE Voting Process.	July 2008
1.1.0; 2.1.0	Major	Revised to support v5010	March 2011
EB1.0	Minor	• Non-substantive adjustments to support re-organization of operating rules into rule sets organized by business transaction (e.g., Eligibility & Benefits, Claim Status, etc.) rather than phase (e.g., Phase I, II, etc.) as approved by the CAQH CORE Board in 2019. • Operating rule naming, versioning and numbering methodologies updated to align with business transaction-based rule sets.	May 2020

Table of Contents

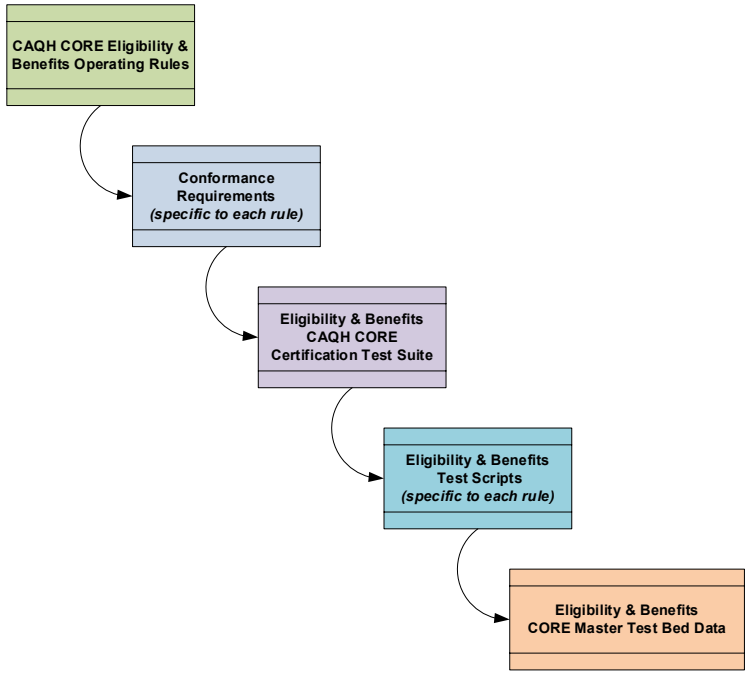
1. Introduction to Eligibility & Benefits CORE Certification Test Suite

1.1. Purpose of This Document

This CAQH CORE Certification Test Suite document contains all of the requirements that must be met in order for an entity seeking Eligibility & Benefits CORE Certification to be awarded an Eligibility & Benefits CORE Certification Seal. As such, this CAQH CORE Certification Test Suite includes:

- Two Master Scenarios describing the end-to-end eligibility information exchange process in non-technical language (see §1.2).
- The specific conformance requirements and detailed testing for each CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule and CAQH CORE Eligibility & Benefits (270/271) Data Content Rule (see §1.3, §1.4 and §3).
- The required CORE Certification Testing for each Rule, including specific detailed step-by-step test scripts by rule. (See §1.5 and §3 for each rule-specific testing requirements.)
- Guidance to help stakeholders better understand the various types of stakeholders to which the CAQH CORE Eligibility & Benefit Operating Rules apply and how to determine when a specific rule detailed test script applies is also included (see §1.4).
- An Appendix that contains the detailed Test Suite Supplement (see §4.1), which provides information and guidance about the Eligibility & Benefits CORE Master Test Bed Data, how the test data are made available, as well as loading and using the Master Test Bed Data. The Test Suite Supplement also includes specific instructions for certain test bed data elements that may be modified when loading and using the test data for certification testing

The figure below depicts the high-level parts of the testing process.



2. Applicability of This Document

The CAQH CORE Certification Test Suite must be used by all stakeholders undergoing Eligibility & Benefits CORE Certification Testing. This is required in order to maintain standard and consistent test results and CAQH CORE Eligibility & Benefits Operating Rule compliance. There are no exceptions to this requirement.

2.1. The Master Scenarios

The Eligibility & Benefits CAQH CORE Certification Test Suite uses two Master Scenarios (§2) to describe both the real time and batch business processes for end-to-end insurance verification/eligibility inquiries using business language, not technical specifications to the extent appropriate.

- Master Scenario #1: Single/Dual Clearinghouse Provider-to-Health Plan Model
- Master Scenario #2: Provider Direct to Health Plan Model

The overall business process for insurance verification/eligibility inquiry does not change from a business viewpoint for each CAQH CORE Eligibility & Benefits Operating Rule. Rather, each eligibility benefit operating rule addresses a critical interoperability activity/task within the common business process.

Using only two Master Scenarios for all rules simplifies rule test scenario development since the key variables for each rule will be only the actual conformance language of the rule, each test scenario's test objectives, assumptions, and detailed step-by-step test scripts.

2.2. Structure of Test Scenarios for all Rules

Each test scenario for each rule contains the following sections:

- Key Rule Requirements (the CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule and CAQH CORE Eligibility & Benefits (270/271) Data Content Rule documents contains the actual rule language and is the final authority for all rule requirements)
- Certification conformance requirements by rule
- Test assumptions by rule
- Detailed step-by-step test scripts addressing each conformance requirement by rule for each stakeholder to which the test script applies
- Each stakeholder may indicate that a specific test script does not apply to it and is required to provide a rationale for indicating a specific test script is not applicable (See §1.5.1 for guidance in determining when a specific test script may not apply).

2.3. Detailed Step-by-Step Test Scripts

2.3.1. Stakeholder Categories −Determining Test Script Applicability

The Detailed Step-by-Step Test Scripts for each rule specify which stakeholder type each test script applies to. The stakeholder categories are Provider, Health Plan, Clearinghouse, and Vendor.

Oftentimes Providers and Health Plans outsource various functions to Clearinghouses. In such cases, a specific Clearinghouse may be acting on behalf of either a Provider stakeholder or a Health Plan stakeholder. Thus, when establishing a testing profile with a CAQH CORE-authorized Testing Vendor a Clearinghouse may be asked to indicate if it is a Provider/Clearinghouse or a Health Plan/Clearinghouse. When a Provider/Clearinghouse role is selected, the Detailed Step-by-Step Test Scripts applicable to a Provider will apply to a Provider/Clearinghouse. Similarly, when a Health Plan/Clearinghouse role is selected, the Detailed Step-by-Step Test Scripts applicable to a Health Plan will apply to a Health Plan/Clearinghouse.

Vendor stakeholders must certify each specific product separate. Thus, when establishing a testing profile with a CAQH CORE-authorized Testing Vendor a vendor stakeholder will be given the option to indicate if the product being certified is a Provider/Vendor product or a Health Plan/Vendor product. The Detailed

Step-by-Step Test Scripts applicable to a Provider will apply to a Provider/Vendor product. Similarly, when a vendor stakeholder is certifying a Health Plan product, the Detailed Step-by-Step Test Scripts applicable to a Health Plan will apply to a Health Plan/Vendor product.

2.3.2. Guidance for Health Plans Seeking Eligibility & Benefits CORE Certification Who Work With an Eligibility & Benefits CORE-certified Clearinghouse

Health plans seeking Eligibility & Benefits CORE Certification that use a clearinghouse to send back eligibility responses to providers, and to receive eligibility inquiries from providers, may have some unique Eligibility & Benefits CORE Certification circumstances. Because there is a clearinghouse, or similar type of intermediary, between the health plan's eligibility system and the provider's eligibility system, the clearinghouse will act as a "proxy" for some of the CORE Certification requirements outlined in the Eligibility & Benefits CAQH Certification Test Suite. Therefore, dependent upon the scenario between the health plan and clearinghouse, the health plan may not have to undergo certification testing for some aspects of the rules, but rather choose the N/A option for each applicable test script. A rationale statement explaining the situation to the CAQH CORE-authorized Testing Vendor will be required to be uploaded for each test script for which the N/A option is chosen.

Reminder: There exist varying scenarios, outlined below for this type of situation. The requirements for meeting the CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule and CAQH CORE Eligibility & Benefits (270/271) Data Content Rule for clearinghouses and health plans differ by situation, as such variability is dependent on how the health plan interacts with the clearinghouse and what services (i.e., functions and capabilities) the clearinghouse provides to the health plan. Therefore, please keep in mind that certification testing will differ by scenario.

2.3.2.1. Clearinghouse receives and returns non-standard data with the health plan

Clearinghouse is responsible for meeting the CORE requirements, except for data content rule, which the health plan system must meet.

2.3.2.2. Clearinghouse receives and returns v5010 270/271 with health plans

Health plan is responsible for meeting the CORE requirements for all applicable rules. However, the clearinghouse may satisfy some requirements for response time and acknowledgements for some health plans, while other health plans will have complete systems capabilities for all CORE rules, and therefore will have to meet more rule requirements.

2.3.2.3. Clearinghouse provides eligibility query/response functions via an ASP (application services health plan)

Clearinghouse is responsible for meeting the CORE requirements for all CORE rules on behalf of the health plan.

2.4. Eligibility & Benefits CORE Certification Test Suite Supplement

The Test Suite Supplement (see Appendix) provides additional information and details about the use and format of the Eligibility & Benefits CORE Master Test Bed Data, as it applies to the CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Real Time and Batch Acknowledgement Requirements and the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule. The supplement is to be used in conjunction with the Eligibility & Benefits CAQH CORE Certification Test Suite. It does not replace any of the CAQH CORE Eligibility & Benefit Operating Rules and CORE Certification Policies but rather is intended to provide additional information and details regarding the use and format of the Eligibility & Benefits CORE Master Test Bed Data.

2.4.1. Master Test Bed

The scope of the Eligibility & Benefits CORE Master Test Bed Data is limited to data needed for entities seeking to become CORE-certified to create and populate their internal files and/or databases. These files and data are then used for internal pre-certification testing and CORE Certification Testing for the CORE rules that require transaction-based testing, e.g.:

- CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Real Time Acknowledgement Requirements
- CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Batch Acknowledgement Requirements
- CAQH CORE Eligibility & Benefits (270/271) Data Content Rule:

Thus, the CAQH CORE-authorized Testing Vendor only uses the Eligibility & Benefits CORE Master Test Bed Data to conduct CORE Certification Testing for the CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Real Time and Batch Acknowledgement Requirements and the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule. The scope of the test bed data is not intended to include all data that an entity may require in order to load their internal systems. Therefore, entities may need to add other data to the master test data when loading internal systems.

Since the CAQH CORE Eligibility & Benefit Operating Rules do not address the specific use and data content of the ISA and GS control segments, the Eligibility & Benefits CORE Master Test Bed Data does not contain nor specify specific values that must be used in these control segments.

Thus, the CAQH CORE-authorized Testing Vendor will be using only the Eligibility & Benefits CORE Master Test Bed Data to conduct CORE Certification Testing for the CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Real Time and Batch Acknowledgement Requirements and the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule .

The Eligibility & Benefits CORE Master Test Bed Data accompanies this Eligibility & Benefits CAQH CORE Certification Test Suite.

- All entities seeking Eligibility & Benefits CORE certification will be required to test against this Eligibility & Benefits CORE Master Test Bed Data.
- This data will be made available to all entities seeking CORE Certification for use of pre-certification internal self-testing.
- The Test Suite Supplement (see Appendix) should be used in accompaniment with the Eligibility & Benefits Master Test Bed Data.

2.4.1.1. Eligibility & Benefits CORE Master Test Bed Data

The Eligibility & Benefits CORE Master Test Bed Data is applicable only to the CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Real Time and Batch Acknowledgement Requirements and the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule; however, CORE Certification Testing related to these rules will be conducted using the same Eligibility & Benefits CORE Master Test Bed Data, thus ensuring reliable and consistent test results for all CAQH CORE-authorized Testing Vendors

The Eligibility & Benefits CORE Master Test Bed Data is comprised of beneficiaries (subscribers/dependents) and their associated health plan coverage. The Test Suite Supplement provides guidance about the Eligibility & Benefits CORE Master Test Bed Data. The Eligibility & Benefits CORE Master Test Bed Data is supplied only in an Excel spreadsheet format in a separate Excel Workbook. Although CORE Certification testing will use this Eligibility & Benefits CORE Master Test Bed Data as presented in the Excel spreadsheet format, the types of transactions that will be tested against this data are specified in the Eligibility & Benefits CAQH CORE Certification Test Suite under the Test Scripts for each of the rules.

The CAQH CORE Certification Test Suite requires that all organizations seeking Eligibility & Benefits CORE certification be tested using the same Eligibility & Benefits CORE Master Test Bed Data. The Eligibility & Benefits CORE Master Test Bed Data is distributed in Excel spreadsheet format so that organizations may easily extract the key data elements and load them into their internal test databases. The CAQH CORE-authorized Testing Vendor will only use the Eligibility & Benefits CORE Master Test Bed Data to conduct CORE Certification Testing for the CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Real Time and Batch Acknowledgement Requirements and the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule. Not all test beneficiaries (subscribers/dependents) and their associated health plans are used in CORE Certification Testing.

3. Master Test Scenarios

3.1. Introduction

This Master CORE Business Process Scenario describes both the real time and batch business processes for end-to-end insurance verification/eligibility inquiries using business language, not technical specifications to the extent appropriate, in which there are either one or two clearinghouses providing services to the healthcare provider and health plan or information source. Since the overall business process for insurance verification/eligibility inquiry does not fundamentally change from a business viewpoint, each CORE rule addresses a critical interoperability activity/task within the common business process. Thus, the focus for this scenario is on the EDI aspects of the overall end-to-end business process and not on attempting to describe all of the activities and tasks typically performed by each of the stakeholders in the process.

3.2. Single/Dual Clearinghouse Provider-to-Health Plan Business Model

3.2.1. Background

This scenario describes the healthcare insurance verification/eligibility end-to-end business process and the key activities and tasks conducted between a healthcare provider where each party uses the services of a healthcare clearinghouse. For purposes of CORE Certification Testing, stakeholders include providers, health plans, clearinghouses, switches, other intermediaries, and solution vendors.

Each stakeholder type is equipped with an automated system (the “system”) appropriate to its needs, e.g., a provider would have a hospital (or health) information system, commonly referred to as an HIS, or an automated practice management system (the “system”), commonly referred to as a PMS.

The “system” is defined as all of the components necessary for the stakeholder to conduct its automated business processes, e.g., all necessary network nodes, all platform components delivered by the vendor, and all the vendor components (e.g. documentation) included with the system. The system may consist of one or many workstations, servers and mainframe systems, and may include capture patient registration information at the point of patient intake (or scheduling) at the workstation if the stakeholder is a provider.

3.2.2. Eligibility Business Process Description

3.2.2.1. Appointment Scheduling Process

An appointment scheduler at the provider’s office is scheduling an appointment for either an office visit or admission (depending on the type of provider) for a patient in 2 weeks while on the phone with the patient. The scheduler inquires about the reason for the appointment, collects data from the patient following prompts on the workstation and enters all of the necessary information into the PMS/HIS.

When all of the necessary patient demographic and insurance information is entered, the scheduler is prompted to submit an insurance verification transaction by either a menu selection or by clicking an icon (as determined by the PMS/HIS vendor user interface design.)

The PMS/HIS automatically edits the eligibility transaction for completeness and valid data values where applicable and prompts the scheduler to correct any invalid or omitted data. When the transaction editing is completed, the PMS/HIS assigns a unique internal tracking number, records the identification and address of the workstation used by the scheduler, and creates the eligibility inquiry transaction.

Using internal tables/files, the PMS/HIS determines the Internet address for its clearinghouse, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the eligibility inquiry transaction, and establishes a communications session with the clearinghouse’s system. The eligibility inquiry transaction created by the PMS/HIS for transfer to its clearinghouse/switch may be either in a proprietary format or a fully enveloped ASC X12 Interchange containing the v5010 270 eligibility inquiry transaction set.

3.2.2.2. Provider Clearinghouse Real Time Eligibility Inquiry Process

The clearinghouse's Internet portal accepts the provider's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the eligibility inquiry transaction, which is then extracted and passed to the appropriate systems in the clearinghouse for further processing. The clearinghouse's system edits the eligibility transaction for completeness and valid data values where applicable. If the eligibility transaction fails editing, the clearinghouse returns to the provider an appropriate error message or acknowledgement describing the reasons for failure and rejection, thereby allowing the provider to correct and re-submit the eligibility transaction. Such error message or acknowledgement may be either a proprietary or valid ASC X12 Acknowledgement, depending on the type and range of services the clearinghouse is providing.

Using internal tables/files and/or an external directory service, the clearinghouse system determines the Internet address for the clearinghouse serving the health plan specified in the provider's eligibility inquiry transaction, creates and envelopes the complete ASC X12 Interchange containing the v5010 270 inquiry, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the ASC X12 v5010 270 Interchange, and establishes a communications session with the health plan's clearinghouse. Depending on the range and type of services being provided to the provider by the clearinghouse, the clearinghouse may or may not have responsibility for creating the correct ASC X12 Interchange containing the v5010 270 Eligibility inquiry or for performing other data validation/transformation and/or editing functions prior to forwarding the eligibility inquiry to either the health plan or the health plan's clearinghouse. Upon successful transfer of the ASC X12 v5010 270 Interchange to the health plan's clearinghouse, the provider's clearinghouse maintains the communications session open and active until receipt of either a ASC X12 v5010 999 or ASC X12 v5010 271 Interchange from the health plan's clearinghouse.[1]

If the ASC X12 v5010 270 Interchange fails the ASC X12 v5010 TR3 implementation guide verification at the health plan's clearinghouse, the provider's clearinghouse receives the 999 Implementation Acknowledgement indicating the acceptance or rejection of the Functional Group, extracts/reformats the acknowledgement and takes appropriate action to resolve the any errors indicated or the rejection. This may be by returning it to the provider's PMS/HIS or correcting the errors within the clearinghouse.

When the ASC X12 v5010 271 eligibility response transaction is received from the health plan's clearinghouse, the clearinghouse's Internet portal records the message receipt date/time, assigns an internal tracking number to the message linked to the ASC X12 v5010 271 Interchange, returns a signal to the health plan's clearinghouse that the ASC X12 v5010 271 Interchange payload has been successfully stored into persistent storage, and passes the ASC X12 v5010 271 Interchange to the clearinghouse's EDI management system for further processing. The clearinghouse's EDI management system processes (validates) the ASC X12 v5010 271 Interchange which may contain either a v5010 271 with AAA Validation Request rejection/error codes or a v5010 271 with the requested benefit data. The EDI management system extracts the v5010 271 response data, creates the required eligibility response transaction required by the provider's PMS/HIS (may be either a proprietary or valid ASC X12 v5010 271 Interchange), and transfers the eligibility response transaction to the provider's PMS/HIS.

3.2.2.3. Health Plan Clearinghouse Real Time Eligibility Inquiry Process

The health plan's clearinghouse Internet portal accepts the provider's clearinghouse's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the ASC X12 v5010 270 Interchange, returns a signal to the provider's clearinghouse that the ASC X12 v5010 270 Interchange payload has been successfully stored into persistent storage, and passes the ASC X12 v5010 270 Interchange to the clearinghouse's EDI management system for further processing. The clearinghouse's EDI management system, processes (validates) the ASC X12 v5010 270 Interchange.

If the ASC X12 v5010 270 Interchange passes ASC X12 v5010 TR3 implementation guide verification, the EDI management system extracts the eligibility inquiry data from the 270 transaction set, creates the required internal eligibility inquiry transaction required by the health plan. Using internal tables/files and/or an external directory service, the clearinghouse system determines the Internet address for the health plan specified in the provider's eligibility inquiry transaction, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the eligibility inquiry transaction, and establishes a

[1] Alternatively, a single clearinghouse may be serving both the provider and the health plan to which the eligibility inquiry transaction is to be transmitted. In this case, the single clearinghouse would not only perform the reformatting of non-standard data and non-standard format received from the provider into the HIPAA-adopted standard, but would then perform the reformatting of the standard data and standard format into non-standard data and non-standard format required by the health plan. A similar set of functions would be performed when processing the eligibility response transaction received from the health plan. See Health Plan Clearinghouse Real Time Eligibility Inquiry Process section in this document for a complete description of this process.

communications session with the health plan if such a communications link is not already open and active. Upon successful transfer of the eligibility inquiry transaction to the health plan, the clearinghouse maintains the communication session open and active pending receipt of the eligibility response transaction from the health plan.

If the ASC X12 v5010 270 Interchange fails ASC X12 v5010 TR3 implementation guide verification, the EDI management system automatically generates the v5010 999 Implementation Acknowledgement indicating the acceptance or rejection of the Functional Group, returns the acceptance or rejection acknowledgement to the provider's clearinghouse, terminates the communications session (if necessary) and discontinues any further processing of the inquiry transaction.

When the eligibility response transaction is received from the health plan, the clearinghouse's EDI management system edits the eligibility response data for correctness and completeness, creates the ASC X12 Interchange containing the v5010 271 eligibility response, passes the ASC X12 v5010 271 Interchange to the open communications session which returns the ASC X12 v5010 271 Interchange to the provider's clearinghouse. The ASC X12 v5010 271 Interchange may contain either a v5010 271 with AAA Validation Request rejection/error codes or a v5010 271 with the requested benefit data.

3.2.2.4. Health Plan Real Time Eligibility Inquiry Process

The health plan's Internet portal accepts the clearinghouse's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the eligibility inquiry transaction, which is then extracted and passed to the health plan's eligibility inquiry system for processing. The eligibility system accesses all of the necessary internal data stores (files, databases, etc.) to process the eligibility inquiry transaction to determine the benefits and status of coverage for the individual identified in the inquiry. The data is then assembled and routed to the health plan's clearinghouse. When the clearinghouse signals successful receipt of the eligibility response transaction to the health plan's system, the communications session may be terminated or maintained open and active as determined between the health plan and its clearinghouse.

3.2.2.5. Provider Real Time Eligibility Response Process

The provider's PMS/HIS receives the eligibility response transaction from its clearinghouse, records the message receipt date/time, assigns an internal tracking number to the message linked to the eligibility response transaction, and matches the tracking number, message receipt date/time to the corresponding eligibility inquiry transaction. The PMS/HIS then processes (validates) the eligibility response transaction, which is routed to the correct workstation for display to the scheduler.

If the eligibility response transaction indicates the inquiry was rejected, the PMS/HIS displays the reasons for such rejection, enabling the scheduler to resolve the rejection by obtaining corrected data as indicated from the patient during the initial appointment/admission scheduling phone call. The PMS/HIS then resubmits the corrected eligibility inquiry.

If the eligibility response transaction contains the requested benefit coverage, benefit status, and patient financial responsibility information, the PMS/HIS displays the benefit information, enabling the scheduler to confirm the benefit coverage and status with the patient and to inform the patient of any co-pay, co-insurance, or deductible amounts during the initial appointment/admission scheduling phone call.

The provider's scheduler then confirms the date and time of the appointment/admission with the patient, reminds the patient of any information required at the time of the appointment/admission and concludes the phone call with the patient.

3.2.2.6. Provider Pre-Appointment Batch Eligibility Process

On a daily basis the provider's PMS/HIS automatically scans all scheduled appointments/admissions for two days in advance of the current date, extracts all of the necessary data, creates one or more batches of eligibility inquiries for each health plan covering the patient appointments/admissions for that date, assigns unique internal tracking numbers and records the date/time for each batch.

Using internal tables/files and/or an external directory service, the PMS/HIS determines the Internet address for each health plan, envelopes the complete ASC X12 Interchange containing the batch of v5010 270 inquiries for each health plan, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the correct batch ASC X12 v5010 270 Interchange, establishes a communications session with each health plan's system and

transfers the batch of eligibility inquiry transactions in either a proprietary non-standard format or ASC X12 v5010 270 Interchange to its clearinghouse for transmission to the health plan's clearinghouse prior to 9:00 pm ET, the daily cut-off time for batch submissions.

3.2.2.7. Provider Clearinghouse Batch Eligibility Inquiry Process

The clearinghouse's Internet portal accepts the provider's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the eligibility inquiry transaction, which is then extracted and passed to the appropriate systems in the clearinghouse for further processing. The clearinghouse's system edits the eligibility transaction for completeness and valid data values where applicable. If the eligibility transaction fails editing, the clearinghouse returns to the provider an appropriate error message or acknowledgement describing the reasons for failure and rejection, thereby allowing the provider to correct and re-submit the eligibility transaction. Such error message or acknowledgement may be either a proprietary or valid ASC X12 Acknowledgement, depending on the type and range of services the clearinghouse is providing.

Using internal tables/files and/or an external directory service, the clearinghouse system determines the Internet address for the clearinghouse serving the health plan specified in the provider's eligibility inquiry transaction, creates and envelopes the complete ASC X12 Interchange containing the v5010 270 inquiry, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the ASC X12 v5010 270 Interchange, and establishes a communications session with the health plan's clearinghouse. Depending on the range and type of services being provided to the provider by the clearinghouse, the clearinghouse may or may not have responsibility for creating the correct ASC X12 Interchange containing the v5010 270 Eligibility inquiry or for performing other data validation/transformation and/or editing functions prior to forwarding the eligibility inquiry to either the health plan or the health plan's clearinghouse. Upon successful transfer of the ASC X12 v5010 270 Interchange to the health plan's clearinghouse, the provider's clearinghouse either terminates (if necessary) or maintains the communications session open and active until receipt of either a ASC X12 v5010 999 or ASC X12 v5010 271 Interchange from the health plan's clearinghouse.[2]

If the ASC X12 v5010 270 Interchange fails ASC X12 v5010 TR3 implementation guide verification at the health plan's clearinghouse, the provider's clearinghouse receives the v5010 999 Implementation Acknowledgement indicating the acceptance or rejection of the Functional Group, extracts/reformats the acceptance or rejection acknowledgement and takes appropriate action to resolve errors indicated or the rejection. This may be by returning it to the provider's PMS/HIS or correcting the errors within the clearinghouse.

When the ASC X12 v5010 271 eligibility response transaction is received from the health plan's clearinghouse, the clearinghouse's Internet portal records the message receipt date/time, assigns an internal tracking number to the message linked to the ASC X12 v5010 271 Interchange, returns a signal to the health plan's clearinghouse that the ASC X12 v5010 271 Interchange payload has been successfully stored into persistent storage, and passes the ASC X12 v5010 271 Interchange to the clearinghouse's EDI management system for further processing. The clearinghouse's EDI management system processes (validates) the ASC X12 v5010 271 Interchange which may contain either a v5010 271 with AAA Validation Request rejection/error codes or a v5010 271 with the requested benefit data. The EDI management system extracts the v5010 271 response data, creates the required eligibility response transaction required by the provider's PMS/HIS (may be either a proprietary or valid ASC X12 v5010 271 Interchange), and transfers the eligibility response transaction to the provider's PMS/HIS.

3.2.2.8. Health Plan Clearinghouse Batch Eligibility Inquiry Process

The health plan's clearinghouse Internet portal accepts the provider's clearinghouse's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the ASC X12 v5010 270 Interchange, returns a signal to the provider's clearinghouse that the ASC X12 v5010 270 Interchange payload has been successfully stored into persistent storage, and passes the ASC X12 v5010 270 Interchange to the clearinghouse's EDI management system for further processing. The clearinghouse's EDI management system, processes (validates) the ASC X12 v5010 270 Interchange.

---

[2] Alternatively, a single clearinghouse may be serving both the provider and the health plan to which the eligibility inquiry transaction is to be transmitted. In this case, the single clearinghouse would not only perform the reformatting of non-standard data and non-standard format received from the provider into the HIPAA-adopted standard, but would then perform the reformatting of the standard data and standard format into non-standard data and non-standard format required by the health plan. A similar set of functions would be performed when processing the eligibility response transaction received from the health plan. See Health Plan Clearinghouse Real Time Eligibility Inquiry Process section in this document for a complete description of this process.

Upon completion of the verification of ASC X12 v5010 270 Interchange against the ASC X12 v5010 TR3 implementation guide, the EDI management system automatically generates the v5010 999 Implementation Acknowledgement indicating acceptance of the Functional Group, returns the ASC X12 v5010 999 Interchange to the provider's clearinghouse, extracts the eligibility inquiry data from the v5010 270 transaction set, and creates the required internal eligibility inquiry transactions required by the health plan.

Using internal tables/files and/or an external directory service, the clearinghouse system determines the Internet address for the health plan specified in the provider's eligibility inquiry transaction, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the eligibility inquiry transaction, and establishes a communications session with the health plan if such a communications link is not already open and active. Upon successful transfer of the eligibility inquiry transactions to the health plan, the clearinghouse either terminates (if necessary) or maintains the communication session open and active pending receipt of the eligibility response transactions from the health plan.

If the ASC X12 v5010 270 Interchange fails ASC X12 v5010 TR3 implementation guide verification, the EDI management system automatically generates the v5010 999 Implementation Acknowledgement indicating rejection of the Functional Group, returns the ASC X12 v5010 999 Interchange to the provider's clearinghouse, terminates the communications session (if necessary) and discontinues any further processing of the inquiry transaction.

When the eligibility response transactions are received from the health plan, the clearinghouse's EDI management system edits the eligibility response data for correctness and completeness, creates the ASC X12 Interchange containing the v5010 271 eligibility responses, passes the ASC X12 v5010 271 Interchange to the communications module which returns the ASC X12 v5010 271 Interchange to the provider's clearinghouse. The ASC X12 v5010 271 Interchange may contain either a v5010 271 with AAA Validation Request rejection/error codes or a v5010 271 with the requested benefit data.

3.2.2.9. Health Plan Batch Eligibility Inquiry Process

The health plan's Internet portal accepts the provider's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the batch ASC X12 v5010 270 Interchange, which is then extracted and passed to the health plan's EDI management system for further processing. The health plan's Internet portal returns the correct HTTP message accepted code to the provider's PMS/HIS and terminates the communications session.

The health plan's EDI management system, processes (validates) the batch ASC X12 v5010 270 Interchange. If the batch ASC X12 v5010 270 Interchange fails ASC X12 TR3 implementation guide verification, the EDI management system automatically generates the 999 Implementation Acknowledgement indicating the rejection of the Functional Group, stages the rejection acknowledgement for subsequent retrieval by the provider's PMS/HIS, and discontinues any further processing of the batch ASC X12 v5010 270 Interchange.

If the batch ASC X12 v5010 270 Interchange passes ASC X12 v5010 TR3 implementation guide ~~syntax~~ verification, the EDI management system automatically generates the 999 Implementation Acknowledgement indicating the acceptance of the ASC X12 v5010 270 Functional Group, and stages the acceptance acknowledgement for subsequent retrieval by the provider's PMS/HIS.

The EDI management system extracts the eligibility inquiry data from the 270 transaction set, creates the required internal inquiry transaction(s) which are routed to the eligibility system for processing. The eligibility system accesses all of the necessary internal data stores (files, databases, etc.) to process the eligibility inquiries to determine the benefits and status of coverage for each of the individuals identified in the inquiries. The data is then assembled and routed to the health plan's EDI management system.

The EDI management system edits the eligibility response data for correctness and completeness, creates the batch(es) ASC X12 Interchange containing the v5010 271 eligibility responses, stages the batch(es) ASC X12 v5010 271 Interchange for subsequent retrieval by the provider's PMS/HIS.

3.2.2.10. Provider's Pre-Appointment Batch Eligibility Response Process

Two hours after transferring the batch ASC X12 v5010 270 Interchange to the health plan's Internet portal, the provider's PMS/HIS establishes a communications session with each health plan's system, requests either a list of available files for retrieval or specific file(s). Specific file(s) may be either an ASC X12 v5010 999 or an ASC X12 v5010 271 Interchange or any combination of these. The health plan's Internet portal responds appropriately to the provider's PMS/HIS request. The provider's PMS/HIS then retrieves the requested and/or available file(s), records the message receipt date/time, assigns internal tracking number(s) to the

message and retrieved file(s) linked to the ASC X12 Interchange(s), and matches the tracking number, message receipt date/time to the corresponding ASC X12 v5010 270 Interchange. The PMS/HIS then processes (validates) the ASC X12 Interchange(s) retrieved.

If the batch ASC X12 v5010 271 Interchange fails ASC X12 TR3 implementation guide verification, the PMS/HIS generates an ASC X12 v5010 999 rejection interchange, establishes a communication session with the appropriate health plan's Internet portal and transfers the ASC X12 v5010 999 interchange to the health plan. The PMS/HIS also generates a notice to the provider's appropriate internal support staff for problem resolution following established internal procedures.

If the ASC X12 v5010 271 Interchange passes ASC X12 v5010 TR3 implementation guide verification, the PMS/HIS extracts the eligibility response data from the v5010 271 transaction set, creates the required internal eligibility response transaction(s) which are routed to the correct workstation for analysis and processing by the designated support staff.

If the v5010 271 eligibility response transaction indicates the inquiry was rejected or that the benefit coverage or status has changed from the earlier inquiry, the PMS/HIS displays the new information, enabling the support staff to contact the patient prior to the appointment/admission to resolve the variances by obtaining corrected data. The PMS/HIS then resubmits the corrected eligibility inquiry.

If the v5010 271 eligibility response transaction contains the requested benefit coverage, benefit status, and patient financial responsibility information, the PMS/HIS displays the benefit information, enabling the support staff to re-confirm the appointment/admission with the patient in advance and remind the patient of any information to bring to the appointment/admission and of any payment responsibilities.

3.3. Provider Direct-to-Health Plan Business Model

3.3.1. Background

This scenario describes the healthcare insurance verification/eligibility end-to-end business process and the key activities and tasks conducted between a healthcare provider connecting directly to a health plan. For purposes of CORE Certification Testing, stakeholders include providers, health plans, clearinghouses, switches, other intermediaries, and solution vendors.

Each stakeholder type is equipped with an automated system (the "system") appropriate to its needs, e.g., a provider would have a hospital (or health) information system, commonly referred to as an HIS, or an automated practice management system (the "system"), commonly referred to as a PMS.

The "system" is defined as all of the components necessary for the stakeholder to conduct its automated business processes, e.g., all necessary network nodes, all platform components delivered by the vendor, and all the vendor components (e.g. documentation) included with the system. The system may consist of one or many workstations, servers and mainframe systems, and may include capture patient registration information at the point of patient intake (or scheduling) at the workstation if the stakeholder is a provider.

3.3.2. Eligibility Business Process Description

3.3.2.1. Appointment Scheduling Process

An appointment scheduler at the provider's office is scheduling an appointment for either an office visit or admission (depending on the type of provider) for a patient in 2 weeks while on the phone with the patient. The scheduler inquiries about the reason for the appointment, collects data from the patient following prompts on the workstation and enters all of the necessary information into the PMS/HIS.

When all of the necessary patient demographic and insurance information is entered, the scheduler is prompted to submit an insurance verification transaction by either a menu selection or by clicking an icon (as determined by the PMS/HIS vendor user interface design.)

The PMS/HIS automatically edits the eligibility transaction for completeness and valid data values where applicable and prompts the scheduler to correct any invalid or omitted data. When the transaction editing is completed, the PMS/HIS assigns a unique internal tracking number, records the identification and address of the workstation used by the scheduler, and creates the eligibility inquiry transaction.

Using internal tables/files and/or an external directory service, the PMS/HIS determines the Internet address for the health plan identified by the patient, creates and envelopes the complete ASC X12 Interchange containing the v5010 270 inquiry, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the ASC X12 v5010 270 Interchange, and establishes a communications session with the health plan's system.

3.3.2.2. Health Plan Real Time Eligibility Inquiry Process

The health plan's Internet portal accepts the provider's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the ASC X12 v5010 270 Interchange, which is then extracted and passed to the health plan's EDI management system for further processing. The health plan's EDI management system, processes (validates) the ASC X12 v5010 270 Interchange.

If the ASC X12 v5010 270 Interchange fails ASC X12 TR3 implementation guide verification, the EDI management system automatically generates the v5010 999 Implementation Acknowledgement indicating the rejection of the Functional Group, returns the rejection acknowledgement to the provider, terminates the communications session and discontinues any further processing of the inquiry transaction.

If the ASC X12 v5010 270 Interchange passes ASC X12 v5010 TR3 implementation guide verification, the EDI management system extracts the eligibility inquiry data from the v5010 270 transaction set, creates the required internal inquiry transaction which is routed to the eligibility system for processing. The eligibility system accesses all of the necessary internal data stores (files, databases, etc.) to process the eligibility inquiry to determine the benefits and status of coverage for the individual identified in the inquiry. The data is then assembled and routed to the health plan's EDI management system.

The EDI management system edits the eligibility response data for correctness and completeness, creates the ASC X12 Interchange containing the v5010 271 eligibility response, passes the ASC X12 v5010 271 Interchange to the open communications session which returns the ASC X12 v5010 271 Interchange to the provider's PMS/HIS. The health plan's Internet portal then terminates the communications session upon successful transfer of the ASC X12 v5010 271 Interchange to the provider's system. The ASC X12 v5010 271 Interchange may contain either a v5010 271 with AAA Validation Request Validation Request rejection/error codes or a v5010 271 with the requested benefit data.

3.3.2.3. Provider's Real Time Eligibility Response Process

The provider's PMS/HIS receives the ASC X12 v5010 271 Interchange from the health plan, records the message receipt date/time, assigns an internal tracking number to the message linked to the ASC X12 v5010 271 Interchange, and matches the tracking number, message receipt date/time to the corresponding ASC X12 v5010 270 Interchange. The PMS/HIS then processes (validates) the ASC X12 v5010 271 Interchange.

If the ASC X12 v5010 271 Interchange fails ASC X12 TR3 implementation guide verification, the PMS/HIS generates a notice to the provider's appropriate internal support staff for problem resolution following established internal procedures. No rejection acknowledgement is returned to the health plan.

If the ASC X12 v5010 271 Interchange passes ASC X12 v5010 TR3 implementation guide verification, the PMS/HIS extracts the eligibility response data from the v5010 271 transaction set, creates the required internal eligibility response transaction which is routed to the correct workstation for display to the scheduler.

If the v5010 271 eligibility response transaction indicates the inquiry was rejected, the PMS/HIS displays the reasons for such rejection, enabling the scheduler to resolve the rejection by obtaining corrected data as indicated from the patient during the initial appointment/admission scheduling phone call. The PMS/HIS then resubmits the corrected eligibility inquiry.

If the v5010 271 eligibility response transaction contains the requested benefit coverage, benefit status, and patient financial responsibility information, the PMS/HIS displays the benefit information, enabling the scheduler to confirm the benefit coverage and status with the patient and to inform the patient of any co-pay, co-insurance, or deductible amounts during the initial appointment/admission scheduling phone call.

The provider's scheduler then confirms the date and time of the appointment/admission with the patient, reminds the patient of any information required at the time of the appointment/admission and concludes the phone call with the patient.

3.3.2.4. Provider's Pre-Appointment Batch Eligibility Process

On a daily basis the provider's PMS/HIS automatically scans all scheduled appointments/admissions for two days in advance of the current date, extracts all of the necessary data, creates one or more batches of eligibility inquiries for each health plan covering the patient appointments/admissions for that date, assigns unique internal tracking numbers and records the date/time for each batch.

Using internal tables/files and/or an external directory service, the PMS/HIS determines the Internet address for each health plan, envelopes the complete ASC X12 Interchange containing the batch of v5010 270 inquiries for each health plan, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the correct batch ASC X12 v5010 270 Interchange, establishes a communications session with each health plan's system and transfers the batch ASC X12 v5010 270 Interchange to the health plan.

3.3.2.5. Health Plan Batch Eligibility Inquiry Process

The health plan's Internet portal accepts the provider's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the batch ASC X12 v5010 270 Interchange, which is then extracted and passed to the health plan's EDI management system for further processing. The health plan's Internet portal returns the correct HTTP message accepted code to the provider's PMS/HIS and terminates the communications session.

The health plan's EDI management system, processes (validates) the batch ASC X12 v5010 270 Interchange. If the batch ASC X12 v5010 270 Interchange fails ASC X12 TR3 implementation guide verification, the EDI management system automatically generates the v5010 999 Implementation Acknowledgement indicating the rejection of the Functional Group, stages the rejection acknowledgement for subsequent retrieval by the provider's PMS/HIS, and discontinues any further processing of the batch ASC X12 v5010 270 Interchange.

If the batch ASC X12 v5010 270 Interchange passes ASC X12 v5010 TR3 implementation guide verification, the EDI management system automatically generates the v5010 999 Implementation Acknowledgement indicating the acceptance of the ASC X12 v5010 270 Functional Group, and stages the acceptance acknowledgement for subsequent retrieval by the provider's PMS/HIS.

The EDI management system extracts the eligibility inquiry data from the v5010 270 transaction set, creates the required internal inquiry transaction(s) which are routed to the eligibility system for processing. The eligibility system accesses all of the necessary internal data stores (files, databases, etc.) to process the eligibility inquiries to determine the benefits and status of coverage for each of the individuals identified in the inquiries. The data is then assembled and routed to the health plan's EDI management system.

The EDI management system edits the eligibility response data for correctness and completeness, creates the batch(es) ASC X12 Interchange containing the v5010 271 eligibility responses, stages the batch(es) ASC X12 v5010 271 Interchange for subsequent retrieval by the provider's PMS/HIS.

3.3.2.6. Provider's Pre-Appointment Batch Eligibility Response Process

Two hours after transferring the batch ASC X12 v5010 270 Interchange to the health plan's Internet portal, the provider's PMS/HIS establishes a communications session with each health plan's system, requests either a list of available files for retrieval or specific file(s). Specific file(s) may be either an ASC X12 v5010 999 an ASC X12 v5010 271 Interchange or any combination of these. The health plan's Internet portal responds appropriately to the provider's PMS/HIS request. The provider's PMS/HIS then retrieves the requested and/or available file(s), records the message receipt date/time, assigns internal tracking number(s) to the message and retrieved file(s) linked to the ASC X12 Interchange(s), and matches the tracking number, message receipt date/time to the corresponding ASC X12 v5010 270 Interchange. The PMS/HIS then processes (validates) the ASC X12 Interchange(s) retrieved.

If the batch ASC X12 v5010 271 Interchange fails ASC X12 TR3 implementation guide verification, the PMS/HIS generates an ASC X12 v5010 999 rejection interchange, establishes a communication session with the appropriate health plan's Internet portal and transfers the ASC X12 v5010 999 interchange to the health plan. The PMS/HIS also generates a notice to the provider's appropriate internal support staff for problem resolution following established internal procedures.

If the ASC X12 v5010 271 Interchange passes ASC X12 v5010 TR3 implementation guide verification, the PMS/HIS extracts the eligibility response data from the v5010 271 transaction set, creates the required internal eligibility response transaction(s) which are routed to the correct workstation for analysis and processing by the designated support staff.

If the v5010 271 eligibility response transaction indicates the inquiry was rejected or that the benefit coverage or status has changed from the earlier inquiry, the PMS/HIS displays the new information, enabling the support staff to contact the patient prior to the appointment/admission to resolve the variances by obtaining corrected data. The PMS/HIS then resubmits the corrected eligibility inquiry.

If the v5010 271 eligibility response transaction contains the requested benefit coverage, benefit status, and patient financial responsibility information, the PMS/HIS displays the benefit information, enabling the support staff to re-confirm the appointment/admission with the patient in advance and remind the patient of any information to bring to the appointment/admission and of any payment responsibilities.

4. Test Scenarios by Rule

The following sections cover certification testing requirements specific to the CAQH CORE Eligibility & Benefits Operating Rules:

- CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule
- CAQH CORE Eligibility & Benefits (270/271) Data Content Rule

4.1. CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Batch Acknowledgement Requirements Test Scenario

4.1.1. Key Rule Requirements

Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.

Requires that

1. A v5010 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 (§3)
2. A v5010 999 must ALWAYS be returned if there are no errors in the Functional Group and enclosed Transaction Set (§3)
3. A v5010 271 eligibility response transaction must ALWAYS be returned for an Interchange, Functional Group and Transaction Set that complies with ASC X12 TR3 implementation guide requirements (§3)
4. A v5010 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. (§3)
5. A v5010 999 must not be returned during the initial communications session in which the 270 batch is submitted (§3)

4.1.2. Conformance Testing Requirements

These scenarios test the following conformance requirements of the CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Batch Acknowledgement Requirements. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario.

1. A v5010 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
    a. A v5010 999 must ALWAYS be returned if there are no errors in the Functional Group and enclosed Transaction Set
2. A v5010 271 eligibility response transaction must ALWAYS be returned for an Interchange, Functional Group and Transaction Set that complies with ASC X12 v5010 TR3 implementation guide requirements
    a. A v5010 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.

4.1.3. Test Scripts Assumptions

1. All communications sessions and logon's are valid, no error conditions are created or encountered.
2. Test scripts will test ONLY for valid and invalid ASC X12 Interchange, Functional Group, Transaction Set and will not test for v5010 271 data content
3. Test scripts will test the following error conditions:
   a. Invalid ASC X12 Interchange (ISA control number match error)
   b. Invalid Functional Group (GS/GE control number match error)
   c. Invalid Transaction Set (missing required segment)
4. Test scripts will test the following valid conditions
   a. Valid ASC X12 Interchange Control Segments
   b. Valid Functional Group Control Segments
   c. Valid ASC X12 v5010 Transaction Set
5. The test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

4.1.4. Detailed Step-By-Step Test Script

REMINDER: CORE Certification Testing is not exhaustive. The CAQH CORE Certification Test Suite does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

NOTE: The references in parentheses after each test scripts are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the "Stakeholder" column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[3]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[4]
1.	A v5010 999 is returned on an invalid Functional Group.	An ASC X12 Interchange containing only a v5010 999 IA.		☐ Pass	☐ Fail	☒	☒	☒	☒	☐
2.	A v5010 999 is returned on a ASC valid ASC X12 Interchange.	An ASC X12 Interchange containing only a v5010 999.		☐ Pass	☐ Fail	☒	☒	☒	☒	☐
3.	A v5010 271 Eligibility Response transaction set is always returned for a valid 270 Eligibility Inquiry Transaction set.	An ASC X12 Interchange is returned containing only a v5010 271 transaction set.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

[3] A checkmark in the box indicates the stakeholder type to which the test applies.

[4] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

4.2. CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Real Time Acknowledgement Requirements Test Scenario

4.2.1. Key Rule Requirements

Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.

Requires that

1. A v5010 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)
2. A v5010 999 must NOT be returned if there are no errors in the Functional Group and enclosed Transaction Set (§2)
3. A v5010 271 eligibility response transaction must ALWAYS be returned for an Interchange, Functional Group and Transaction Set that complies with ASC X12 TR3 implementation guide requirements (§2)
4. A v5010 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. (§2)

4.2.2. Conformance Testing Requirements

These scenarios test the following conformance requirements of the CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Real Time Acknowledgement Requirements. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario.

1. A v5010 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 999 must NOT be returned if there are no errors in the Functional Group and enclosed Transaction Set
3. A v5010 271 eligibility response transaction must ALWAYS be returned for an Interchange, Functional Group and Transaction Set that complies with ASC X12 v5010 TR3 implementation guide requirements
4. A v5010 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.

4.2.3. Test Scripts Assumptions

1. All communications sessions and logon's are valid; no error conditions are created or encountered.
2. Test scripts will test ONLY for valid and invalid ASC X12 Interchange, Functional Group, Transaction Set and will not test for v5010 271 data content
3. Test scripts will test the following error conditions:
   a. Invalid ASC X12 Interchange (ISA control number match error)
   b. Invalid Functional Group (GS/GE control number match error)
   c. Invalid Transaction Set (missing required segment)
4. Test scripts will test the following valid conditions
   a. Valid ASC X12 Interchange Control Segments
   b. Valid Functional Group Control Segments
   c. Valid ASC X12 v5010 Transaction Set
5. The test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

4.2.4. Detailed Step-By-Step Test Script

REMINDER: CORE Certification Testing is not exhaustive. The CAQH CORE Certification Test Suite does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

NOTE: The references in parentheses after each test scripts are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the "Stakeholder" column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[5]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[6]
1.	A v5010 999 is returned on an invalid Functional Group.	An ASC X12 Interchange containing only a v5010 999 IA.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	A v5010 999 is not returned on a valid ASC X12 Interchange.	No v5010 999 is returned.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
3.	A v5010 271 Eligibility Response transaction set is always returned for a valid v5010 270 Eligibility Inquiry Transaction set.	An ASC X12 Interchange is returned containing only a v5010 271 transaction set.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

[5] A checkmark in the box indicates the stakeholder type to which the test applies.

[6] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

4.3. CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Companion Guide Requirements Test Scenario

4.3.1. Key Rule Requirements

Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.

All CORE-certified entities' Companion Guides covering the v5010 270/271 eligibility inquiry and response transactions must follow the format/flow as defined in the CAQH CORE Master Companion Guide Template for HIPAA Transactions.

This rule does not require any CORE-certified entity to modify any other existing companion guides that cover other HIPAA-adopted transaction implementation guides.

4.3.2. Conformance Testing Requirements

These scenarios test the following conformance requirements of the CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Companion Guide Requirements. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario.

Submission to an authorized CAQH CORE-authorized Testing Vendor the following

1. A copy of the table of contents of its official v5010 270/271 companion document
2. A copy of a page of its official v5010 270/271 companion document depicting its conformance with the format for specifying the v5010 270/271 data content requirements.

Such submission may be in the form of a hard copy paper document, an electronic document, or a URL where the table of contents and an example of the v5010 270/271 content requirements of the companion document is located

4.3.3. Test Scripts Assumptions

1. The detailed content of the v5010 270/271 companion document will not be submitted to the CAQH CORE-authorized Testing Vendor
2. The detailed content of the v5010 270/271 companion document will not be examined nor evaluated
3. Test script will test ONLY that the table of contents of the companion document is
   a. Customized and specific to the entity undergoing this test
   b. Conforms to the flow s specified in the Table of Contents of the CAQH CORE Master Companion Document Template
   c. Conforms to the presentation format for depicting segments, data elements and codes as specified in the CAQH CORE Master Companion Document Template
4. The test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

4.3.4. Detailed Step-By-Step Test Script

REMINDER: CORE Certification Testing is not exhaustive. The CAQH Certification Test Suite does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

NOTE: The references in parentheses after each test scripts are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the "Stakeholder" column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[7]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[8]
1.	Companion Document conforms to the flow and format of the CAQH CORE Master Companion Document Template.	Submission of the Table of Contents of the v5010 270/271 companion document, including a example of the v5010 270/271 content requirements.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	Companion Document conforms to the format for presenting each segment, data element and code flow and format of the CAQH CORE Master Companion Document Template.	Submission of a page of the v5010 270/271 companion document depicting the presentation of segments, data elements and codes showing conformance to the required presentation format.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

[7] A checkmark in the box indicates the stakeholder type to which the test applies.

[8] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

4.4. CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Batch Response Time Requirements Test Scenario

4.4.1. Key Rule Requirements

Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.

1. Maximum response time when processing in batch mode for the receipt of a v5010 271 response to a v5010 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. (§5)
2. v5010 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 270 inquiries and to the health plan (or information source) in the case of a batch of v5010 271 responses. (§5)
3. Conformance with this maximum response time rule shall be considered achieved if 90 percent of all required responses as specified in the CORE 150: Eligibility and Benefit Batch Acknowledgement Rule version 1.0.0 are returned within the specified maximum response time as measured within a calendar month. (§5)
4. Each CORE-certified 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. (§5)

4.4.2. Conformance Testing Requirements

These scenarios test the following conformance requirements of the CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Batch Response Time Requirements. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario.

Capturing, logging, auditing, matching and reporting the date (YYYYMMDD), time (HHMMSS) and control numbers from its own internal systems and its trading partners.

4.4.3. Test Scripts Assumptions

1. All transactions, data, communications session are valid, no error conditions are created or encountered.
2. The provider's PMS/HIS system generates all of the required data necessary for its clearinghouse to generate the batch ASC X12/v5010 270 eligibility inquiries.
3. The provider's clearinghouse's EDI management system generates a syntactically correct X12 interchange containing the v5010 270 eligibility inquiry, therefore, no v5010 999 acknowledgement is to be returned by the health plan's system.
4. All HTTP/S communications sessions between all parties are successfully established with the respective Internet portals communications servers; therefore, no HTTP POST error messages are created by any of communications servers.

4.4.3. Test Scripts Assumptions
5. The health plan's eligibility system successfully locates and verifies the individuals identified in the batch v5010 270 inquiry and outputs the required data required by its clearinghouse system to successfully generate a syntactically correct ASC X12 interchange containing the v5010 271 eligibility responses.
6. The health plan's EDI management system generates a syntactically correct ASC X12 interchange containing the v5010 271 eligibility response.
7. The test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

4.4.4. Detailed Step-By-Step Test Script:

REMINDER: CORE Certification Testing is not exhaustive. The CAQH CORE Certification Test Suite does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

NOTE: The references in parentheses after each test scripts are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the "Stakeholder" column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[9]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[10]
1.	Verify that outer most communications module(s) transmits all required data elements in the eligibility inquiry message. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the ASC X12 v5010 Transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent.	Output a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
2.	Verify that outer most communications module(s) captures, assigns, logs and links all required data elements from the ASC X12 v5010 271 Interchange to the submitted ASC X12 v5010 270 Interchange. If transactions use an alternate communication method to	Output a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

[9] A checkmark in the box indicates the stakeholder type to which the test applies.

[10] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[9]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[10]
	HTTP/S, entities must store enough information from the ASC X12 v5010 Transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent.									
3.	Verify that outer most communications module(s) transmits all required data elements in the eligibility response message. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the ASC X12 v5010 Transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent.	Output a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
4.	Verify that outer most communications module(s) captures, assigns, logs and links all required data elements from the ASC X12 v5010 270 Interchange to the submitted ASC X12 v5010 271 Interchange. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the ASC X12 v5010 transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent.	Output a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

4.5. CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Real Time Response Time Requirements Test Scenario

4.5.1. Key Rule Requirements

Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.

1. Maximum response time when processing in real time mode for the receipt of a v5010 271 (or in the case of an error, a v5010 999 response from the time of submission of a v5010 270 inquiry must be 20 seconds (or less). v5010 999 response errors must be returned within the same response timeframe. (§4)
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. (§4)
3. Each CORE-certified 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. (§4)

4.5.2. Conformance Testing Requirements

These scenarios test the following conformance requirements of the CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Real Time Response Time Requirements. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario.

Capturing, logging, auditing, matching and reporting the date (YYYYMMDD), time (HHMMSS) and control numbers from its own internal systems and its trading partners.

4.5.3. Test Scripts Assumptions

1. All transactions, data, communications session are valid; no error conditions are created or encountered.
2. The provider's PMS/HIS system generates a syntactically correct X12 interchange containing the v5010 270 eligibility inquiry, therefore, no v5010 999 acknowledgement is to be returned by the health plan's system.
3. The provider's PMS/HIS system's communications module successfully establishes the HTTP/S communication session with the health plan's Internet portal communications server; therefore, no HTTP POST error message is created by the health plan's communications server.
4. The health plan's eligibility system successfully locates and verifies the individual identified in the v5010 270 inquiry and outputs the required data required by its EDI management system to successfully generate a syntactically correct ASC X12 interchange containing the v5010 271 eligibility response.
5. The health plan's EDI management system generates a syntactically correct ASC X12 interchange containing the v5010 271 eligibility response.
6. The test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

4.5.4. Detailed Step-By-Step Test Script:

REMINDER: CORE Certification Testing is not exhaustive. The CAQH CORE Certification Test Suite does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

NOTE: The references in parentheses after each test scripts are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the "Stakeholder" column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[11]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[12]
1)	Verify that outer most communications module(s) transmits all required data elements in the eligibility inquiry message. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the ASC X12 v5010 Transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent.	Output a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
2)	Verify that outer most communications module(s) captures, assigns, logs and links all required data elements from the ASC X12 v5010 271 Interchange to the submitted ASC X12 v5010 270 Interchange. If transactions use an alternate communication method to HTTP/S, entities must store enough	Output a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

[11] A checkmark in the box indicates the stakeholder type to which the test applies.

[12] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[11]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[12]
	information from the ASC X12 v5010 Transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent.									
3)	Verify that outer most communications module(s) transmits all required data elements in the eligibility response message. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the ASC X12 v5010 Transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent.	Output a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
4)	Verify that outer most communications module(s) captures, assigns, logs and links all required data elements from the ASC X12 v5010 270 Interchange to the submitted ASC X12 v5010 271 Interchange. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the ASC X12 v5010 Transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent.	Output a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

4.6. CAQH CORE Eligibility & Benefits (270/271) Data Content Rule: Electronic Delivery of Patient Financial Information Rule Requirements Test Scenario

4.6.1. Key Rule Requirements

Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.

Requirements for v5010 271 Eligibility Inquiry Response

1. When the individual is located in the system, the health plan must be return:
    a. 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. (§1)
    b. The patient financial responsibility for co-insurance, co-payment and deductibles (§1)

To specify the co-insurance responsibility

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.(§1)
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.(§1)

To specify the co-payment responsibility

4. 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. (§1)
5. 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.(§1)

To specify the deductible responsibility

6. 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.(§1)
7. 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.(§1)
8. 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 benefit coverage level for each type of service, e.g., individual or family coverage. (§1)

Eligibility Dates

9. The 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 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. (§1)

4.6.1. Key Rule Requirements

Requires a health plan (or information source) to:

10. Respond to an explicit inquiry for a CORE-required service type with patient financial responsibility. (§1)
11. 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. (§4)
12. Specify the Health Plan base deductible amount only on the EB segment where EB03=30-Health Benefit Plan Coverage. (§1)
13. 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. (§1)
14. 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. (§1)
15. 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. (§1)
16. Return patient liability information (co-pay, co-insurance, and deductible information) for a CORE-required explicit v5010 270 inquiry. (§1)
17. Return both family and individual Health Plan base and remaining deductible amounts as applicable to the health plan coverage. (§1)
18. Not return base and remaining deductible amounts for a specific benefit (service type) when the amount is not different than for the health plan. (§1)
19. Return deductible amounts only in U.S. amounts. (§1)
20. Return the date(s) for the Health Plan base deductible only if different than the Health Plan Coverage date. (§1)
21. Return the date(s) for a Benefit-specific base deductible only if different than the Health Plan Coverage date. (§1)

Prohibits a health plan (or information source) from:

22. 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. (§1)

Allows a health plan (or information source) to:

Return patient liability information (co-pay, co-insurance, and deductible information) at its discretion for 9 specified Service Type Codes. (§1)

Specifies that:

23. Only Code 29-Remaining can be used in EB06 data element to specify the remaining deductible amount. (§1)
24. Service type codes that must be supported for an explicit inquiry. (§1)

Requires a receiver of the v5010 271 Response to:

25. Detect and extract all data elements to which the rule applies. (§1)
26. Display to the end user text that appropriately describes these data elements. (§1)

4.6.2. Conformance Testing Requirements:

These scenarios test the following conformance requirements of the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule: Electronic Delivery of Patient Financial Information Rule Requirements. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario.

1. The creation of an eligibility response v5010 271 transaction generated using the Eligibility & Benefits CORE Master Test Bed Data providing the following information about the individual identified in the v5010 270 eligibility transaction
   a. patient financial responsibility, including in-network and out-of-network
   b. health plan benefit coverage dates based on base deductible
   c. health plan name if one exists.
2. System receiving the v5010 271 response must demonstrate its capability to detect and extract the data elements addressed in this rule and display such data and appropriate text to the end user.

4.6.3. Test Scripts Assumptions

1. A syntactically correct ASC X12 Interchange containing the v5010 270 inquiry transaction set is created by the submitter's system; therefore no v5010 999 acknowledgements are to be returned by the health plan's system.
2. A communications session between all parties is successfully established in compliance with the CAQH CORE Connectivity Rule vC1.1.0 and vC2.2.0; therefore, no error messages are created by any of communications servers.
3. Automated transaction certification testing will be conducted between the entity and its selected CAQH CORE-authorized Testing Vendor using the CAQH CORE Connectivity Rule vC1.1.0 and vC2.2.0.
4. The health plan's eligibility system successfully locates and verifies the individual identified in the v5010 270 inquiry and outputs the data required to successfully generate the v5010 271 eligibility response required by this rule.
5. The health plan's EDI management system generates a syntactically correct ASC X12 interchange containing the v5010 271 eligibility response.
6. The Eligibility & Benefits CORE Master Test Bed Data contains all of the values necessary to enable the entity to generate a response transaction covering the Detailed Step-by-Step Test Scripts.

4.6.4. Detailed Step-By-Step Test Script

REMINDER: CORE Certification Testing is not exhaustive. The CAQH CORE Certification Test Suite does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

NOTE: The references in parentheses after each test scripts are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the "Stakeholder" column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[13]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[14]
1.	Create a valid v5010 271 response transaction as defined in the CORE rule indicating the **name of the health plan** covering the individual specified in the v5010 270 eligibility inquiry The health plan is not required to obtain such a health plan name from outside its own organization.	Output a valid fully enveloped v5010 271 eligibility response transaction set with the correct health plan name in EB05-1204.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	Extract from a valid v5010 271 response transaction as defined in the CORE rule the data indicating the **name of the health plan** covering the individual specified in the 270 eligibility inquiry. The health plan is not required to obtain	Provide a screen print of the output from Test #2 showing that the required information is displayed to the information requester.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

[13] A checkmark in the box indicates the stakeholder type to which the test applies.

[14] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[13]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[14]
	such a health plan name from outside its own organization.									
3.	Create a valid v5010 271 response transaction as defined in the CORE rule indicating the patient financial responsibility for each of the benefits covering the individual.	Output a valid fully enveloped v5010 271 eligibility response transaction set with the correct co-insurance, co-payment, and deductible patient financial responsibilities for both in/out of network in either EB08-954 or EB07-782 at either the subscriber loop 2110C or dependent loop 2100D levels.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
4.	Extract from a valid v5010 271 response transaction as defined in the CORE rule the data indicating the patient financial responsibility for each of the benefits covering the individual.	Provide a screen print of the output from Test #10 showing that the required information is displayed to the information requester.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
5.	Create a valid v5010 271 response transaction as defined in the CORE rule specifying the Health Plan remaining deductible amount.	Output a valid fully enveloped v5010 271 eligibility response transaction set with the correct Health Plan remaining deductible amount.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
6.	Create a valid v5010 271 response transaction as defined in the CORE rule specifying a benefit-specific remaining deductible amount different than the Health Plan remaining deductible amount.	Output a valid fully enveloped v5010 271 eligibility response transaction set with the correct benefit-specific remaining deductible amount.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[13]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[14]
7.	Create a valid v5010 271 response transaction as defined in the CORE rule specifying patient liability for a CORE-required explicit service type.	Output a valid fully enveloped v5010 271 eligibility response transaction set with the correct patient liability for the requested service type.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
8.	Create a valid v5010 271 response transaction as defined in the CORE rule indicating the date(s) for the Health Plan base deductible for the health plan covering the individual only if different than the Health Plan Coverage date.	Output a valid fully enveloped v5010 271 eligibility response transaction set with the date(s) applicable to the Health Plan Base deductible only if different than the Health Plan Coverage date.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
9.	Create a valid v5010 271 response transaction as defined in the CORE rule indicating the date(s) for a benefit-specific base deductible only if different than the Health Plan Coverage date.	Output a valid fully enveloped v5010 271 eligibility response transaction set with the date(s) applicable to the benefit-specific base deductible only if different than the Health Plan Coverage date.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
10.	Extract from a valid v5010 271 response transaction as defined in the CORE rule the data required to be returned by a health plan in Test Scripts #1 through #5.	Provide a screen print of the output from Tests #1 through #6 showing that the required information is displayed to the end user.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

4.7. CAQH CORE Eligibility & Benefits (270/271) Data Content Rule: Normalizing Patient Last Name Rule Requirements Test Scenario

4.7.1. Key Rule Requirements

Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.

Requires a health plan (or information source) to:

1. Normalize the last name submitted on the v5010 270 before using submitted last name. (§2.3.2)
2. Normalize internally-stored last name before using internally-stored last name. (§2.3.2)
3. Return the v5010 271 response with AAA segment using appropriate error code(s) as required by the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule: AAA Error Code Reporting Requirements when normalized names are not successfully matched or validated. (§2.3.2)
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 2.3.3. (§2.3.2.)
5. Return the v5010 271 response as required by the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule when normalized names are successfully matched or validated. (§2.3.2)

Requires a receiver of the v5010 271 response to:

6. Detect all data elements addressed by the rule as returned in the v5010 271 response. (§2.3.4)
7. Display to the end user text uniquely describing the specific error condition(s) and data elements returned in the v5010 271. (§2.3.4)
8. Ensure that displayed text accurately represents the Follow Up Action without changing meaning and intent of the Follow Up Action. (§2.3.4)

Recommendations for submitters of the v5010 270:

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. (§2.3.1)
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. (§2.3.1)
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. (§2.3.1)

4.7.2. Conformance Testing Requirements

Conformance must be demonstrated by successful completion of the Detailed Step-By-Step Test Scripts specified below with a CAQH CORE-authorized Testing Vendor.

The Detailed Step-By-Step Test Scripts specify each specific test that must be completed by each stakeholder type. There are one or more Detailed Step-By-Step Test Scripts for each of the following conformance testing requirements of the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule: Normalizing Patient Last Name Rule Requirements.

There may be other requirements of the rule not specified here or in The Detailed Step-By-Step Test Scripts. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in these Conformance Testing Requirements and Detailed Step-by-Step Test Scripts.

1. The health plan must demonstrate its system capability to normalize both submitted and internally stored last names and return the required AAA errors when normalized names do not match.
2. The health plan must demonstrate its system has the capability to normalize both submitted and internally stored last names and:
    a. Return the internally stored un-normalized last name when both submitted and internally stored un-normalized last names do not match and the normalized last names do match.
    b. Return the required INS segment.
    c. Return the v5010 271 response required by the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule.
3. The receiver of the v5010 271 response must demonstrate it system has the capability to extract and make available to the end user
    a. The AAA and corresponding AAA Error Code Reporting Rule Error Condition Descriptions.
    b. The INS segment information.
4. The last name returned by the health plan.

4.7.3. Test Scripts & Assumptions

1. The health plan has loaded into its testing system the Eligibility & Benefits CORE Master Test Bed Data which contains all of the values necessary to generate a response transaction covering each of the requirements specified in the Conformance Testing Section above and in the Detailed Step-b y-Step Test Scripts below.
2. The CAQH CORE-authorized Testing Vendor's test system has transmitted to the health plan a v5010 270 in which the subscriber last name data element contains either one of the character strings and/or special characters specified in the rule.
3. A syntactically correct ASC X12 Interchange containing the v5010 270 inquiry transaction set is created by the submitter's system; therefore no v5010 999 acknowledgement is to be returned by the health plan's system.
4. A communications session between all parties is successfully established in compliance with the CAQH CORE Connectivity Rule vC1.1.0 and vC2.2.0; therefore, no error messages are created by any of communications servers.
5. The health plan's EDI management system generates a syntactically correct ASC X12 interchange containing the v5010 271 eligibility response.
6. The test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

4.7.4. Detailed Step-by-Step Test Scripts

REMINDER: CORE Certification Testing is not exhaustive. The CAQH CORE Certification Test Suit does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

NOTE: The references in parentheses after each test script are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the "Stakeholder" column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

Note: The CAQH CORE-authorized Testing Vendors will generate one or more randomly generated v5010 270 inquiries based on the Eligibility & Benefits Master Test Bed Data that will cause the health plan to encounter each of the described error conditions in Test Scripts #1 and #2.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [15]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [16]
1.	Create a valid v5010 271 response transaction indicating that the normalized submitted and internally-stored last names do not match.	Output a valid v5010 271 transaction containing the AAA segment with AAA03=73 Invalid/Missing Subscriber/Insured Name.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	Create a valid v5010 271 response transaction in which the un-normalized internally-stored last name is returned when the normalized submitted and internally-stored last names match.	Output a valid v5010 271 transaction containing the INS segment as required by the CORE Name Normalization rule in which the NM103-1035 in Loop 2100C contains the un-normalized internally-stored last name.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

[15] The checkmark in each box below indicates the stakeholder type to which the test script applies.

[16] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [15]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [16]
3.	Extract from a valid v5010 271 response transaction the patient identification data elements received in the NM1 and DMG segments in Loop 2100C and the information contained in the AAA segment.	Provide a screen print of the output from Test #1 showing that the required information is displayed to the information requester.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
4.	Extract from a valid v5010 271 response transaction the last name as received in the NM103-1035 in Loop 2100C and the information contained in the INS segment.	Provide a screen print of the output from Test #2 showing that the required information is displayed to the information requester.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

4.8. CAQH CORE Eligibility & Benefits (270/271) Data Content Rule: AAA Error Code Reporting Requirements Test Scenario

4.8.1. Key Rule Requirements

Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.

Requires a health plan (or information source) to:

1. Return a AAA segment for each error condition detected. (§3.3.1)
2. Return code "N" in the AAA01 Valid Request Indicator data element. (§3.3.1)
3. Return the specified Reject Reason Code in AAA03 as specified for the error condition detected. (§3.3.1)
4. Return code "C" in the AAA04 Follow-up Action Code data element. (§3.3.1)
5. Return submitted data elements used. (§3.3.1)
6. Return a AAA segment for each error condition detected along with submitted data elements used when conducting a pre-query evaluation. (§3.3.1)
7. Return a AAA segment for each missing and required data element when conducting a pre-query evaluation. (§3.3.1)
8. Return a AAA segment for an invalid MID when conducting a pre-query evaluation. (§3.3.1)
9. Return a AAA segment for an invalid DOB when conducting a pre-query evaluation. (§3.3.1)
10. Return a AAA segment for each error condition detected along with submitted data elements used when conducting a post-query evaluation. (§3.3.1)

Requires a receiver of the v5010 271 response to:

11. Detect all combinations of error conditions from the AAA segments in the v5010 271 response. (§3.3.2)
12. Detect all data elements addressed by the rule as returned in the v5010 271 response. (§3.3.2)
13. Display to the end user text uniquely describing the specific error condition(s) and data elements returned in the v5010 271. (§3.3.2)
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. (§3.3.2)

Defines:

15. Pre-query evaluation of patient identification elements. (§3.3.3)
16. Post-query evaluation of patient identification elements. (§3.3.4)
17. Query using one or more of submitted patient identification data elements. (§3.3.5)

4.8.1. Key Rule Requirements

Not Required of health plans:

18. To use any specific search and match criteria or logic. (§3.2.3)
19. To use any specific combination of submitted identification data elements. (§3.2.3)
20. To perform a pre-query evaluation. (§3.2.3)
21. To perform DOB validation. (§3.2.3)

4.8.2. Conformance Testing Requirements

Conformance must be demonstrated by successful completion of The Detailed Step-By-Step Test Scripts specified below with a CAQH CORE-authorized Testing Vendor.

The Detailed Step-By-Step Test Scripts specify each specific test that must be completed by each stakeholder type. There are one or more Detailed Step-By-Step Test Scripts for each of the following conformance testing requirements of the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule: AAA Error Code Reporting Requirements.

There may be other requirements of the rule not specified here or in The Detailed Step-By-Step Test Scripts. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in these Conformance Testing Requirements and Detailed Step-by-Step Test Scripts.

1. The health plan must demonstrate its system capability to detect the various error conditions described and return the required AAA errors and submitted data elements when each error condition is detected.
2. The receiver of the v5010 271 must demonstrate its system capability to appropriately display text to the end user of the AAA errors code, the Error Condition Descriptions and the returned data elements.

4.8.3. Test Scripts Assumptions

1. The health plan has loaded into its testing system the Eligibility & Benefits CORE Master Test Bed Data which contains all of the values necessary to generate a response transaction covering each of the requirements specified in the Conformance Testing Section above and in the Detailed Step-b y-Step Test Scripts below.
2. The CAQH CORE-authorized Testing Vendor's test system has transmitted to the health plan a v5010 270 which may contain one or more of the error conditions described in the rule.
3. A syntactically correct X12 Interchange containing the v5010 270 inquiry transaction set is created by the submitter's system; therefore no v5010 999 acknowledgement is to be returned by the health plan's system.
4. A communications session between all parties is successfully established in compliance with the CAQH CORE Connectivity Rule vC1.1.0 and vC2.2.0; therefore, no error messages are created by any of communications servers.
5. The health plan's EDI management system generates a syntactically correct ASC X12 interchange containing the v5010 271 eligibility response.
6. The test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

4.8.4. Detailed Step-by-Step Test Script

REMINDER: CORE Certification Testing is not exhaustive. The CAQH CORE Certification Test Suite does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

NOTE: The references in parentheses after each test script are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the "Stakeholder" column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

Note: The CAQH CORE-authorized Testing Vendor will generate one or more randomly generated v5010 270 inquiries based on the Eligibility & Benefits Master Test Bed Data that will cause the health plan to encounter each of the described error conditions in Test Scripts #1 and #2.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [17]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [18]
•	Create a valid v5010 271 response transaction indicating that the v5010 270 inquiry is being rejected because the health plan could not correctly identify the patient.	Output a valid v5010 271 transaction containing the patient identifying data elements submitted and used, the AAA segment with AAA Reject Reason Code corresponding to the error condition detected and other required AAA segment data elements and codes as specified.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
•	Extract from a valid v5010 271 response transaction the patient identification data elements received in Loop 2100C and the information contained in the AAA segment.	Provide a screen print of the output from Test #1 showing that the required information is displayed to the information requester.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

[17] The checkmark in each box below indicates the stakeholder type to which the test script applies.

[18] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

4.9. CAQH CORE Connectivity Rule v1.1.0 Test Scenario

4.9.1. Key Rule Requirements

Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.

Real time requests

1. Must include a single inquiry or submission (e.g. one eligibility inquiry to one information source for one patient). (§2.2)

Batch requests

2. Are sent in the same way as real time requests. (§2.3)

Batch submissions

3. Response must be only the standard HTTP message indicating whether the request was accepted or rejected (see below for error reporting.) (§2.3)
4. Message receivers must not respond to a batch submission with an ASC X12 response such as a v5010 999 as described in the CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule in the HTTP response to the batch request, even if their systems' capabilities allow such a response. (§2.3)

Batch responses

5. Should be picked up after the message receiver has had a chance to process a batch submission (§2.3.1)

Required Data Elements

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 ASC X12 data. (§2.4.1)
7. Information Sources must publish their detailed specification for the message format in their publicly available Companion Guide. (§2.4.1)
8. In order to comply with the CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule Section 4: Real Time Response Time Requirements and Section 5: Batch 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. (§2.4.1)
9. Message senders must include the date and time the message was sent in the HTTP Message Header tags. (§2.4.1)

Date and Time Requirements

10. Date must be sent and logged using 8 digits (YYYYMMDD) (§2.4.2)
11. Time must be sent and logged using a minimum of 6 digits (HHMMSS). (§2.4.2)

Security

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. (§2.5)

User ID and Password

13. CORE-certified entity will employ User ID and Password as the default minimum criteria authentication mechanism. (§2.5.1)

4.9.1. Key Rule Requirements

14. Issuance, maintenance and control of password requirements may vary by participant and should be issued in accordance with the organizations' HIPAA Security Compliance policies. (§2.5.1)
15. The User ID and Password authentication must be encrypted by the HTTP/S protocol, but passed outside of the ASC X12 payload information as described in the HTTP Message format section. (§2.5.1)
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. (§2.5.1)
17. Due to programming requirements of POSTing over HTTP/S, use of a digital certificate is required to establish communications. CORE-certified entities will make available information on how to obtain the receiver's root public certificate. (§2.5.1)
18. No additional security for file transmissions, such as the separate encryption of the ASC X12 payload data, is required in this CORE rule for connectivity. By mutual consent, organizations can implement additional encryption, but HTTP/S provides sufficient security to protect healthcare data as it travels the Internet. (§2.5.1)

Response Time, Time Out Parameters and Re-transmission

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. (§2.6)
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. (§2.6)
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. (§2.6)

Authorization Errors

22. If the username and/or password included in the request are not valid according to the message receiver, the message receiver must send back an HTTP 403 Forbidden error response with no data content. (§2.7.1)

Batch Submission Acknowledgement

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 ASC X12 content has been validated or approved. (§2.7.2)

Real Time Response or Response to Batch Response Pickup

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 ASC X12 data content as specified by the CORE 150 and 151 Eligibility and Benefits Batch and Real Time Acknowledgements Rules version 1.1.0. (§2.7.3)

Server Errors

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. (§2.7.4)
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. (§2.7.4)

4.9.2. Conformance Testing Requirements

These scenarios test the following conformance requirements of the CAQH CORE Connectivity Rule vC1.1.0. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario.

1. The Information Source must demonstrate the ability to respond in their production environment to valid and invalid logon/connection requests with the appropriate HTTP errors as described in the Response Message Options & Error Notification section of this rule.
2. The Information Source must demonstrate the ability to log, audit, track, and report the required data elements as described in the HTTP Message Format section of this rule.

4.9.3. Test Scripts Assumptions

1. Each HTTP/S message must contain an ASC X12 Interchange as the payload
2. No editing or validation of the ASC X12 Interchange will be performed
3. All communications sessions and logon's are valid, no error conditions are created or encountered
4. Test scripts will test for valid and invalid logon attempts
5. Test scripts will test for the ability to log, audit, track and report on the required data elements
6. The test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

4.9.4. Detailed Step-By-Step Test Script

REMINDER: CORE Certification Testing is not exhaustive. The CAQH CORE Certification Test Suite does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

NOTE: The references in parentheses after each test scripts are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the "Stakeholder" column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[19]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[20]
1.	Valid Logon Attempt.	HTTP 200 OK		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	Invalid Logon Attempt.	HTTP 403 Forbidden response		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
3.	Verify that communications server/module creates, assigns, logs, links the required data elements to HTTP message payload.	Output a system generated audit log report showing all required data elements		☐ Pass	☐ Fail	☒	☒	☒	☒	☐

[19] A checkmark in the box indicates the stakeholder type to which the test applies.

[20] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

4.10. CAQH CORE Connectivity Rule vC2.2.0 Test Scenario [21]

4.10.1. Key Rule Requirements

Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.

Requires a CAQH CORE Connectivity Rule vC2.2.20 CORE-certified Health Plan and Health Plan Vendor to implement a Server and to:

1. Implement Server capability to support both Message Envelope Standards and Message Exchanges specified in the rule for Real Time. (§4.1.1, §4.2, §6.3.1) [22]
2. Implement Server capability to support both Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered. (§4.1.1, §4.2, §6.3.2)
3. Implement Server capability and enforce one of two specified Submitter Authentication Standards for both Real Time and/or Batch. (§4.1.1)
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. (§4.3.5.1)
5. Have the capability to receive and process large batch transaction files if batch is supported. (§4.3.5.2)
6. Publish detailed specifications in a Connectivity Companion Guide on its public web site as required. (§4.3.7)

If a CAQH CORE Connectivity Rule vC2.2.0 CORE-certified Health Plan and Health Plan Vendor elects to optionally implement a Client, it is required to:

7. Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified in the rule for Real Time. (§4.1.1, §4.2, §6.3.1)
8. Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered. (§4.1.1, §4.2, §6.3.2)
9. Implement Client capability to support both specified Submitter Authentication Standards for both Real Time and/or Batch. (§4.1.1)

[21] This test scenario, conformance testing requirements, test script assumptions and detailed step-by-step test scripts are applicable to the CAQH Core Connectivity Rule v2.2.0.

[22] Section numbers reference the specific section in the CAQH CORE Connectivity Rule v2.2.0 that specifies the details of this requirement.

4.10.1. Key Rule Requirements
Requires a CAQH CORE Connectivity Rule vC2.2.0 CORE-certified Clearinghouse and other Intermediaries to implement a Server and to:
10. Implement Server capability to support both Message Envelope Standards and Message Exchanges specified in the rule for Real Time. (§4.1.2, §4.2, §6.3.1)
11. Implement Server capability to support both Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered. (§4.1.2, §4.2, §6.3.2)
12. Implement Server capability and enforce one of two specified Submitter Authentication Standards for both Real Time and/or Batch. (§4.1.2)
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. (§4.3.5.1)
14. Have the capability to receive and process large batch transaction files if batch is supported. (§4.3.5.2)
15. Publish detailed specifications in a Connectivity Companion Guide on its public web site as required. (§4.3.7)
Requires a CAQH CORE Connectivity Rule vC2.2.0 CORE-certified Clearinghouse and other Intermediaries to implement a Client and to:
16. Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified in the rule for Real Time. (§4.1.2, §4.2, §6.3.1)
17. Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered. (§4.1.2, §4.2, §6.3.2)
18. Implement Client capability to support both specified Submitter Authentication Standards for both Real Time and/or Batch. (§4.1.2)
Requires a CAQH CORE Connectivity Rule vC2.2.0 CORE-certified Provider and Provider Vendor to implement a Client and to:
19. Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified in the rule for Real Time. (§4.1.3, §4.2, §6.3.1)
20. Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered. (§4.1.3, §4.2, §6.3.2)
21. Implement Client capability to support both specified Submitter Authentication Standards for both Real Time and/or Batch. (§4.1.3)
If a CAQH CORE Connectivity Rule vC2.2.0 CORE-certified Provider and Provider Vendor elects to optionally implement a Server, it is required to:
22. Implement Server capability to support both Message Envelope Standards and Message Exchanges specified in the rule for Real Time. (§4.1.3, §4.2, §6.3.1)
23. Implement Server capability to support one of two Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered. (§4.1.3, §4.2, §6.3.2)
24. Implement Server capability and enforce one of two both specified Submitter Authentication Standards for both Real Time and/or Batch. (§4.1.3)

4.10.1. Key Rule Requirements
Requires all CAQH CORE Connectivity Rule vC2.2.0 CORE-certified Message Receivers to: 25. Track the times of any received inbound messages. (§4.3.4.1) 26. Respond with the outbound message for the received inbound message. (§4.3.4.1) 27. Include the date and time the message was sent in HTTP+MIME or SOAP+WSDL Message Header tags. (§4.3.4.1)
Specifies: 28. Message Enveloping specifications for HTTP MIME Multipart (Envelope Standard A). (§4.2.1) 29. HTTP MIME Multipart payload attachment handling. (§4.2.1.8) 30. Message Enveloping specifications for SOAP+WSDL (Envelope Standard B). (§4.2.2) 31. XML Schema specification for SOAP. (§4.2.2.1) 32. Web Services Definition Language (WSDL) specification. (§4.2.2.2) 33. SOAP payload attachment handling. (§4.2.2.11) 34. Request and response handling for real time, batch, and batch response pickup. (§4.3.1) 35. Submitter authentication and authorization handling. (§4.3.2) 36. Error handling for both Envelope Messaging Standards. (§4.3.3) 37. Envelope metadata fields, including descriptions, intended use syntax and value-sets applicable to both Enveloping Messaging Standards. (§4.4)

4.10.2. Conformance Testing Requirements

The CORE Detailed Step-By-Step Test Scripts will not include comprehensive testing requirements for all possible permutations of the CAQH CORE Connectivity Rule vC2.2.0.

Conformance must be demonstrated by successful completion of the Detailed Step-By-Step Test Scripts specified below with a CAQH CORE-authorized Testing Vendor.

The Detailed Step-By-Step Test Scripts specify each specific test that must be completed by each stakeholder type for both Real Time and Batch communications. There are one or more Detailed Step-By-Step Test Scripts for each of the following conformance testing requirements of the CAQH CORE Connectivity Rule vC2.2.0. Batch Connectivity Test Scripts are only required to be completed if an entity supports Batch communications.

There may be other requirements of the rule not specified here or in The Detailed Step-By-Step Test Scripts. Notwithstanding, CAQH CORE Connectivity Rule vC2.2.0 CORE-certified entities are required to comply with all specifications of the rule not included in these Conformance Testing Requirements and Detailed Step-by-Step Test Scripts.

1. A health plan or health plan vendor must demonstrate it has implemented the server specifications for both Message Enveloping Standards.
2. A health plan or health plan vendor must demonstrate it has implemented one of the two submitter authentication standards.
3. A clearinghouse, switch or other intermediary must demonstrate it has implemented the server specifications for both Message Envelope Standards.
4. A clearinghouse, switch or other intermediary must demonstrate it has implemented the client specifications for one of the two Message Envelope Standards.
5. A clearinghouse that handles submissions to health plan must demonstrate it has implemented both submitter authentication standards.
6. A provider or provider vendor must demonstrate it has implemented the client specifications for one of the two Message Envelope Standards.
7. A provider or provider vendor must demonstrate it has implemented both submitter authentication standards.

4.10.3. Test Scripts Assumptions
1. All tests will be conducted over HTTP/S.
2. The message payload is an ASC X12 Interchange.
3. No editing or validation of the message payload will be performed.
4. All submitter authentications are valid; no error conditions are created or encountered.
5. Testing will not be exhaustive for all possible levels of submitter authentication.
6. Test scripts will test for the ability to log, audit, track and report on the required data elements.
7. Rule specifications addressing payload attachment handling are not being tested.
8. Rule specifications addressing error handling are not being tested.
9. The test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

4.10.4. Detailed Step-by-Step Test Script

REMINDER: CORE Certification is not exhaustive. The CAQH CORE Certification Test Suite does not include comprehensive testing requirements that test for all possible permutations of each rule. See Test Assumption above.

NOTE: The references in parentheses after each test script are references to the above rule items for which the test script is testing – items could be referring to Key Rule Requirement(s), the Conformance Testing Requirement(s) or the associated Test Script Assumption(s). An individual test script may be testing for more than one item, and, as noted in the "Stakeholder" column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [23]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [24]
Real Time Connectivity Test Scripts										
1.	Implement and enforce **one of two** Submitter Authentication standards on communications **server**.									
1.1	Implement and enforce use of Username/Password over SSL on communications **server.**	Communications server accepts a valid logon by a client using Username/Password, which is embedded in the message envelope as specified in the CAQH CORE Connectivity Rule v2.2.0.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
1.2	Implement and enforce use of X.509 Certificate over SSL on communications **server.**	Communications server accepts a valid logon by a client using X.509 Certificate over SSL.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	On the authenticated connection as per Test #1, implement capability to support **both** Message Envelope Standards and envelope metadata for Real Time as a communications **server**.									
2.1	Implement SOAP+WSDL Message Envelope Standard and envelope metadata as a communications **server**.	Communications server accepts a valid logon by a client conforming to the SOAP+WSDL envelope and metadata specifications, and successfully completes the		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

[23] The checkmark in each box below indicates the stakeholder type to which the test script applies.

[24] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [23]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [24]
		Real-time message interactions as specified in §6.3.1 of the CAQH CORE Connectivity Rule v2.2.0.								
2.2	Implement HTTP MIME Multipart Message Envelope Standard and envelope metadata as a communications **server.**	Communications server accepts a valid logon by a client conforming to the HTTP MIME Multipart envelope and metadata specifications, and successfully completes the Real-time message interactions as specified in §6.3.1 of the CAQH CORE Connectivity Rule v2.2.0.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
3.	Implement capability to support **both** Submitter Authentication standards as a communications **client**.									
3.1	Implement Username/Password submitter authentication method as a communications **client.**	Client successfully logs on to a communications server with Username/Password, which is embedded in the message envelope as specified in the CAQH CORE Connectivity Rule v2.2.0.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
3.2	Implement X.509 certificate submitter authentication method as a communications **client.**	Client successfully logs on to a communications server with X.509 certificate.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
4.	On the authenticated connection as per Test #3, implement capability to support **one of two** Message Envelope Standards and envelope metadata for Real Time as a communications **client**.									

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [23]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [24]
4.1	Implement SOAP+WSDL Message Envelope Standard and envelope metadata as a communications **client.**	Communications client successfully logs on to a communications server using the SOAP+WSDL Message Envelope Standard and envelope metadata specifications, and successfully completes the Real-time message interactions as specified in §6.3.1 of the CAQH CORE Connectivity Rule v2.2.0.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
4.2	Implement HTTP MIME Multipart Message Envelope Standard and envelope metadata as a communications **client**.	Communications client successfully logs on to a communications server using the HTTP MIME Multipart Message Envelope Standard and envelope metadata specifications, and successfully completes the Real-time message interactions as specified in §6.3.1 of the CAQH CORE Connectivity Rule v2.2.0.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
5.	Verify that communications **server** creates, assigns, logs, links the required metadata elements to message payload.	Output a system generated audit log report showing all required data elements		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
6.	Verify that communications **client** creates, assigns, logs, links the required metadata elements to message payload.	Output a system generated audit log report showing all required data elements		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [23]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [24]
Batch Connectivity Test Scripts (Required only if Batch is supported)										
7.	Implement and enforce **one of two** Submitter Authentication standards on communications **server**.									
7.1	Implement and enforce use of Username/Password over SSL on communications **server.**	Communications server accepts a valid logon by a client using Username/Password, which is embedded in the message envelope as specified in the CAQH CORE Connectivity Rule v2.2.0		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
7.2	Implement and enforce use of X.509 Certificate over SSL on communications **server.**	Communications server accepts a valid logon by a client using X.509 Certificate over SSL		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
8.	On the authenticated connection as per Test #7, implement capability to support **both** Message Envelope Standards and envelope metadata for Batch as a communications **server**.									
8.1	Implement SOAP+WSDL Message Envelope Standard and envelope metadata as a communications **server**.	Communications server accepts a valid logon by a client conforming to the SOAP+WSDL envelope and metadata specifications, and successfully completes the Batch message interactions as specified in §6.3.2 of the CAQH CORE Connectivity Rule v2.2.0.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [23]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [24]
8.2	Implement HTTP MIME Multipart Message Envelope Standard and envelope metadata as a communications **server.**	Communications server accepts a valid logon by a client conforming to the HTTP MIME Multipart envelope and metadata specifications, and successfully completes the Batch message interactions as specified in §6.3.2 of the CAQH CORE Connectivity Rule v2.2.0.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
9.	Implement capability to support **both** Submitter Authentication standards as a communications **client**.									
9.1	Implement Username/Password submitter authentication method as a communications **client.**	Client successfully logs on to a communications server with Username/Password, which is embedded in the message envelope as specified in the CAQH CORE Connectivity Rule v2.2.0		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
9.2	Implement X.509 certificate submitter authentication method as a communications **client.**	Client successfully logs on to a communications server with X.509 certificate.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
10.	On the authenticated connection as per Test #9, implement capability to support **one of two** Message Envelope Standards and envelope metadata for Batch as a communications **client**.									

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [23]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [24]
10.1	Implement SOAP+WSDL Message Envelope Standard and envelope metadata as a communications **client** .	Communications client successfully logs on to a communications server using the SOAP+WSDL Message Envelope Standard and envelope metadata specifications, and successfully completes the Batch message interactions as specified in §6.3.2 of the CAQH CORE Connectivity Rule v2.2.0.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
10.2	Implement HTTP MIME Multipart Message Envelope Standard and envelope metadata as a communications **client**.	Communications client successfully logs on to a communications server using the HTTP MIME Multipart Message Envelope Standard and envelope metadata specifications, and successfully completes the Batch message interactions as specified in §6.3.2 of the CAQH CORE Connectivity Rule v2.2.0.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
11.	Verify that communications **server** creates, assigns, logs, links the required metadata elements to message payload.	Output a system generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
12.	Verify that communications **client** creates, assigns, logs, links the required metadata elements to message payload.	Output a system generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

5. Appendix

5.1. Test Suite Supplement

5.1.1. Using This Supplement

This Supplement is to be used in conjunction with the Eligibility & Benefits CORE Certification Test Suite. It does not replace any of the CAQH CORE Eligibility & Benefits Operating Rules, but rather provides additional information and details regarding the use and format of the Eligibility & Benefits CORE Master Test Bed Data as it applies to the CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Real Time and Batch Acknowledgement Requirements and the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule.

Topics in this Supplement are organized as follows:

- §5.1,2 and subsections provides a high-level overview of the Eligibility & Benefits CORE Master Test Bed Data, where the data are found, and how that document is organized
- §5.1.3 is a high-level overview of the use of the Eligibility & Benefits CORE Master Test Bed Data by the CAQH CORE-authorized Testing Vendor(s)
- §5.1.4 and subsections identifies specific allowable exceptions for users when loading the Eligibility & Benefits CORE Master Test Bed Data into their respective system; allowable exceptions relate to the modification or non-use of some of the test data elements
- §5.1.5 specifies that only the Eligibility & Benefits CORE Master Test Bed Data can be used for certification testing along with identifying certain data that is not included in the master test bed data
- §5.1.6 discusses at a high level the Eligibility & Benefits CAQH CORE Certification Test Suite certification testing requirements
- §5.1.7 provides an example of the mapping of some of the Eligibility & Benefits CORE test bed data elements to the ASC X12 v5010 270 transaction set

5.1.2. Eligibility & Benefits CORE Certification Master Test Bed Data

5.1.3. About the Base Test Data and Format

The Eligibility & Benefits CORE Master Test Bed Data (specified in a separate Excel workbook) is comprised of 24 base test “cases” consisting of 16 subscriber only cases and 8 subscriber-with-dependent cases. Also included in the master test bed are data for 13 health plans. Each beneficiary (subscriber and dependent) is assigned to a specific health plan. The base test data are specified in a human-readable format in a separate Excel workbook, described in detail below. Although actual CORE Certification Testing will use this Eligibility & Benefits CORE Master Test Bed Data as presented in the base test data, the types of transactions that will be tested against this data are specified in the Eligibility & Benefits CAQH CORE Certification Test Suite under the Detailed Test Script for the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule.

Users should extract all of the test bed data for health plans and beneficiaries from the Excel workbook. Beneficiaries who are dependents of a subscriber are identified as a dependent in the test bed data. Beneficiaries marked as a dependent should be extracted and may be loaded as subscriber to accommodate those health plans that require the assignment of a unique member ID to each beneficiary. In the context of this Appendix and the Eligibility & Benefits CORE Master Test Bed Data, CAQH CORE defines beneficiary to mean a person who is eligible to receive benefits under a health benefits plan whether or not the person is the subscriber or a dependent.

The test bed data are provided only in an Excel spreadsheet format. The Excel workbook contains multiple tabs (spreadsheets) as follows:

- Tab 1: The title page of the workbook
- Tabs 2 - 25: Beneficiary test data
- Tabs 26 - 38: Health plan test data

Test bed data are provided in both upper and lower case characters for ease of human readability. Users with systems that require all upper case characters will need to convert lower case characters accordingly when loading the data into their internal system.

5.1.4. Loading the Test Data and How Vendors Use the Data

Users may load the test data into their internal systems via manual data entry or by exporting the data into any file format supported by Excel for further automatic processing.

CAQH CORE-authorized Testing Vendors will use only the Eligibility & Benefits CORE Master Test Bed Data to test each entity according to their stakeholder type. Since CORE Certification Testing is not exhaustive, not all test beneficiaries (subscribers/dependents) and their associated health plans may be used in testing. Nevertheless, users should extract and load all of the Eligibility & Benefits CORE Master Test Bed Data into their internal systems. The specific internal system into which the Eligibility & Benefits CORE Master Test Bed Data are loaded is determined by each user, e.g., a development or production or test system, and may vary by user.

There are fields (cells) in both the Health Plan and Beneficiary data that can be modified in the Eligibility & Benefits CORE Master Test Bed Data. The specific fields are outlined below and highlighted in the actual Eligibility & Benefits CORE Master Test Bed Excel file. Many of the modifiable fields are data elements that are not addressed in or required by the CAQH CORE Eligibility & Benefit Operating Rules, but are needed for testing. This said, users are not permitted to modify:

- Dates
- Deductible and co-pay amounts that are explicitly shown as zero dollar (0$) amounts
- Any patient demographic

Should an entity determine it needs to modify any of Eligibility & Benefits CORE Master Test Bed Data in order to load it into their internal systems, such modifications and how the data was adjusted should be reported to CAQH so lessons learned can be applied as rules are updated.

5.1.5. Allowable Exceptions When Loading Specific Test Data

These exceptions are included here for ease of reference.

5.1.5.1. Health Plan Data Options

Group #

The Group number is not validated by either of the CAQH CORE-authorized Testing Vendor(s) in any of the certification test scripts. Therefore the Group number can be modified, or not used, by any health plan or information source based on its eligibility system requirements for Group number when undergoing certification testing.

Health Plan #

The Health Plan number is not validated by either of the CORE-authorized Testing Vendor(s) in any of the certification test scripts. Therefore the Health Plan number can be modified, or not used, by any health plan or information source based on its eligibility system requirements for Plan number when undergoing certification testing.

Health Plan Name

The Health Plan Name is required by the CORE rule and its presence in the v5010 271 response transaction is validated by the CAQH CORE-authorized Testing Vendor(s). However, the actual name value of the Health Plan Name is not validated by the CAQH CORE-authorized Testing Vendor(s)in any of the certification test scripts. Therefore, while the Health Plan Name must be loaded into an entity's testing system, the name value can be modified by any health plan or information source based on its eligibility system requirements for Health Plan Name when undergoing certification testing. When a user modifies the Health Plan

Name for any of the health plan test data tabs it must also modify the Health Plan Name on the corresponding beneficiary test data tab in order to retain the appropriate association of the beneficiary to the correct health plan.

Health Plan Coverage Level

The CAQH CORE-authorized Testing Vendor(s) can accommodate a health plan or information source modifying the Coverage Level (EB02) from Employee to Individual as needed in order to load the benefit into its eligibility system. Therefore the Coverage Level can be modified by any health plan or information source based on its eligibility system requirements for coverage level when undergoing certification testing.

Health Plan Patient Liability

The CAQH CORE-authorized Testing Vendor(s) can accommodate a health plan or information source modifying the data value for Patient Liability data (In-Network and Out-of-Network Annual Base and Remaining Deductible, Co-Payment and Co-Insurance) as needed in order to load the benefit into its eligibility system. When the cell contains a data value that is not an explicit zero dollar (0$) amount, the actual data value may be modified to an appropriate data value for loading into the eligibility system, but a value MUST be loaded. Additionally, all zero dollar (0$) amounts MUST be loaded. Therefore, some of the Patient Liability amounts can be modified by any health plan or information source based on its eligibility system requirements for such data when undergoing certification testing. The constraints for not allowing modification of zero dollar (0$) amounts are related to the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule: Electronic Delivery of Patient Financial Information Rule which specify requirements for using a zero dollar (0$) amount in the v5010 277 response transaction.

ASC X12 Information Source Name

The name “Plan A Certification Payer” is used only in the NM103 segment in the 2100A Information Source loop. The name of the Information Source is not validated by the CAQH CORE-authorized Testing Vendor(s) in any of the certification test scripts. Therefore this value can be modified by any health plan or information source based on its eligibility system requirements when undergoing certification testing.

5.1.5.2. Beneficiary Data Options

Member ID

The CAQH CORE-authorized Testing Vendor(s) accommodate health plan and information source needs (e.g., length, format, datatype) regarding Member ID (MID) in their testing products. Thus, a health plan or information source may modify the MID in the Eligibility & Benefits CORE Master Test Bed Data in order to load the test data into its eligibility system.

Dependent

The CAQH CORE-authorized Testing Vendor(s) can accommodate health plan or information source needs regarding loading dependents in the Eligibility & Benefits CORE Master Test Bed Data with a unique Member ID (MID) into the health plan or information source eligibility systems as follows:

A health plan or information source may load the subscriber in its eligibility system using the MID as specified in the Eligibility & Benefits CORE Master Test Bed Data for the subscriber and then separately load the dependent from the Eligibility & Benefits CORE Master Test Bed Data into it eligibility system as a subscriber using the MID as specified in the Eligibility & Benefits CORE Master Test Bed Data for the dependent.

Or alternatively, a health plan or information source may modify the dependent’s MID in the Eligibility & Benefits CORE Master Test Bed Data to correspond to the subscriber’s MID as specified in the Master Test Bed Data and then load the dependent appropriately in its eligibility system.

Employee ID

The Employee ID is not validated by the CAQH CORE-authorized Testing Vendor(s) in any of the certification test scripts. Therefore the Employee ID can be modified, or not used, by a health plan or information source based on its eligibility system requirements for Employee ID when undergoing certification testing.

Provider Name

The Provider Name is not validated by the CAQH CORE-authorized Testing Vendor(s) in any of the certification test scripts. Therefore the Provider Name can be modified, or not used, by a health plan or information source based on its eligibility system requirements for Provider Name when undergoing certification testing.

NPI (National Provider ID)

The NPI is not validated by the CAQH CORE-authorized Testing Vendor(s) in any of the certification test scripts. Therefore the NPI can be modified by a health plan or information source based on its eligibility system requirements for NPI when undergoing certification testing.

Gender

The Gender of a beneficiary is not validated by the CAQH CORE-authorized Testing Vendor(s) in any of the certification test scripts. Therefore Gender can be modified, or not used, by a health plan or information source based on its eligibility system requirements for Gender when undergoing certification testing.

ASC X12 Information Receiver Name

The Information Receiver Name is used only in the NM103 segment in the 2100B Information Receiver loop. The name of the Information Receiver is not validated by the CAQH CORE-authorized Testing Vendor(s) in any of the certification test scripts. Therefore this value can be modified by any health plan or information source based on its eligibility system requirements when undergoing certification testing.

Identifiers and Other Data on the ASC X12 Control Segments

The CAQH CORE Eligibility & Benefit Operating Rules do not address the specific use and data content of the ISA, GS and ST Control Segments. However, some test scripts for the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule require that the entity undergoing certification testing must be able to conduct a valid ASC X12 Interchange containing either a v5010 270 inquiry or v5010 271 response transaction set.

The Master Test Bed Data does not specify any specific values that must be used in these control segments. Users are referred to the X12N HIPAA-adopted v5010 270/271 Implementation Guide Appendix for the proper use and values.

5.1.6. Using the Test Data

All CAQH CORE-authorized Testing Vendor(s) will use only data from the Eligibility & Benefits CORE Master Test Bed Data, combined with the Eligibility & Benefits CORE Certification Test Suite Scenarios and Detailed Test Scripts, when conducting CORE Certification Testing for the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule.

Although the Eligibility & Benefits CORE Master Test Bed Data are comprised of 32 beneficiaries (subscribers/dependents) and 13 associated health plans, the actual CORE Certification Testing does not include all beneficiaries (subscribers/dependents) and associated health plans. Each CAQH CORE-authorized Testing Vendor will determine which of the beneficiaries (subscribers/dependents) and associated health plans will be used during actual certification testing. This means that CAQH CORE-authorized Testing Vendor(s) will only create v5010 270s and v5010 271s and accept corresponding v5010 270s and v5010 271s that match the actual or modified beneficiary and health plan information in the Eligibility & Benefits CORE Master Test Bed Data.

The Eligibility & Benefits CORE Master Test Bed Data does not contain ISA/GS sender and receiver IDs. The actual v5010 270 and v5010 271 transaction sets sent during certification testing should have appropriate ISA/GS sender and receiver IDs as agreed to between the CAQH CORE-authorized Testing Vendor and the user, as well as appropriate control numbers at the ISA/GS/ST/BHT03 levels as required by the ASC X12 Standards and the HIPAA-adopted v5010 270/271 Implementation Guides. Batch test transaction cases may contain multiple eligibility requests and responses in each message. Therefore, organizations planning to undergo CORE-certification testing with a CAQH CORE-authorized Testing Vendor should extract the Eligibility & Benefits CORE Master Test Bed Data needed to appropriately load their internal databases for internal testing and CORE Certification Testing purposes.

The Eligibility & Benefits CORE Master Test Bed Data are not intended to provide all of the data elements that the user may need to completely populate its internal test file or test database in order to test for Eligibility & Benefits CORE compliance against the Detailed Test Scripts. Depending upon their specific

database structure requirements, users may be required to add other test data, or modify the Eligibility & Benefits CORE Master Test Bed Data as outlined in §4.1.3.

5.1.7. Test Data and Eligibility & Benefits CORE Certification

The Eligibility & Benefits CAQH CORE Certification Test Suite defines specific certification testing requirements and detailed Test Scripts for each of the CAQH CORE Eligibility & Benefits Operating Rules. These detailed Test Scripts are not intended to exhaustively and comprehensively test all requirements of the CORE rules. Rather, the Test Scripts focus on a key subset of each rule's requirements. Consequently, the scope of the Eligibility & Benefits CORE Master Test Bed Data are limited to data needed for the entity seeking to become Eligibility & Benefits CORE-certified to create and populate its internal files and/or databases for internal pre-certification testing and CORE Certification Testing for the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule.

Use of any non-CORE base test bed data for CORE Certification Testing outside of the guidelines set forth in §5.1 may result in unsuccessful testing results, which will not be accepted by CAQH.

5.1.8. Eligibility & Benefits CORE Certification Master Test Bed Data References

5.1.8.1. v5010 270/271 ASC X12 Reference Sheet

This table provides an example of the data mapping from the Eligibility & Benefits CORE Master Test Bed base data to its respective ASC X12 data element.

HEALTH PLAN				ASC X12 Mapping
Field	Min Len	Max Len	Data Attributes	Loop/Segment
NPI	10	10	Alpha Numeric	2100B/NM109 with 2100B / NM108 = "XX"
Subscriber ID	2	30	Alpha Numeric	2100C/NM109 with NM108 = "MI"
Subscriber First Name	1	25	Alpha Numeric	2100C/NM104
Subscriber Last Name	1	35	Alpha Numeric	2100C/NM103
Subscriber DOB	1	35	CCYYMMDD	2100C/DMG02 with DMG01 = “D8”
Service Type Code	1	2	Alpha Numeric	2110C or 2110D/EB03
Dependent First Name	1	25	Alpha Numeric	2100D/NM104
Dependent Last Name	1	35	Alpha Numeric	2100D/NM103
Dependent DOB	1	35	CCYYMMDD	2100D/DMG02 with DMG01 = "D8"
Health Plan Name	1	50	Alpha Numeric	2110C or 2110D/EB05
Health Plan Number	1	17	Alpha Numeric	2100C/REF02 with REF01 = “18”
Group Number	1	17	Alpha Numeric	2100C/REF02 with REF01 = “6P”