Payment & Remittance CAQH CORE Certification Test Suite
Version PR1.0
May 2020

Revision History For Payment & Remittance CAQH CORE Certification Test Suite

Version	Revision	Description	Date
3.0.0	Major	Phase III CORE EFT & ERA Operating Rules Voluntary Certification Master Test Suite balloted and approved by the CAQH CORE Voting Process.	June 2012
PR.1.0	Minor	• Non-substantive adjustments to support re-organization of operating rules into rule sets organized by business transaction (e.g., Eligibility & Benefits, Claim Status, etc.) rather than phase (e.g., Phase I, II, etc.) as approved by the CAQH CORE Board in 2019. • Operating rule naming, versioning and numbering methodologies updated to align with business transaction-based rule sets.	May 2020

Table of Contents

1. Introduction To Payment & Remittance CAQH CORE Certification Test Suite

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

- Key rule requirements for each CAQH CORE Payment & Remittance Operating Rule
- The specific conformance requirements and detailed testing for each CAQH CORE Payment & Remittance Operating Rule
- The required Certification Testing for each rule, including specific detailed step-by-step test scripts by rule
- Guidance to help stakeholders better understand the various types of stakeholders to which the CAQH CORE Payment & Remittance Operating Rules apply and how to determine when a specific detailed test script applies is also included

Note that the CAQH CORE Guiding Principles apply to the entire set of rules, including the Test Suite. CORE Certification Testing is not exhaustive and does not use production-level testing.

1.1. Applicability Of This Document

This CAQH CORE Certification Test Suite must be used by all stakeholders undergoing certification testing for the CAQH CORE Payment & Remittance Operating Rules.

1.2. Structure of Test Scenarios For All Rules

Each test scenario for each rule contains the following sections:

- Key Rule Requirements (the CAQH CORE Operating Rules document 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 §1.3 for guidance in determining when a specific test script may not apply.)

1.3. Detailed Step-By-Step Test Scripts

1.3.1. Stakeholder Categories-Determining Test Script Applicability

The Detailed Step-by-Step Test Scripts for each rule specify for which stakeholder type each test script applies. The stakeholder categories are:

- Provider
- Health Plan
- Clearinghouse
- 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 Certification Test 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 separately (see CAQH CORE Guiding Principles). Thus, when establishing a Certification Test Profile with a CAQH CORE-authorized Testing Vendor you will be given the option to indicate if the product you are certifying 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 you are 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.

1.3.2. Guidance for Health Plans Seeking Payment & Remittance CORE Certification Who Work With a CORE-certified Clearinghouse or Intermediary

Health plans that outsource to a clearinghouse or other intermediary various business functions related to ERA and EFT may have some unique CORE Certification issues. Because there is a clearinghouse, or similar type of intermediary, between the health plan and the provider, the clearinghouse will act as a "proxy" for some of the CORE Certification requirements outlined in this CAQH CORE Certification Test Suite. (NOTE: Such clearinghouses and intermediaries must be CORE-certified as well). Therefore, dependent upon the scenario between the health plan and clearinghouse, the health plan may not have to undergo certification testing for some of the rules, but rather may choose the N/A option for testing for a rule, and then upload a rationale statement explaining the situation to the CAQH CORE-authorized Testing Vendor.

Reminder: There exist varying scenarios for this type of situation. The requirements for meeting the CAQH CORE rule requirements 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.

1.3.3. Guidance for Providers Seeking Payment & Remittance CORE Certification Who Work With a CORE-certified Clearinghouse or Intermediary

Provider organizations seeking CORE Certification that use a clearinghouse to receive electronic remittance advices from payers may have some unique CORE Certification issues. Because there is a clearinghouse, or similar type of intermediary, between the provider and the payer, the clearinghouse will act as a "proxy" for some of the CORE Certification requirements outlined in this CAQH CORE Certification Test Suite. (NOTE: Such clearinghouses and intermediaries must be CORE-certified as well). Therefore, dependent upon the scenario between the provider and clearinghouse, the provider may not have to undergo certification testing for some of the rules, but rather may choose the N/A option for testing for a rule, and then upload a rationale statement explaining the situation to the CAQH CORE-authorized testing vendor.

Reminder: There exist varying scenarios for this type of situation. The requirements for meeting the CAQH CORE rule requirements for clearinghouses and providers differ by situation, as such variability is dependent on how the provider interacts with the clearinghouse and what services (i.e., functions and capabilities) the clearinghouse provides to the provider. Therefore, please keep in mind that certification testing will differ by scenario.

2. CAQH CORE Payment & Remittance (835) Infrastructure Rule Test Scenario

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:

Claim Payment/Advice Connectivity Requirements (§4.1)

1. Entities must be able to support the CAQH CORE Connectivity Rule vC2.2.0.
2. The requirement to support the CAQH CORE Connectivity Rule vC2.2.0 does not apply to retail pharmacy.

Claim Payment/Advice Batch Acknowledgement Requirements (§4.2)

3. A receiver of a v5010 835 transaction must return:
    a. A v5010 999 Implementation Acknowledgement for each Functional Group of v5010 835 transactions to indicate that the Functional Group was either accepted, accepted with errors or rejected, and
    b. To specify for each included v5010 835 transaction set that the transaction set was either accepted, accepted with errors or rejected.
4. A health plan must be able to accept and process a v5010 999 for a Functional Group of v5010 835 transactions.
5. When a Functional Group of v5010 835 transactions is either accepted with errors or rejected, the v5010 999 Implementation Acknowledgement must report each error detected to the most specific level of detail supported by the v5010 999 Implementation Acknowledgement.
6. The requirements specified in this section do not currently apply to retail pharmacy.

Dual Delivery of v5010 835 and Proprietary Paper Claim Remittance Advices (§4.3)

7. A health plan that currently issues proprietary paper claim remittance advices is required to continue to offer such paper remittance advices to each provider during that provider's initial implementation testing of the v5010 835 for a minimum of 31 calendar days from the initiation of implementation.
    a. If the 31 calendar day period does not encompass a minimum of three payments to the provider by the health plan, the health plan is required to offer to continue to issue proprietary paper claim remittance advices for a minimum of three payments.
    b. At the conclusion of this time period, delivery of the proprietary paper claim remittance advices will be discontinued. At the provider's discretion, the provider may elect to not receive the proprietary paper claim remittance advices, to choose a shorter time period, or to discontinue receiving the proprietary paper claim remittance advices before the end of the specified timeframe by notifying the health plan of this decision.
    c. Upon mutual agreement between the provider and the health plan, the timeframe for delivery of the proprietary paper claim remittance advices may be extended by an agreed-to timeframe, at which time the health plan will discontinue delivery of the proprietary paper claim remittance advices.
    d. If the provider determines it is unable to satisfactorily implement and process the health plan's electronic v5010 835 following the end of the initial dual delivery timeframe and/or after an agreed-to extension, both the provider and health plan may mutually agree to continue delivery of the proprietary paper claim remittance advices.
8. The requirements specified in this section do not currently apply to retail pharmacy.

2.1. Key Rule Requirements

Claim Payment/Advice Companion Guide (§4.4)

9. All CORE-certified entities' Companion Guides covering the v5010 835 must follow the format/flow as defined in the CAQH CORE v5010 Master Companion Guide Template for HIPAA Transactions.
10. The requirements specified in this section do not currently apply to retail pharmacy.

2.2. Conformance Testing Requirements

These scenarios test the following conformance requirements of the CAQH CORE Payment & Remittance (835) Infrastructure Rule. 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 999 is returned to indicate acceptance, acceptance with errors, or rejection of the Functional Group and the enclosed Transaction Set(s).
    a. Use of the CAQH CORE Connectivity Rule vC2.2.0 is required
2. A 999 is accepted and processed.
    a. Use of the CAQH CORE Connectivity Rule vC2.2.0 is required
3. Companion Document conforms to the flow and format of the CAQH CORE v5010 Master Companion Guide Template.
4. Companion Document conforms to the format for presenting each segment, data element and code flow and format of the CAQH CORE v5010 Master Companion Guide Template.
5. A health plan that currently issues proprietary paper claim remittance advices is required to continue to offer such paper remittance advices to each provider during that provider's initial implementation testing of the v5010 835.

2.3. Test Scripts Assumptions

1. A communications session between all parties is successfully established in compliance with the CAQH CORE Connectivity Rule vC2.2.0.
2. All communications sessions and logons are valid; no error conditions are created or encountered.
3. All transactions, data, communications session are valid; no error conditions are created or encountered.
4. Test scripts will test ONLY for valid and invalid ASC X12 Interchange, Functional Group, Transaction Set and will not test for v5010 835 data content.
5. The detailed content of the v5010 835 companion document will not be examined nor evaluated.
    a. The detailed content of the v5010 835 companion document will not be submitted to the CAQH CORE-authorized Testing Vendor.
    b. Test script will test ONLY that the table of contents of the companion document is:
        i. Customized and specific to the entity undergoing this test

***2.3. Test Scripts* Assumptions**
ii. Conforms to the flow as specified in the Table of Contents of the CAQH CORE v5010 Master Companion Document Template iii. Conforms to the presentation format for depicting segments, data elements and codes as specified in the CAQH CORE v5010 Master Companion Document Template 6. The test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

2.4. Detailed Step-By-Step Test Scripts

NOTES:

1. 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.
2. 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 [1]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [2]
1.	A 999 is returned for each Functional Group of v5010 835 transactions received (Key Rule Requirements #1 and #3)	An ASC X12 Interchange containing only a 999		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
2.	A 999 is accepted and processed for each Functional Group of v5010 835 transactions received (Key Rule Requirements #1 and #4)	An ASC X12 Interchange containing a Functional Group of an 835 is accepted		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
3.	A health plan that currently issues proprietary paper claim remittance advices is required to offer to continue such paper remittance advices to each provider during that provider's initial implementation testing of the v5010 835 (Key Rule Requirement #7)	Submission of attestation that proprietary paper claim remittance advices will be delivered per the rule requirements		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

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

[2] 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 [3]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [4]
4.	Companion Document conforms to the flow and format of the CAQH CORE v5010 Master Companion Guide Template (Key Rule Requirement #9)	Submission of the Table of Contents of the v5010 835 companion document, including a example of the 835 content requirements		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
5.	Companion Document conforms to the format for presenting each segment, data element and code flow and format of the CAQH CORE v5010 Master Companion Guide Template (Key Rule Requirement #9)	Submission of a page of the v5010 835 companion document depicting the presentation of segments, data elements and codes showing conformance to the required presentation format		☐ 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.

3. CAQH CORE Payment & Remittance CARCs and RARCs Rule Test Scenario

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.

Requires that:

Uniform Use of Claim Adjustment Reason Codes, Remittance Advice Remark Codes, Claim Adjustment Group Codes & NCPDP Reject Codes (§4.1.2)

1. A CORE-certified health plan or its PBM agent must align its internal codes and corresponding business scenarios to the CORE-defined Claim Adjustment/Denial Business Scenarios specified in §4.1.1 and the CARC, RARC, CAGC and NCPDP Reject Code combinations specified in the *CORE-required Code Combinations for CORE-defined Business Scenarios.doc*.

Use of CORE-required CARC/RARC/CAGC/NCPDP Reject Code Combinations (§4.1.3)

2. A CORE-certified health plan or its PBM agent must support the maximum CORE-required CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC combinations in the v5010 835, as specified in *CORE-required Code Combinations for CORE-defined Business Scenarios.doc.*
    a. No other CARC/RARC/CAGC or CARC/NCPDP Reject Codes/CAGC combinations are allowed for use in the CORE-defined Claim Adjustment/Denial Business Scenarios.
    b. When specific CORE-required CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC combinations are not applicable to meet the health plan's or its PBM agent's business requirements within the CORE-defined Business Scenarios, the health plan and its PBM agent is not required to use them.
    c. The only exception to this maximum set of CORE-required CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC combinations is when the respective code committees responsible for maintaining the codes create a new code or adjust an existing code. Then the new or adjusted code can be used with the Business Scenarios and a CAQH CORE process for updating the Code Combinations will review the ongoing use of these codes within the maximum set of codes for the Business Scenarios.
    d. A deactivated code must not be used.

3. In the case where a health plan or its PBM agent wants to use an existing code combination that is not included in the maximum code combination set for a given CORE-defined Business Scenario, a new CARC/RARC code combination must be requested in accordance with the CAQH CORE process for updating the *CORE-required Code Combinations for CORE-defined Business Scenarios.doc.*

Basic Requirements for Receivers of the v5010 835 (§4.2)

4. When receiving a v5010 835 a CORE-certified product (e.g., a vendor's provider-facing system or solution) extracting the data from the v5010 835 for manual processing must make available to the end user:
    a. Text describing the CARC/RARC/CAGC and CARC/NCPDP Reject Codes *included in the remittance advice,* ensuring that the actual wording of the text displayed accurately represents the corresponding code description specified in the code lists without changing the meaning and intent of the description

And

    b. Text describing the corresponding CORE-defined Claim Adjustment/Denial Business Scenario.

3.1. Key Rule Requirements

5. The requirement to make available to the end user text describing the corresponding CORE-defined Claim Adjustment/Denial Business Scenario does not apply to retail pharmacy.
6. This requirement does not apply to a CORE-certified entity that is simply forwarding the v5010 835 to another system for further processing.

3.2. Conformance Testing Requirements

These scenarios test the following conformance requirements of the CAQH CORE Payment & Remittance CARCs and RARCs Rule. 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. Health plan must align its internal codes and corresponding business scenarios to the CORE-defined Claim Business Scenarios and maximum CORE-required Code Combinations in the v5010 835.
2. A vendor's provider-facing system or solution must be able to extract and make available to the end-user appropriate text accurately describing the business scenario and meaning of the code combination.

3.3. Test Scripts Assumptions

1. The test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

3.4. Detailed Step-By-Step Test Scripts

NOTES:

1. 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.
2. 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 [5]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [6]
1.	Health plans must align its internal codes and corresponding business scenarios to the CORE-defined Claim Business Scenarios and maximum CORE-required Code Combinations in the v5010 835 (Key Rule Requirements #1-3)	When submitting testing certification documentation to CAQH CORE, a health plan will be asked to sign an attestation form that its system has been modified to map the CORE-defined Business Scenarios		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	A vendor's provider-facing system or solution must be able to extract and make available to the end-user appropriate text accurately describing the business scenario and meaning of the code combinations (Key Rule Requirement #4)	Submit a screen shot of the remittance advice showing that the required information is displayed		☐ 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. CAQH CORE Payment & Remittance Reassociation (CCD+835) Rule Test Scenario

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.

Requires that:

Receipt of the CORE-required Minimum CCD+ Data Required for Reassociation (§4.1)

1. A CORE-certified health plan must proactively inform the healthcare provider during EFT (CCD+) and ERA (v5010 835) enrollment that it will need to contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for successful reassociation.
2. A CORE-certified healthcare provider must proactively contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for successful reassociation.

Elapsed Time between Sending the v5010 835 and the CCD+ Transactions (§4.2)

3. A CORE-certified health plan must release for transmission to the healthcare provider the v5010 835 corresponding to the CCD+ :
    a. No sooner than three business days based on the time zone of the health plan prior to the CCD+ Effective Entry Date and
    b. No later than three business days after the CCD+ Effective Entry Date.
4. A CORE-certified health plan must ensure that the both CCD+ Effective Entry Date and the corresponding v5010 835 BPR16 date are the same valid banking day.
5. For retail pharmacy, the CORE-certified health plan may release for transmission the v5010 835 any time prior to the CCD+ Effective Entry Date of the corresponding EFT; and no later than three days after the CCD+ Effective Entry Date (§4.2.1).

Elapsed Time Auditing Requirements (§4.2.2)

6. A CORE-certified health plan must ensure the v5010 835 and corresponding CCD+ meet the elapsed time requirements.
7. A CORE-certified health plan is required to have the capability to track and audit this elapsed time requirement.

Resolving Late/Missing EFT and ERA Transactions (§4.3)

8. A CORE-certified health plan must establish written Late/Missing EFT and ERA Transactions Resolution Procedures defining the process a healthcare provider must use when researching and resolving both late or missing CCD+ payment and/or the corresponding late or missing v5010 835.
9. For retail pharmacy, a late or missing v5010 835 is defined as a maximum elapsed time of four business days following the receipt of the CCD+.
10. The Late/Missing EFT and ERA Resolution Procedures must be delivered to the healthcare provider during its EFT and ERA enrollment with the health plan.

4.2. Conformance Testing Requirements

These scenarios test the following conformance requirements of the CAQH CORE Payment & Remittance Reassociation (CCD+835) Rule. 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 CORE-certified health plan must proactively inform the healthcare provider during EFT (CCD+) and ERA (v5010 835) enrollment that it will need to contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for successful reassociation.
2. A CORE-certified health plan must release for transmission to the healthcare provider the v5010 835 corresponding to the CCD+ no sooner than three business days before and no later than three business days after the CCD+ Effective Entry Date.
3. A CORE-certified health plan is required to have the capability to track and audit this elapsed time requirement.

4.3. Test Scripts Assumptions

1. The test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

4.4. Detailed Step-By-Step Test Scripts

NOTES:

1. 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.
2. 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 [7]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [8]
1.	A CORE-certified health plan must proactively inform the healthcare provider during EFT (CCD+) and ERA (v5010 835) enrollment that it will need to contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for successful reassociation (Key Rule Requirement #1)			☐ Pass	☐ Fail	☐	☒	☒	☒	☐
a.		If written instructions are provided, health plan must submit documentation showing the actual method/approach used for informing provider to contact its financial institution		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
OR										
b.		If verbal instructions are provided, when submitting testing certification documentation to CAQH CORE, a health plan will be asked to sign an attestation form stating it verbally informs providers to contact their financial institutions		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	A CORE-certified health plan must release for transmission to the healthcare provider the v5010 835 corresponding to the CCD+ no sooner than three business days before and no later than three									

[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.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [7]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [8]
	business days after the CCD+ Effective Entry Date (Key Rule Requirement #3)									
a.		Submit five time stamped, real world, de-identified examples of v5010 835 and CCD+ transactions that meet the elapsed time requirements AND When submitting testing certification documentation to CAQH CORE a health plan will be asked to sign an attestation form that its system has been modified to support the elapsed time requirements specified in the rule		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
OR										
b.		When submitting testing certification documentation to CAQH CORE a health plan will be asked to sign an attestation form that its system has been modified to support the elapsed time requirements specified in the rule		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	A CORE-certified health plan is required to have the capability to track and audit this elapsed time requirement (Key Rule Requirement #7)	Submit an audit log or other documentation demonstrating capability to capture, log, audit and track the necessary data elements. Any PHI in the audit log/documentation must first be de-identified prior to submission.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

5. CAQH CORE Payment & Remittance EFT Enrollment Data Rule Test Scenario

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.

Requires that:

CORE-required Maximum EFT Enrollment Data Elements (§4.2)

1. A health plan (or its agent or vendors offering EFT enrollment) is required to collect no more data elements than the maximum data elements defined in Table 4.2-1 CORE-required Maximum EFT Enrollment Data Set.
2. Both the Individual Data Element name and its associated description must be used by a health plan (or its agent or vendors offering EFT enrollment) when collecting EFT enrollment data either electronically or via a manual paper-based process.
3. The Individual Data Element Name and its associated description must not be modified.
4. When a Data Element Group (DEG) is designated as required, all of the Individual Data Elements designated as required within the DEG must be collected by the health plan.
    a. Data Element Groups are composed of Data Elements that can be logically related where each single discrete data element can form a larger grouping or a set of data elements.
5. Individual Data Elements designated as optional may be collected depending on the business needs of the health plan.
6. When a DEG is designated as optional, the collection of the optional DEG is at the discretion of the health plan.
7. When a health plan exercises its discretion to collect an optional DEG, any included Individual Data Element designated as required must be collected.
8. When a health plan collects an optional Individual Data Element that is composed of one more optional Sub-element, the optional Sub-element may be collected at the discretion of the health plan.
9. When a health plan collects a required Individual Data Element that is composed of one or more optional Sub-elements, the optional Sub-element may be collected at the discretion of the health plan.
10. Not collecting an Individual Data Element identified as optional does not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set.
11. The collection of multiple occurrences of DEGs for another context does not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set.
12. A health plan must develop and make available to the healthcare provider (or its agent) specific written instructions and guidance for the healthcare provider (or its agent) when providing and submitting the data elements in Table 4.2-1.
    a. The health plan’s specific instructions and guidance are not addressed in this CAQH CORE rule.
13. When an enrollment is being changed or cancelled, the health plan must make available to the provider instructions on the specific procedure to accomplish a change in their enrollment or to cancel their enrollment.

5.1. Key Rule Requirements

CORE Master Template for Collecting Manual Paper-Based Enrollment EFT Enrollment Data (§4.3.1)

14. The name of the health plan (or its agent or the vendor offering EFT) and the purpose of the form will be on the top of the form, e.g., Health Plan X: Electronic Funds Transfer (EFT) Authorization Agreement.
15. A health plan (or its agent or a vendor offering EFT) is required to use the format, flow, and data set including data element descriptions of Table 4.2-1 as the CORE Master EFT Enrollment Submission Form when using a manual paper-based enrollment method.
16. All CORE-required EFT Enrollment data elements must appear on the paper form in the same order as they appear in Table 4.2-1.
17. A health plan (or its agent) cannot revise or modify:
    a. The name of a CORE Master EFT Enrollment Data Element Name
    b. The usage requirement of a CORE Master EFT Enrollment Data Element
    c. The Data Element Group number of a CORE Master EFT Enrollment Data Element
18. Beyond the data elements and their flow, a health plan (or its agent) must:
    a. Develop and make available to the healthcare provider (or its agent) specific written instructions and guidance for the healthcare provider (or its agent) when completing and submitting the enrollment form, including when using paper
    b. Provide a number to fax and/or a U.S. Postal Service or email address to send the completed form
    c. Include contact information for the health plan, specifically a telephone number and/or email address to send questions
    d. Include authorization language for the provider to read and consider
    e. Include a section in the form that outlines how the provider can access online instructions for how the provider can determine the status of the EFT enrollment
    f. Clearly label any appendix describing its purpose as it relates to the provider enrolling in EFT
    g. Inform the provider that it must contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the ERA. *See CORE EFT & ERA Reassociation (CCD+/835) Rule*

CORE Master Template for Electronic Enrollment EFT Enrollment Data (§4.3.2)

19. When electronically enrolling a healthcare provider in EFT, a health plan (or its agent) must use the CORE Master EFT Enrollment Data Element Name and Sub-element Name as specified in Table 4.2-1 without revision or modification.
20. The flow, format and data set including data element descriptions established by this rule must be followed.
21. When using an XML-based electronic approach, the Data Element Name and Sub-element Name must be used exactly as represented in the table enclosed in angle brackets (i.e., < >) for the standard XML element name; and all spaces replaced with an underscore [_] character, e.g., <Provider_Address>.
22. A health plan (or its agent or vendors offering EFT enrollment) will offer an electronic way for provider to complete and submit the EFT enrollment.

5.1. Key Rule Requirements

CORE Electronic Safe Harbor for EFT Enrollment to Occur Electronically (§4.4)

23. Specifies that all health plans and their respective agents must implement and offer to any trading partner an electronic method and process for collecting the CORE-required Maximum EFT Enrollment Data Set.

Time Frame for Rule Compliance (§4.5)

24. Not later than the date that is six months after the date of certification, a health plan or its agent that uses a paper-based form to collect and submit the CORE-required Maximum EFT Enrollment Data Set must convert all its paper-based forms to comply with the data set specified in this rule.
25. If a health plan or its agent does not use a paper-based manual method and process to collect the CORE-required Maximum EFT Enrollment Data Set at time of certification, it is not required by this rule to implement a paper-based manual process on or after the date of certification.
26. It will be expected that at the time of certification all electronic EFT enrollment will meet this rule requirement and that, upon certification, the health plan (or its agent) will inform its providers that an electronic option is now available, if not previously available.

5.2. Conformance Testing Requirements

These scenarios test the following conformance requirements of the CAQH CORE Payment & Remittance EFT Enrollment Data Rule. 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. Health plans must use the CORE-required Maximum EFT Enrollment Data Set for electronic enrollment.
2. Health plans must use the CORE-required Maximum EFT Enrollment Data Set for paper-based enrollment.
3. Health plans must conform to the CORE EFT Master Template flow and format when collecting the CORE-required Maximum EFT Enrollment Data Set for electronic enrollment.
4. Health plans must conform to the CORE EFT Master Template flow and format when collecting the CORE-required Maximum EFT Enrollment Data Set for paper-based enrollment.
5. Health plans must offer an electronic method for EFT enrollment.
6. The required timeframe for conversion of proprietary paper forms to compliant paper forms is six months from date of certification.

5.3. Test Scripts Assumptions

1. The test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

5.4. Detailed Step-By-Step Test Scripts

NOTES:

1. 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.
2. 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 [9]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [10]
1.	A health plan must use the CORE Master EFT Enrollment Data Element Name and Sub-element Name as specified for manual paper-based enrollment without revision or modification (Key Rule Requirements #1 through #10 and #19)	Submit a copy of complete paper EFT enrollment form		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	A health plan must use the CORE Master EFT Enrollment Data Element Name and Sub-element Name as specified for electronic enrollment without revision or modification (Key Rule Requirements #1 through #10 and #19)	Submit a copy of a screen shot of the complete electronic EFT enrollment form		☐ 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 [11]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [12]
3.	A health plan must use the CORE EFT Master Template format flow when using a manual paper-based enrollment method (Key Rule Requirement #14 through #18)	Submit a copy of complete paper EFT enrollment form		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
4.	A health plan must use the CORE EFT Master Template format flow for electronic enrollment method (Key Rule Requirement #19 through #22)	Submit a copy of a screen shot of the complete electronic EFT enrollment form		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
5.	A health plan must implement an electronic method and process for collecting the CORE-required Maximum EFT Enrollment Data Set. (Key Rule Requirement #23)									
a.		Enable the CAQH CORE-authorized Testing Vendor to access and view health plan's online enrollment system		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
OR										
b.		Submit description that is shared with providers of how enrollment is offered electronically and submit a copy of the complete electronic EFT enrollment capability, e.g., screen shots		☐ 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]
6.	Not later than 6 months from date of CORE Certification a health plan must convert its existing paper-based forms to comply with the CORE-required data set (Key Rule Requirement #24)	When submitting testing certification documentation to CAQH CORE, a health plan will be asked to sign an attestation form attesting that its existing paper-based forms have been/will be converted to the CORE-required data set. Six months from date of certification, CAQH CORE will follow-up with certified entity to confirm usage		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

6. CAQH CORE Payment & Remittance ERA Enrollment Data Rule Test Scenario

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.

Requires that:

CORE-required Maximum ERA Enrollment Data Elements (§4.2)

1. A health plan (or its agent or vendors offering ERA enrollment) is required to collect no more data elements than the maximum data elements defined in Table 4.2-1 CORE-required Maximum ERA Enrollment Data Set.
2. Both the Individual Data Element name and its associated description must be used by a health plan (or its agent or vendors offering ERA enrollment) when collecting ERA enrollment data either electronically or via a manual paper-based process.
3. The Individual Data Element Name and its associated description must not be modified.
4. When a Data Element Group (DEG) is designated as required, all of the Individual Data Elements designated as required within the DEG must be collected by the health plan.
    a. Data Element Groups are composed of Data Elements that can be logically related where each single discrete data element can form a larger grouping or a set of data elements.
5. Individual Data Elements designated as optional may be collected depending on the business needs of the health plan.
6. When a DEG is designated as optional, the collection of the optional DEG is at the discretion of the health plan.
7. When a health plan exercises its discretion to collect an optional DEG, any included Individual Data Element designated as required must be collected.
8. When a health plan collects an optional Individual Data Element that is composed of one more optional Sub-element, the optional Sub-element may be collected at the discretion of the health plan.
9. When a health plan collects a required Individual Data Element that is composed of one or more optional Sub-elements, the optional Sub-element may be collected at the discretion of the health plan.
10. Not collecting an Individual Data Element identified as optional does not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set.
11. The collection of multiple occurrences of DEGs for another context does not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set.
12. A health plan must develop and make available to the healthcare provider (or its agent) specific written instructions and guidance for the healthcare provider (or its agent) when providing and submitting the data elements in Table 4.2-1.
    a. The health plan’s specific instructions and guidance are not addressed in this CORE rule.
13. When an enrollment is being changed or cancelled, the health plan must make available to the provider instructions on the specific procedure to accomplish a change in their enrollment or to cancel their enrollment.

6.1. Key Rule Requirements

CORE Master Template for Collecting Manual Paper-Based Enrollment ERA Enrollment Data (§4.3.1)

14. The name of the health plan (or its agent or the vendor offering ERA) and the purpose of the form will be on the top of the form, e.g., Health Plan X: Electronic Funds Transfer (ERA) Authorization Agreement.
15. A health plan (or its agent or a vendor offering ERA) is required to use the format, flow, and data set including data element descriptions of Table 4.2-1 as the CORE Master ERA Enrollment Submission Form when using a manual paper-based enrollment method.
16. All CORE-required ERA Enrollment data elements must appear on the paper form in the same order as they appear in Table 4.2-1.
17. A health plan (or its agent) cannot revise or modify:
    a. The name of a CORE Master ERA Enrollment Data Element Name
    b. The usage requirement of a CORE Master ERA Enrollment Data Element
    c. The Data Element Group number of a CORE Master ERA Enrollment Data Element
18. Beyond the data elements and their flow, a health plan (or its agent) must:
    a. Develop and make available to the healthcare provider (or its agent) specific written instructions and guidance for the healthcare provider (or its agent) when completing and submitting the enrollment form, including when using paper
    b. Provide a number to fax and/or a U.S. Postal Service or email address to send the completed form
    c. Include contact information for the health plan, specifically a telephone number and/or email address to send questions
    d. Include authorization language for the provider to read and consider
    e. Include a section in the form that outlines how the provider can access online instructions for how the provider can determine the status of the ERA enrollment
    f. Clearly label any appendix describing its purpose as it relates to the provider enrolling in ERA
    g. Inform the provider that it must contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the ERA. *See CORE ERA & ERA Reassociation (CCD+/835) Rule*

CORE Master Template for Electronic Enrollment ERA Enrollment Data (§4.3.2)

19. When electronically enrolling a healthcare provider in ERA, a health plan (or its agent) must use the CORE Master ERA Enrollment Data Element Name and Sub-element Name as specified in Table 4.2-1 without revision or modification.
20. The flow, format and data set including data element descriptions established by this rule must be followed.
21. When using an XML-based electronic approach, the Data Element Name and Sub-element Name must be used exactly as represented in the table enclosed in angle brackets (i.e., < >) for the standard XML element name; and all spaces replaced with an underscore [_] character, e.g., <Provider_Address>.
22. A health plan (or its agent or vendors offering ERA enrollment) will offer an electronic way for provider to complete and submit the ERA enrollment.

6.1. Key Rule Requirements

CORE Electronic Safe Harbor for ERA Enrollment to Occur Electronically (§4.4)

23. Specifies that all health plans and their respective agents must implement and offer to any trading partner an electronic method and process for collecting the CORE-required Maximum ERA Enrollment Data Set.

Time Frame for Rule Compliance (§4.5)

24. Not later than the date that is six months after the date of certification, a health plan or its agent that uses a paper-based form to collect and submit the CORE-required Maximum ERA Enrollment Data Set must convert all its paper-based forms to comply with the data set specified in this rule.
25. If a health plan or its agent does not use a paper-based manual method and process to collect the CORE-required Maximum ERA Enrollment Data Set at time of certification, it is not required by this rule to implement a paper-based manual process on or after the date of certification.
26. It will be expected that at the time of certification all electronic ERA enrollment will meet this rule requirement and that upon certification, the health plan (or its agent) will inform its providers that an electronic option is now available, if not previously available.

6.2. Conformance Testing Requirements

These scenarios test the following conformance requirements of the *CORE ERA Enrollment Data Rule*. 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. Health plans must use the CORE-required Maximum ERA Enrollment Data Set for electronic enrollment.
2. Health plans must use the CORE-required Maximum ERA Enrollment Data Set for paper-based enrollment.
3. Health plans must conform to the CORE ERA Master Template flow and format when collecting the CORE-required Maximum ERA Enrollment Data Set for electronic enrollment.
4. Health plans must conform to the CORE ERA Master Template flow and format when collecting the CORE-required Maximum ERA Enrollment Data Set for paper-based enrollment.
5. Health plans must offer an electronic method for ERA enrollment.
6. The required timeframe for conversion of proprietary paper forms to compliant paper forms is six months from date of certification.

6.3. Test Scripts Assumptions

1. The test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

6.4. Detailed Step-By-Step Test Scripts

NOTES:

1. 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.
2. 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 [13]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [14]
1.	A health plan must use the CORE Master ERA Enrollment Data Element Name and Sub-element Name as specified for manual paper-based enrollment without revision or modification (Key Rule Requirements #1 through #10 and #19)	Submit a copy of complete paper ERA enrollment form		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	A health plan must use the CORE Master ERA Enrollment Data Element Name and Sub-element Name as specified for electronic enrollment without revision or modification (Key Rule Requirements #1 through #10 and #19)	Submit a copy of a screen shot of the complete electronic ERA enrollment form		☐ 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 [15]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [16]
3.	A health plan must use the CORE ERA Master Template format flow when using a manual paper-based enrollment method (Key Rule Requirement #14 through #18)	Submit a copy of complete paper ERA enrollment form		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
4.	A health plan must use the CORE ERA Master Template format flow for electronic enrollment method (Key Rule Requirement #19 through #22)	Submit a copy of a screen shot of the complete electronic ERA enrollment form		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
5.	A health plan must implement an electronic method and process for collecting the CORE-required Maximum ERA Enrollment Data Set. (Key Rule Requirement #23)									
a.		Enable the CAQH CORE-authorized Testing Vendor to access and view health plan's online enrollment system		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
OR										
b.		Submit description that is shared with providers of how enrollment is offered electronically and submit a copy of the complete electronic ERA enrollment capability, e.g., screen shots		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

[15] A checkmark in the box indicates the stakeholder type to which the test 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]
6.	Not later than 6 months from date of CORE Certification a health plan must convert its existing paper-based forms to comply with the CORE-required data set (Key Rule Requirement #24)	When submitting testing certification documentation to CAQH CORE, a health plan will be asked to sign an attestation form attesting that its existing paper-based forms have been/will be converted to the CORE-required data set. Six months from date of certification, CAQH CORE will follow-up with certified entity to confirm usage		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

7. CAQH CORE Connectivity Rule vC2.2.0 Test Scenario [17]

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 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) [18]
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 by the appropriate CAQH CORE Companion Guide Rule. (§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)

[17] 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.

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

7.1. 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 by the appropriate CAQH CORE Companion Guide Rules. (§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)

7.1. 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)

7.2. 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.

7.3. 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.

7.4. 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 [19]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [20]
Real Time Connectivity Test Scripts										
1.	Implement and enforce **one of two** Submitter Authentication standards on communications **server** (Key Rule Requirement #3 and #12)									
1.1	Implement and enforce use of Username/Password over SSL on communications **server** (Key Rule Requirement #3 and #12)	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** (Key Rule Requirement #3 and #12)	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** (Key Rule Requirement #1, #10 and #37)									
2.1	Implement SOAP+WSDL Message Envelope Standard and envelope metadata as a communications **server** (Key	Communications server accepts a valid logon by a client conforming to the SOAP+WSDL envelope and		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [19]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [20]
	Rule Requirement #1, #10 and #37)	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								
2.2	Implement HTTP MIME Multipart Message Envelope Standard and envelope metadata as a communications **server** (Key Rule Requirement #1, #10 and #37)	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** (Key Rule Requirement #18, #21)									
3.1	Implement Username/Password submitter authentication method as a communications **client** (Key Rule Requirement #18, #21, and #24)	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** (Key Rule Requirement #18, #21, #24)	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** (Key Rule Requirement #16, #19 and #37)									

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [19]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [20]
4.1	Implement SOAP+WSDL Message Envelope Standard and envelope metadata as a communications **client** (Key Rule Requirement #16, #19 and #37)	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** (Key Rule Requirement #16, #19 and #37)	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 (Key Rule Requirement #25 and #27)	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 (Key Rule Requirement #25 and #27)	Output a system generated audit log report showing all required data elements		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [19]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [20]
Batch Connectivity Test Scripts (Required only if Batch is supported)										
7.	Implement and enforce **one of two** Submitter Authentication standards on communications **server** (Key Rule Requirement #3 and #12)									
7.1	Implement and enforce use of Username/Password over SSL on communications **server** (Key Rule Requirement #3 and #12)	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** (Key Rule Requirement #3 and #12)	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** (Key Rule Requirement #2, #11 and #37)									
8.1	Implement SOAP+WSDL Message Envelope Standard and envelope metadata as a communications **server** (Key Rule Requirement #2, #11 and #37)	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 [19]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [20]
8.2	Implement HTTP MIME Multipart Message Envelope Standard and envelope metadata as a communications **server** (Key Rule Requirement #2, #11 and #37)	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** (Key Rule Requirement #18, #21)									
9.1	Implement Username/Password submitter authentication method as a communications **client** (Key Rule Requirement #18, #21, and #24)	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** (Key Rule Requirement #18, #21, #24)	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** (Key Rule Requirement #16, #19 and #37)									

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [19]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [20]
10.1	Implement SOAP+WSDL Message Envelope Standard and envelope metadata as a communications **client** (Key Rule Requirement #17, #20, and #37)	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** (Key Rule Requirement #17, #20, and #37)	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 (Key Rule Requirement #25 and #27)	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 (Key Rule Requirement #25 and #27)	Output a system generated audit log report showing all required data elements		☐ Pass	☐ Fail	☒	☐	☒	☒	☐