



Committee on Operating Rules
for Information Exchange

A CAQH Initiative

CORE Phase I Policies and Operating Rules

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v5010 Update March 2011

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Phase I Glossary: <http://www.caqh.org/pdf/CLEAN5010/PIGlossary.pdf>

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Phase I CORE 100 Eligibility and Benefits Guiding Principles **version 1.1.0 March 2011**

This document provides the Phase I CORE guiding principles and underlying assumptions that are associated with all Phase I CORE rules.

CORE GUIDING PRINCIPLES

- *All CORE Participants and CORE-certified entities will work towards achieving CORE's mission.*
- *All stakeholders are key to CORE's success; no single organization, nor any one segment of the industry, can do it alone.*
- *CAQH will strive to include participation by all key stakeholders in the CORE rule making process. CORE has established Governing Procedures; under these Procedures, each CORE member that meets CORE voting criteria will have one vote on CORE issues and rules.*
- *CAQH serves as the facilitator, while CORE participants draft and vote on the rules.*
- *Participation in CORE does not commit an organization to adopt the resulting CORE Operating Rules.*
- *Use of and participation in CORE is non-exclusive.*
- *CORE will not be involved in trading partner relationships, and will not dictate relationships between trading partners.*
- *To promote interoperability, rules will be built upon HIPAA-adopted standards, and CORE will coordinate with other key industry bodies (for example, X12 and Blue Exchange).*
- *Where appropriate, CORE will address the emerging interest in XML.*
- *Whenever possible, CORE has used existing market research and proven rules. CORE Operating Rules reflect lessons learned from other organizations that have addressed similar issues.*
- *CORE Operating Rules will support the Guiding Principles of HHS's National Health Information Network (NHIN).*
- *CAQH research indicated that there will be benefit to the health care industry as a result of adopting eligibility operating rules. CORE will have Measures of Success for Phase I (methodology to measure success and evaluate market impact) and CAQH will report aggregate findings by stakeholder type. Full benefits may not be experienced until Phase II.*
- *CORE will provide guidance to stakeholders regarding staff implementation and training needs.*
- *Safeguards will be put in place to make sure that a health plan's benefit and payment information is shared only with the requested provider and is not available to other participating health plans.*
- *CORE will not build a switch, database, or central repository of information.*
- *All CORE recommendations and rules will be vendor neutral.*
- *All of the Phase I CORE Operating Rules are expected to evolve as Phase I is a starting point.*
- *Rules will not be based on the least common denominator but rather will encourage feasible Phase I progress.*
- *CORE will promote and encourage voluntary adoption of the rules.*
- *CORE participants do not support "phishing."*

Phase I CORE 100 Eligibility and Benefits Guiding Principles
version 1.1.0 March 2011

UNDERLYING ASSUMPTIONS FOR ALL CORE PHASE I RULES

- Phase I CORE Operating Rules apply only to ASC X12 005010X279A1 Eligibility and Benefit Request and Response (270/271) transactions; DDE (Direct Data Entry) transactions and web-based transactions are not part of the Phase I scope.
- All Phase I CORE Operating Rules assume a successful communication connection has been established and that all parties in the transaction routing path are CORE-certified.
- Phase I CORE Operating Rules are a floor, not a ceiling; certified entities can go beyond the Phase I CORE Operating Rules, e.g. provider accumulator information.
- CORE complies with all antitrust provisions of the law.
- Organizations may sign the Pledge at any time after the CORE Operating Rules are developed and approved by the CORE voting members, and may withdraw from the Pledge at any time.
- No individual CORE participant owns the rules or the underlying intellectual property; CAQH CORE owns the rules and intellectual property.
- The CORE Operating Rules will not specify how participants implement any changes to current processes and procedures. CORE will not assume any of the expenses that an organization incurs in making such changes.
- Neither CORE nor participating organizations will be liable if incorrect information is transmitted.
- Complying with CORE Operating Rules does not release any organization adopting the rules from ensuring that it is in compliance with all other applicable rules, regulations and legal requirements.
- All organizations that operate under the CORE Operating Rules are HIPAA-compliant, and organizations intending to operate under the CORE Operating Rules will be asked to attest to this fact. However, CORE will not test for HIPAA compliance.
- CORE Operating Rules address both real-time and batch transactions, with movement towards real-time.
- There will not be changes or amendments to the rules unless approved by a CORE vote.

UNDERLYING PRINCIPLES AND ASSUMPTIONS FOR SPECIFIC RULES

The Pledge

- Signing the Pledge does not automatically allow the organization to participate in the CORE rule making process; to become involved in the CORE rule making process, the organization must be a CORE participant.
- All stakeholders that sign the Pledge and become CORE-certified stay CORE-certified to maintain their name on the CORE Pledge. There will be a web-based listing of entities that have signed the Pledge.

Certification

- There will be a web-based listing of entities that are CORE-certified.

Enforcement

- An organization certified under the CORE Operating Rules will be party to the CORE enforcement process.
- The CORE enforcement process requires all parties involved in the complaint to be CORE-certified, except for providers that are not CORE-certified but are an end-user of a CORE-certified product.
- CORE-certified entities are permitted to work with any entity of their choice, including entities not participating in CORE.

Phase I CORE 101 Eligibility and Benefits Pledge
version 1.1.0 March 2011

The Council for Affordable Quality Healthcare (CAQH[®]) has created the Committee on Operating Rules for Information Exchange (CORE[®]). CORE's mission is to use common business rules (the "Operating Rules") to promote interaction of healthcare trading partners and the exchange of healthcare-related information in a consistent, clear, and standardized manner and in compliance with applicable laws and regulations. Developing consistency between trading partners, and thus promoting interoperability, would benefit the healthcare industry by improving the usefulness of healthcare information and reducing administrative costs for stakeholders involved in healthcare data exchange. CORE's vision (the "CORE Vision") is attached as Exhibit A.

Phase I of CORE's mission is focused on promulgating Operating Rules to increase the usefulness of, and reduce the administrative challenges associated with, eligibility and benefit inquiries by giving providers access to a patient's eligibility information at the time of service (or before) using the provider's preferred electronic means. Subsequent phases will broaden the Operating Rules to expand the Operating Rules surrounding eligibility and benefit inquiries and to include additional administrative transaction types consistent with the CORE Vision. As additional Operating Rules are promulgated in subsequent phases, Participant and CORE may incorporate those additional Operating Rules into this Pledge by executing a separate addendum that incorporates the additional Operating Rules into this Pledge. The CORE Phase I Operating Rules are attached as Exhibit B.

_____ ("Participant") hereby endorses CORE's mission.

In furtherance of CORE's mission, Participant pledges to adopt, implement, and comply with the CORE Operating Rules as promulgated by CORE and in effect as of the date of this Pledge, in accordance with the timeframes set forth in the Phase I CORE Operating Rules, as and to the extent applicable to Participant's business. In addition, Participant pledges to use reasonable efforts to encourage Participant's trading partners to use the CORE Operating Rules. Moreover, Participant will participate in the CORE Certification Program described in the CORE Operating Rules ("Certification") to the extent applicable.¹ Finally, with the goal of improving the quality and utility of the Phase I CORE Operating Rules on an ongoing basis, Participant pledges to provide feedback (which may be either qualitative or quantitative) relating to the Phase I CORE Operating Rules.

By signing this Pledge, the Participant also agrees to be publicly recognized as a supporter of CORE's mission and an endorser of the Phase I CORE Operating Rules. CORE may use Participant's name and logo (as provided by Participant and subject to any reasonable restrictions around use of the logo provided by the Participant to CORE in writing) solely in connection with such CORE publicity. CORE will make any materials using Participant's name or logo available to Participant promptly after release and will respond to Participant promptly and in good faith if Participant objects to CORE's use of Participant's name or logo. In particular, CORE will discontinue any use of Participant's name or logo to the extent requested to do so by Participant in writing. Participant, at its option, may participate in the CORE Work Group responsible for designing CORE's publicity campaign "CORE Marketing Work Group." Participant may describe itself as an "endorser of the Phase I CORE Operating Rules" or an "endorser of CORE" as long as this Pledge is in effect. Participant may describe itself as "CORE-Certified" only after achieving certification in accordance with the Phase I CORE Operating Rules. Participant may not otherwise use the CORE name or trademarks without CORE's prior written consent.

Participant recognizes that the Phase I CORE Operating Rules have been developed by a team of representative members of the healthcare industry that have been coordinated by CORE through CAQH and the stakeholders participating in

¹ This clause is meant to address entities that are not subject to Certification (e.g., associations or industry groups) and to address the differences in Certification applicable to different participant-types that are subject to Certification (e.g., providers, payers, vendors, and clearinghouses).

Phase I CORE 101 Eligibility and Benefits Pledge
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CORE, and Participant agrees that neither CAQH nor CORE (nor their respective members, representatives, and/or agents) will be held responsible for the results of using the Phase I CORE Operating Rules in Participant's business and that neither CAQH nor CORE (or their respective members, representatives, and/or agents) shall have any liability to Participant arising from or related to the Phase I CORE Operating Rules or their use by Participant. Remedies for breach of the Phase I CORE Operating Rules are as set forth in the Phase I CORE Operating Rules; this Pledge does not create any additional remedies against Participant.

Participant recognizes that, as a standard, the Phase I CORE Operating Rules are being made publicly available for use by the healthcare industry in anticipation of broad industry adoption. As such, Participant acknowledges that it has no intellectual property rights in the Phase I CORE Operating Rules and that any intellectual property rights in the Phase I CORE Operating Rules are owned by CAQH and CORE.

Participant represents that its participation with CORE and this Pledge to use the Phase I CORE Operating Rules are entirely voluntary. Participant may withdraw from using the Phase I CORE Operating Rules at any time by submitting sixty (60) days written notice to CORE. In addition, CORE (including CORE as acting through CAQH) may terminate this Pledge upon written notice if Participant loses its Certification and such Certification is not reinstated within one-hundred eighty (180) days, or if Participant fails to obtain Certification within one-hundred eighty (180) days of execution of this Pledge. In the event of termination of the Pledge for any reason, Participant must immediately stop using all CORE trademarks, including any references to being "CORE-certified."

Accepted:

Acknowledged:

Participant:

Council for Affordable Quality Healthcare

on behalf of CORE

By: _____

By: _____

Name: _____

Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

Phase I CORE® Seal Application

version 1.1.0 March 2011



A. Contact Information

Organization

Name of product being certified (*if applicable*)

Contact Name (*individual responsible for your organization's CORE-certification process*)

Mailing Address

Phone

Fax

Email

B. Required Documents (Please attach the following with this application)

Certifiers

1. Certification testing results documentation (as provided by the CORE-authorized certification testing vendor with which you worked).
2. HIPAA attestation form (requires executive-level signature).
3. Health Plan IT exemption request (if applicable; requires executive-level signature).
4. Signed Pledge (Unless previously submitted)

Endorsers

1. Signed Pledge

C. Phase I CORE Certification and Endorsement Terms and Conditions

1. An entity's Seal will be revoked as a result of a validated complaint of non-compliance (see Phase I CORE 105 Enforcement Policy for more information).
2. Certification is required for each Phase of CORE rules.
3. Re-certification and re-endorsement is required for each substantive change made to Phase I CORE and additional Phase rules. Substantive changes will occur no more than once per year.
4. To health plans granted an exemption, the 12-month IT system exemption period will begin on the day that the health plan is granted its CORE Seal.
5. After receiving a Phase I CORE Seal, the entity may market itself as a CORE Endorser or CORE-Certified.

D. CAQH CORE Responsibilities

1. CORE will notify you of your "certification" queue status at the time CORE receives your application.
2. CORE will complete its assessment within 30 business days unless there are extenuating circumstances.
3. CORE will grant your stakeholder-specific CORE Seal following review and approval of its application.
4. Entities receiving the Phase I CORE Seal will be promoted in CORE marketing materials and on the CAQH Website.

Phase I CORE® Seal Application

version 1.1.0 March 2011



E. Fees

Please review the fee structure and notes below to determine your CORE Seal fee.
Then check the appropriate box under the stakeholder type for the Seal you are requesting.

Health Plans

- | | |
|---|-------------|
| <input type="checkbox"/> Below \$75 million in net annual revenue | \$4,000 fee |
| <input type="checkbox"/> \$75 million and above in net annual revenue | \$6,000 fee |

Clearinghouses

- | | |
|---|------------------------------|
| <input type="checkbox"/> Below \$75 million in net annual revenue | \$4,000 fee |
| <input type="checkbox"/> EHNAC HNAP-EHN accredited | - apply 10% (\$400) discount |
| <input type="checkbox"/> \$75 million and above in net annual revenue | \$6,000 fee |
| <input type="checkbox"/> EHNAC HNAP-EHN accredited | - apply 10% (\$600) discount |

Vendors

- | | |
|---|-------------|
| <input type="checkbox"/> Below \$75 million in net annual revenue | \$4,000 fee |
| <input type="checkbox"/> \$75 million and above in net annual revenue | \$6,000 fee |

Providers

- | | |
|--|-------------|
| <input type="checkbox"/> Up to \$1 billion in net annual revenue | \$500 fee |
| <input type="checkbox"/> \$1 billion and above in net annual revenue | \$1,500 fee |

Endorser

(Only for entities that do not create, transmit or use eligibility data.) No fee

Fee Notes:

1. There is no charge to Federal or State government entities to receive the CORE Seal.
2. There is no charge to CAQH member plans to receive the CORE Seal.
3. This fee is a one-time cost for Phase I certification, unless an entity becomes decertified or if substantive changes to the rules are approved by a full CORE vote (Reference Phase I CORE 102 Eligibility and Benefits Certification Policy, version 1.1.0.)
4. Per the Phase I CORE 102 Eligibility and Benefits Certification Policy, vendor products, and not entire vendor organizations, receive the Certification Seal.
5. The CORE Certification Seal fee does not include the fee for CORE certification testing. See <http://www.caqh.org> for a list of CORE-authorized testing companies and their associated testing fees.
6. Any Clearinghouse/EHN entity actively seeking CORE certification as of June 1, 2009 or later that has already achieved EHNAC HNAP-EHN accreditation can take advantage of the partnership program discount. The Clearinghouse/EHN will indicate that it holds a current EHNAC HNAP-EHN accreditation when submitting a CORE Seal application. (CAQH will confirm EHNAC-EHN accreditation status independently.)

After reviewing this document and ensuring you have all the required documentation, please submit your check and required certification and testing documentation to:

CAQH
RE: Phase I CORE Seal
601 Pennsylvania Ave, NW
South Building, Suite 500
Washington, DC 20004
Email: CORE@caqh.org Fax: 202-861-1454

Phase I CORE® HIPAA Attestation Form*
version 1.1.0 March 2011



[_____] (“Entity”), in consideration of the Committee on Operating Rules for Information Exchange (CORE) deeming Entity eligible to apply to participate in the Phase I CORE Certification Program, hereby submits this attestation to compliance with applicable provisions of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the standards promulgated thereunder.

Entity recognizes that CORE does not certify compliance with any aspect of HIPAA or define “HIPAA Compliance.” Entity will not rely on CORE for these determinations.

Entity hereby represents and warrants the following:

- (a) it is, and shall remain, to the best of its knowledge, compliant with standards promulgated by the Secretary of the U.S. Department of Health and Human Services (the “Secretary”) under the Administrative Simplification provisions of Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) that govern health care eligibility benefit inquiry and response, including, as applicable, Parts 160 and 162 of Title 45 of the Code of Federal Regulations, as may be amended from time to time;
- (b) it can send and receive, as applicable or in the case of a software vendor, support the ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) transactions or the current version of such implementation specifications adopted under HIPAA (the “Transaction”);
- (c) it is, and shall remain, to the best of its knowledge, compliant with applicable provisions of the Privacy and Security requirements of Title 45 of the Code of Federal Regulations, Subtitle A, Subchapter C, Parts 160 and 164, as may be amended from time to time.

Entity acknowledges that CORE will rely on this attestation and that any omissions, misrepresentations, or inaccuracies may be a basis for CORE to deny CORE certification.

Entity agrees to notify CORE if it discovers that any of the representations and warranties were not true when made or if it fails to remain compliant with any of the applicable standards set forth above. Entity understands that a loss of compliance with the standards set forth above, or in the case of a software vendor, the ability to support the transaction, may affect CORE certification. The undersigned representative of Entity affirms that he or she is duly empowered to represent the Entity for purposes of this attestation and has knowledge confirming the accuracy of this attestation.

Signature

Printed Name

Position

Date

Please submit this form along with your organization’s CORE Phase I Seal Application.

**For Entities Seeking CORE Phase I Certification. If your organization is seeking CORE-Endorsement, please refer to the CORE Endorsement Overview*

Phase I CORE 102: Eligibility and Benefits Certification Policy
version 1.1.0 March 2011

GUIDING PRINCIPLES

- *After signing the CORE Pledge, the entity has 180 days to complete CORE certification testing.*
- *CORE will not certify Phases that CORE has not clearly defined and voted upon.*
- *CORE certification testing will be required by any entity seeking CORE certification. CORE will authorize testing entities to conduct CORE certification testing. All CORE-authorized testing entities will need to be capable of testing for all Phase I CORE Operating Rules.*
- *Certification will be available for both real-time and batch processing. However, if an entity does not support batch transactions, it will not be required to comply with the batch rules. An entity that supports both real-time and batch will be required to comply with rules for both. The test scripts allow for the ability to test for both types of processing for each rule.*
- *Upon successful completion of CORE certification testing, CORE entities will receive a CORE certification “Seal” from CAQH.*
- *Entities seeking CORE certification will be required to adopt all of Phase I CORE Operating Rules that apply to their business and will be responsible for all their own company-related testing costs.*
- *CORE will not oversee trading partner relationships. CORE-certified entities may work with non-CORE-certified entities if they so desire.*
- *Role of HIPAA compliance:*
 - *It will be assumed by CORE that any covered entity under HIPAA applying for CORE certification will be HIPAA compliant; when submitting testing certification documentation to CORE, covered entities will be asked to sign an attestation form attesting that they are HIPAA compliant to the best of their knowledge (“Attestation Form”) for security, privacy, and the ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) Technical Report Type 3 transaction. HIPAA compliance will not be defined by CORE.*
- *Role of CORE-authorized testing vendors:*
 - *CORE-authorized testing vendors will be expected to sign the Attestation Form on their own behalf as well, demonstrating that they support a compliant 270/271 transaction.*
- *Who will be certified:*
 - *Certification testing will vary based on participant type. Associations, medical societies and the like will not be certified; instead, these entities will receive a Phase I CORE “Endorser” Seal after signing the Pledge. Entities successfully achieving Phase I CORE certification will receive the Phase I CORE “Seal” that corresponds with their testing application as testing varies by stakeholder type. There will be five different types of CORE “Seals”:*
 - *CORE-certified health plan*
 - *CORE-certified vendor (product specific)*
 - *CORE-certified clearinghouse*
 - *CORE-certified provider*
 - *CORE Endorser (for entities that do not create, use, or transmit eligibility information)*
 - *A parent corporation seeking certification will not be certified unless all subsidiaries of the corporation are compliant with Phase I CORE Operating Rules. Otherwise, each subsidiary of the parent must individually seek certification. For vendors, CORE will apply only to vendor products rather than corporate entities.*
 - *Ancillary services are not assumed to be subsidiaries, as a subsidiary is a legal entity of its own that serves as one of the types of key stakeholders that can become certified, e.g., health plan, vendor, or clearinghouse.*

Phase I CORE 102: Eligibility and Benefits Certification Policy **version 1.1.0 March 2011**

- *If a Phase I CORE-certified entity is acquired by an entity that is not Phase I CORE-certified, that company will only be allowed to be Phase I CORE-certified if the acquired company is the only business that is applicable to the Phase I CORE Operating Rules. If this is not the case, then the newly merged company will be required to seek certification.*
- *Endorsers will not become certified, but will be expected to participate in the CORE public relations campaign, provide CORE feedback and input when requested to do so, and encourage their members to consider participating in CORE.*

POLICY

Section 1: Fees

- Entities seeking Phase I CORE certification will be charged two fees: fees related to Phase I CORE certification testing as determined by the CORE-authorized Testing Vendor and the fee for the Phase I CORE Seal as determined by CORE. The goal of CORE is to develop a low-cost certification process in order to support CORE market adoption by small and large entities.

Section 2: Period for Which Certification Applies

- Once certified, Phase I CORE-certified entities will remain compliant with applicable Phase I CORE Operating Rules throughout any system upgrades. When vendors release new versions of their products that affect the functionality of Phase I CORE Operating Rules, such versions will need to become Phase I CORE-certified in order to maintain the Phase I CORE Seal.
- Assuming certification is not revoked, Phase I CORE certification, except for vendor products, will remain valid until a new version of the Phase I CORE Operating Rules is established by vote. In Phase I, revisions will not be made to the Phase I CORE Operating Rules more than once (1) per year. Although revisions to the rules will become official 20 business days after enacted by CORE, CORE-certified entities will determine when/if they will become compliant with new phases of the rules.

Section 3: Key Steps

The five key steps of CORE certification are presented below:

Subsection 3.1: Step 1: Existing entities currently engaged in HIPAA testing will be “authorized” by CORE as CORE-authorized Testing Vendors if they meet certain criteria.

- CORE-authorized Testing Vendors will test the Phase I CORE Certification Test Suite developed by the CORE Testing Subgroup.
- CORE will allow any interested entity to apply to CORE to become a CORE-authorized Testing Vendor. However, to become a CORE-authorized Testing Vendor, an interested testing entity must be capable of testing for all Phase I CORE Operating Rules and meet a CORE developed set of criteria. An RFP process will identify authorized companies.
- CORE will list any testing entity that is a CORE-authorized testing entity on its website.

Subsection 3.2: Step 2: CORE participants seeking certification will work with the CORE-authorized Testing Vendor of their choice to test for CORE compliance.

- Certification testing will differ by role of generator/submitter in the eligibility transaction.
- Any fee/cost imposed by a CORE-authorized Testing Vendor will be independent and separate from the fee CORE will charge to obtain the Phase I CORE Seal. Certification testing fees will be established by each CORE-authorized Testing Vendor; thus prices will be market-driven.
- A CORE-authorized Testing Vendor will only provide paperwork to an entity seeking certification after demonstrating successfully their ability to conform with the Phase I CORE Operating Rules.

Phase I CORE 102: Eligibility and Benefits Certification Policy **version 1.1.0 March 2011**

Subsection 3.3: Step 3: CORE will grant the appropriate Phase I CORE Seal after an entity provides all documentation required, including documentation from a CORE-authorized Testing Vendor demonstrating the entity's compliance with Phase I CORE Operating Rules through successful testing.

- CORE will be responsible for providing the official Phase I CORE Seal (after compliance is proven).
- CORE (or its agents) will review test results and maintain a record of Phase I CORE-certified entities.
- Applicants will be responsible for ensuring that an authorized person signs the final Phase I CORE certification application and the HIPAA attestation, indicating that to the best of the potential applicant's knowledge, the applicant is HIPAA compliant for security, privacy, and the ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) Technical Report Type 3 (or, in the case of a vendor, supports the ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) transaction).
 - See attached Attestation form.
- Upon receiving documentation of successful completion of Phase I CORE certification testing from an applicant, CORE will have a maximum of 20 business days to complete its assessment of the documentation and respond to the applicant with a clear response of approval or need for clarification. CORE will inform those who apply for certification of the "certification" queue status at the time of their application submission. CORE will complete its assessment within 30 business days unless there are extenuating circumstances. CORE will report on its website:
 - List of certified entities.
 - The number of certification applications it has received.
 - The number that are in process/were rejected on a monthly basis.
- The fee for the Phase I CORE Seal will be based upon a sliding, stakeholder-specific fee scale, similar to the approach of the current CORE membership fee policy. There will be an "early adopters" CORE certification discount on the fee for the Phase I CORE Seal to encourage entities to become Phase I CORE-certified as quickly as possible after the final Phase I CORE Operating Rules are approved.
- The cost of the Phase I CORE Seal will be a one-time fee, unlike the CORE participation fee, which is an annual fee. The Phase I CORE Seal indicates that an entity/product is Phase I CORE-certified, while the CORE participation fee allows entities to participate in the CORE rule writing and voting process. CORE participants may voluntarily decide whether or not to become CORE-certified entities.
- Phase I CORE certification will be effective until a new version of the Phase I CORE Operating Rules is made available, provided an organization has no complaints filed against it, except for vendors, who will be required to seek new Phase I CORE certification when a new version of a previously CORE-certified eligibility and benefits product is released.
- If an entity removes its name from the Pledge, it automatically loses Phase I CORE certification.
- As stated in the Pledge, a Phase I CORE-certified entity is permitted to market its Phase I CORE Seal only if the entity's Phase I CORE Seal is valid and current.

Subsection 3.4: (Potential) Step 4: Re-certification will be required if an entity's Seal is revoked as a result of a validated complaint of non-compliance. (See enforcement for steps involved in the complaint process.)

- See enforcement process regarding how a validated complaint of non-compliance will be defined and pursued.

Subsection 3.5: Step 5: Re-certification when Phase I CORE Operating Rules are modified.

- Phase I CORE Operating Rules will become official 20 business days after being approved by CORE; however, adoption of the rules is not required by participants until 180 business days after signing the Pledge, and a similar timeframe for participant adoption will be added for revisions.
- CORE reserves the right to revise rule(s) in Phase I.

Phase I CORE 102: Eligibility and Benefits Certification Policy
version 1.1.0 March 2011

- Minor modifications that would improve a rule will not require re-certification.
- Major substantive changes, e.g. new phases, will require re-certification and re-signing of the Pledge.
- Except for vendors and entities with validated non-compliance, re-certification will be required only after CORE membership approves, by vote, major modifications, changes, or deletions to Phase I CORE Operating Rules. Only one major modification will be permitted in the first year of Phase I.
- Generally, Phase I CORE Operating Rules will not be amended between CORE rule versions unless government regulations are issued that impact the rules or as necessary to address problems that arise upon implementation. In this scenario, adoption of the modified rule(s) by CORE participants will be within a reasonable timeframe but will acknowledge/comply with Federal mandates.

Section 4: Certification Testing Appeals Process

- Prior to any appeal being submitted, it is assumed efforts have already been taken to try to resolve the issue privately between an entity seeking certification and a CORE-authorized Testing Vendor, but efforts have not succeeded.
- In the event an entity seeking Phase I CORE certification is not satisfied with its testing results, it is permitted to file an appeal of the results to CORE.
- CORE will have 20 business days to investigate the issue. If the appeal is deemed valid, CORE will ask the CORE-authorized Testing Vendor to re-test the results in question within 21 business days of request.
- The Enforcement Committee will have oversight of this process. Please see the Phase I CORE 105 Eligibility and Benefits Enforcement Policy version 1.1.0 for more details.

Phase I CORE 103: Eligibility and Benefits Certification Exemption Policy version 1.1.0 March 2011

BACKGROUND

This rule addresses certification exemptions that health plans seeking Phase I CORE certification may request when the health plan has a scheduled migration of an existing IT system(s) if the remainder of the health plan's IT systems are Phase I CORE compliant. This rule is complementary and does not replace the following Phase I CORE policies, which are already part of the Phase I CORE 102 Eligibility and Benefits Certification Policy version 1.1.0.

- *Entities may seek certification for their subsidiaries versus their corporate entity. The Phase I CORE Seal will apply to the subsidiary or the corporation, whichever entity seeks CORE certification.*
- *If a CORE-certified entity is acquired by an entity that is not Phase I CORE-certified, that company will only be allowed to be CORE-certified if the acquired company is the only business that is applicable to the Phase I CORE Operating Rules. If this is not the case, then the newly merged company will be required to seek certification.*

POLICY

Section 1: Required Criteria to be granted a Phase I CORE Health Plan IT System Exemption: Any health plan seeking an IT System Certification Exemption must meet the following criteria:

Subsection 1.1: Membership Percentage

Percentage of a health plan's full membership eligibility data that is processed by the IT system(s) in question:

- No more than 30 percent of a health plan's total membership can be processed by the IT system(s) to be covered by the exemption.

Subsection 1.2: Timing

Time period for which the IT system(s) in question must be scheduled for migration:

- Migration must be scheduled for completion no later than 12 months from the date of when the health plan is granted Phase I CORE certification.
- If migration is not completed within the agreed-upon 12 months from the date of Phase I CORE certification, the health plan will be de-certified (see below).

Section 2: Deadlines for exemptions

- First-time IT system *Phase I exemptions* will only be granted until December 31st, 2007. Therefore, by December 31st, 2008, all Phase I CORE-certified health plans will be fully Phase I compliant unless, after December 31st, 2007, a Phase I CORE-certified health plan acquires another health plan that is not Phase I CORE-certified. If such an acquisition occurs by a Phase I CORE certified health plan, that health plan can seek additional/new IT system exemptions for its newly acquired entity.
- Exemptions that are due to newly acquired entities will only be granted if the same above parameters on time periods and percentage of membership are met.

Section 3: Exemption Request and Review Process

Subsection 3.1: Exemption Request

Any health plan seeking an exemption must follow the Phase I CORE Certification Policy, excluding the IT system(s) for which they are seeking the exemption.

- When providing CAQH with the documentation to prove successful Phase I CORE certification testing and attest to HIPAA compliance, the health plan must provide CAQH with an executive-level attestation stating that the health plan meets the agreed-upon IT system exemption criteria and has the ability to identify those transactions to which the exemption applies. As a result, CORE will be able to accurately respond to those Requests for Review of Possible Non-Compliance that are the result of IT system exemptions.

Phase I CORE 103: Eligibility and Benefits Certification Exemption Policy version 1.1.0 March 2011

- If possible, the plan will communicate to CAQH, in a way that is most meaningful to the market/providers, the systems/groups/products for which Phase I CORE Operating Rule eligibility data will not be available until after the exemption time period expires.
- If the proper Phase I CORE certification documentation is received, CAQH will be responsible for granting exemptions just as it is responsible for granting Phase I CORE Seals.
- The 12-month IT system exemption period will begin on the day that the health plan is granted Phase I CORE certification (a CORE Seal) by CAQH.

Subsection 3.2: Review Process

On or before the last business day of the month in which exemption ends, the health plan must communicate to CORE that the migration is/is not complete.

- If a Phase I CORE-certified health plan with an exemption communicates to CORE that the IT system migration was not completed in the agreed-upon timeframe, the CORE Enforcement Committee will agree, via conference call/meeting, to remove the health plan's CORE Seal unless extenuating circumstances exist.
- Decisions by the CORE Enforcement Committee to remove the Phase I CORE Seal, or not to remove the Phase I CORE Seal due to extenuating circumstances, shall be subject to review by the CORE Steering Committee within 20 business days. Decisions by the Steering Committee shall be final.
- If de-certified, the health plan will need to reapply for Phase I CORE certification.
- The Phase I CORE Enforcement Policy outlines the steps to become re-certified after being de-certified. Health plans wanting to become re-certified due to non-compliance with an IT exemption rule will need to be re-certified for all CORE Phase I transactions.

Section 4: Communication Concerning Which CORE-certified Systems Have Exemptions

- In Phase I, all CORE-certified entities will be listed on the CAQH website (see Phase I CORE 102 Eligibility and Benefits Certification Policy version 1.1.0).
- There will be an asterisk (*) next to those certified health plans that have an IT system exemption. The asterisk will indicate that a portion of the plan's membership systems are not Phase I CORE compliant; detailed information identifying those systems/groups/products specific to each plan will be provided, if available.
 - The asterisk will only be removed when the health plan communicates to CAQH that its exempted system(s) are in compliance.

Phase I CORE® Certification
Health Plan IT Exemption Request Form
version 1.1.0 March 2011



A. Contact Information

Organization: _____

Contact Name: _____

Mailing Address: _____

Phone: _____

Email: _____

B. Required Criteria to be Granted a CORE Health Plan IT System Exemption:

Any health plan seeking an IT System Certification Exemption must meet the following criteria or gain approval from the CORE Steering Committee for an exception:

1. Membership Percentage

Percentage of a health plan's full membership eligibility data that is processed by the IT system(s) in question:

- No more than 30 percent of a health plan's total membership can be processed by the IT system(s) to be covered by the exemption.

2. Timing

Time period for which the IT system(s) in question must be scheduled for migration:

- Migration must be scheduled for completion no later than 12 months from the date of when the health plan is granted CORE certification.
- If migration is not completed within the agreed-upon 12 months from the date of CORE certification, the health plan could be de-certified (see below).

C. Exemptions and Requests for Exceptions

- IT system exemptions and exceptions will be reviewed and granted on an individual health plan basis as decided by the CORE Steering Committee.
- Exemptions that are due to newly acquired entities will only be granted if the same above parameters on time periods and percentage of membership are met.
- Approving exceptions will be the responsibility of the CORE Steering Committee.

D. Required Documents

Please attach the following with this application:

1. HIPAA Attestation Form (signed by your organization's appropriate senior executive).
2. A list of the states, markets and systems for which the exemption applies. The list should provide enough detailed information for providers to easily determine when your health plan will begin providing CORE compliant transactions in their practice area.

By signing this form, your organization is stating that your health plan meets the agreed-upon IT system exemption criteria.

Signature: _____

Name: _____

Title: _____

Please submit this form with your CORE Seal Application.

Phase I CORE 104: Eligibility and Benefits Testing Policy **version 1.1.0 March 2011**

GUIDING PRINCIPLES

- *The Phase I CORE 104 Eligibility and Benefits Testing Policy will be used to gain Phase I CORE certification only; it does not outline trading partner implementation interoperability testing activities.*
- *Third parties that have become CORE-authorized Testing Vendors through a standard CORE evaluation process will be used by interested parties to test for Phase I CORE Operating Rules compliance. CORE will authorize any testing entity that meets CORE's testing entity criteria. A key criteria in becoming a CORE-authorized Testing Vendor will be that the entity is capable of testing for all Phase I Operating Rules.*
- *A prerequisite for obtaining a stakeholder-specific Phase I CORE Seal will be the successful completion of a stakeholder-specific Phase I CORE Certification Test Suite, which will be demonstrated through proper documentation from a CORE-authorized Testing Vendor.*
- *All parties essential to the success of the eligibility transaction will be addressed in the Phase I CORE certification testing process: providers, health plans, clearinghouses, and vendors. Phase I CORE certification testing will vary by stakeholder type, e.g., provider, health plan, clearinghouses, vendors. Associations, medical societies and the like will not undergo certification testing as they are endorsers of CORE rather than certified entities.*
- *The Phase I CORE testing protocol will be scoped only to demonstrate conformance with Phase I CORE Operating Rules, and not overall compliance with HIPAA; however, each entity submitting an application for Phase I CORE certification will sign a statement affirming that it is HIPAA compliant to the best of its knowledge.*

POLICY

Section 1: Key Steps

Subsection 1.1: Step 1: CORE pre-certification, self-testing

- To prepare for certification, entities seeking Phase I CORE certification can review rules and conduct internal testing as they see appropriate.

Subsection 1.2: Step 2: Phase I CORE certification processing testing

- A CORE-authorized Testing Vendor performs testing with an entity seeking Phase I CORE certification based upon Phase I CORE testing criteria specific to the participant's stakeholder type.
- Testing entities would build the already-defined Phase I CORE Test Suite specification standards, and entities seeking Phase I CORE certification could work with the testing vendor of their choice to test and/or use a testing website developed by one or more of the companies to conduct their Phase I CORE certification testing. If website approach is taken, individual company testing results would not be shared publicly. The Phase I CORE Certification Test Suite will include scenario-based testing and expected outcomes.
- Phase I CORE Certification Test Suites will focus on current industry eligibility 'pain points' and therefore include testing for all of the Phase I CORE Operating Rules, including the following:

**Phase I CORE 104: Eligibility and Benefits Testing Policy
version 1.1.0 March 2011**

Phase I CORE Operating Rule	Key Aspect of CORE Stakeholder-Specific Testing ¹			
	Providers	Health Plans	Vendors	Clearinghouses
Connectivity Rule	Yes	Yes	Yes	Yes
Response Time Rule: Batch and Real Time	Yes ²	Yes ²	Yes ²	Yes ²
270/271 Data Content Rule	Yes	Yes	Yes	Yes
Acknowledgements Rule: Batch and Real Time	Yes	Yes	Yes	Yes
Companion Guide	Yes	Yes	Yes	Yes
System Availability	Yes	Yes	Yes	Yes

Subsection 1.3: Step 3: CORE-authorized Testing Vendor verifies, with documentation, that an entity seeking Phase I CORE certification has successfully completed testing; participant can apply to CORE to obtain the Phase I CORE Seal by sending documentation to CORE. (Certification Process begins, please see Phase I CORE 102 Eligibility and Benefits Certification Policy version 1.1.0.)

Subsection 1.4: Step 4: Certification Testing Appeals Process

- Prior to any appeal being submitted, it is assumed efforts have already been taken to try and resolve the issue privately between an entity seeking certification and a CORE-authorized testing vendor, but efforts have not succeeded.
- In the event an entity seeking CORE certification is not satisfied with its testing results, it will be permitted to file a written appeal of the results to CORE, under the guidance of the Enforcement Committee (please see CORE 105: Eligibility and Benefits Enforcement Policy version 1.1.0.)
- CORE will have 20 business days to investigate the issue. If the appeal is deemed valid, CORE will ask the CORE-authorized testing entity to re-test the results in question within 21 business days of request.

¹ Entities will be tested under the stakeholder-specific test bed for which they want to receive Phase I CORE certification, e.g. health plan gets tested on health plan test bed in order to receive Phase I CORE Health Plan Seal.

² Certification in Phase I is not exhaustive. For example, as part of certification testing, these stakeholders will need to demonstrate their ability to capture response time statistics. The actual delivery of such statistics by a Phase I CORE-certified entity will only be required in response to a verified compliance complaint.

Phase I CORE 105: Eligibility and Benefits Enforcement Policy
version 1.1.0 March 2011

GUIDING PRINCIPLES

- *CORE stakeholders will be encouraged to privately resolve disputes before submitting a formal complaint of non-compliance against a Phase I CORE-certified entity.*
- *Enforcement will be a complaint-driven process that will require documentation (electronic or paper) demonstrating multiple instances of non-compliance.*
- *Any healthcare provider that is an end-user of a Phase I CORE-certified product/service may lodge a complaint against a Phase I CORE-certified entity. Beyond end-users, only an organization that is Phase I CORE-certified and involved in the alleged non-compliant transactions may file a complaint.*
- *The details of a specific complaint will remain confidential. Names or other identifying information will not be publicly released. This information will only be used and disclosed by CORE for its non-compliance review. If an entity is found to be in actual violation of a Phase I CORE Operating Rule(s), its certification will be terminated and its name removed from the CORE website if the complaint is not remedied per the CORE enforcement timeline.*
- *The complaint process will be progressive, but will last no more than six (6) months between filing of complaint and resolution. Extensions may be granted on a case-by-case basis due to mitigating factors decided upon by the CORE Enforcement Committee.*
- *The CORE Enforcement Committee will consist of a balance of stakeholder types from the CORE membership (certified health plans, vendors, PMS, provider vendors, clearinghouses, and providers). No one stakeholder type will be permitted to have a dominant representation.*
- *Entities are permitted to withdraw a complaint at any time during the complaint process.*
- *Personal health information (PHI) must not be submitted without appropriate authorization.*
- *CORE will accept and review any submitted complaint that contains the required documentation.*

POLICY

Every effort must be made to resolve problems before a complaint is filed. Conformance language for each rule should assist entities with what is required of Phase I CORE-certified entities.

Subsection 1.1: Step 1: Complaint formally filed with CORE, including proper documentation.

- Includes a completed CORE-developed form, Request for Review of Possible Non-Compliance, that outlines the violation, and at least five documented examples of the violation(s) over a 30-day period, demonstrating that the violation was not a one-time occurrence but occurred in multiple instances.
- Organization filing complaint must do so within 90 days of the most recent compliance violation(s) for which it is being filed.

Subsection 1.2: Step 2: CORE, under the guidance of the CORE Enforcement Committee, reviews complaint form for completeness and timeliness, and verifies/dismisses complaint.

- Information gathered from entity filing complaint.
- Organization in question given an opportunity to respond to complaint in writing.
- CORE must respond to the complaint within 20 business days.
- All organizations involved in the complaint must respond to requests for information by CORE within 20 business days. The complaint must be deemed valid or invalid within 30 business days after all documentation is reviewed by CORE and requests for information are received.

(Process ends if inquiry dismissed. If inquiry verified, process continues.)

Section 2: For Verified Complaints Only

Subsection 2.1: Step 1: Entities found to be out of compliance with a Phase I CORE Operating Rule(s) will be informed by CORE that they have a defined grace period (40 business days) in order to remedy the problem by successfully re-testing for compliance with the rule(s) or be de-certified.

Phase I CORE 105: Eligibility and Benefits Enforcement Policy
version 1.1.0 March 2011

- A CORE Enforcement Committee composed of objective participants will review verified complaints, and will be responsible for providing any extension to this grace period.
- CORE Enforcement Committee terms will be limited to one year from date of appointment.
- Conflicts of interest will be avoided on a case-specific basis at the request of the entity being reviewed for non-compliance. If a member of the CORE Enforcement Committee is party to a complaint, then he/she will recuse him/herself for the duration of the resolution of the complaint.
- The membership of the CORE Enforcement Committee will be appointed by the CORE Steering Committee from nominations made by CORE Steering Committee members and/or CORE members. Until there is an equal representation of stakeholders, or until a sufficient number of certified entities exist, Subgroup and/or Work Group Chairs will serve on the CORE Enforcement Committee.
- 10 business days after the grace period, entities will prove they have remedied the problem by presenting to the CORE Enforcement Committee documentation of at least five instances on five different business days over a span of 10 business days in which there was no issue of compliance with the entity that filed the complaint, in addition to providing documentation of successful re-testing.
- The CORE Enforcement Committee will be responsible for granting variances to the 40 business day grace period.

Section 3: For Complaints not Remedied

Subsection 3.1: Step 1: De-certification/removal of Phase I CORE Seal.

Section 4: For De-Certified Entities Interested in Re-Certification

Subsection 4.1: Step 1: A de-certified entity may seek re-certification; entities are responsible for all fees associated with re-certification, including any fees for a new Phase I CORE Seal.

- Entities seeking re-certification due to non-compliance will only need to do so for the rule with respect to which they were found to be non-compliant. CORE-authorized Testing Vendors will provide documentation on the entity's compliance with the rule specific to the applicable Phase I CORE Certification Test Suite.

Phase I CORE 105: Eligibility and Benefits Enforcement Policy
version 1.1.0 March 2011

Request for Review of Possible Non-Compliance Form

PREREQUISITES

- 1) Entity filing complaint must be party to the transaction and Phase I CORE-certified. Any healthcare provider that is an end-user of a Phase I CORE-certified product/service may lodge a complaint against a Phase I CORE-certified entity.
- 2) Entities being filed against must be Phase I CORE-certified.
- 3) Filing this form assumes reasonable steps have already been taken by the organization to try to resolve the issue privately with its trading partner, but such efforts were not successful.
- 4) At least five documented examples of the violation(s) over a 30-day period must be provided with this form.
- 5) Entity must file a complaint within 90 days of the most recent compliance violation(s) for which it is being filed.
- 6) The details of a specific complaint remain private. Names or other identifying information will not be publicly released. This information will only be used and disclosed by CORE for its non-compliance review. If an entity is found to be in actual violation of a Phase I CORE Operating Rule(s), its certification will be terminated and its name removed from the CORE website if the complaint is not remedied per the CORE enforcement timeline.
- 7) Entities are permitted to withdraw a complaint any time during the complaint process.

**Phase I CORE 105: Eligibility and Benefits Enforcement Policy
version 1.1.0 March 2011**

If you have any questions about this form, contact CAQH at: (202) 861-6380 or CORE@caqh.org

CORE: Non-Compliance Complaint Form			
Please provide your contact information (All fields required.)			
Organization Name and Type (Health Plan, Provider, Clearinghouse, Vendor)			
Name (First and Last)			
Street Address	City/Town	State	Zip
Telephone Number		Email Address	
Organization filing complaint against (All fields required.)			
Organization Name and Type (Health Plan, Provider, Clearinghouse, Vendor)			
Name (First and Last)			
Street Address	City/Town	State	Zip
Telephone Number		Email Address	

**Phase I CORE 105: Eligibility and Benefits Enforcement Policy
version 1.1.0 March 2011**

CORE: Non-Compliance Complaint Form

When did this alleged violation occur? mm/dd/yyyy (Required field)

- 1.
- 2.
- 3.
- 4.
- 5.

Have efforts been made to address the problem? Who at the company in question have you been working with to resolve the issue?

Identify the rule complaint category. (Required field.) Select one category listed below per complaint submission. Complete this form again to file a complaint for another category.

- Response Time
- System Availability
- Service Type and Benefit Summary
- Patient Financial Responsibility
- Acknowledgements
- Connectivity Safe Harbor
- Companion Guide

**Phase I CORE 105: Eligibility and Benefits Enforcement Policy
version 1.1.0 March 2011**

CORE: Non-Compliance Complaint Form

Describe, in detail, the alleged violation. (Required field.) You may attach/upload additional pages as needed. Please enclose at least five examples of your complaint.

Please sign and date this complaint. (Required filed)

SIGNATURE:

DATE:

Phase I CORE 105: Eligibility and Benefits Enforcement Policy
version 1.1.0 March 2011

SUBMISSION PROCESS

Filing a complaint with CORE is voluntary. However, without the information required on the Non-Compliance Complaint Form, CORE may not be able to proceed with a complaint. Names or other identifying information will remain private unless an entity is found to be in actual violation of a Phase I CORE rule(s), and then their certification will be terminated and their name removed from the CORE website if the complaint is not remedied per the CORE enforcement timeline.

To submit a complaint electronically please:

- Send as an attachment by email to CORE@caqh.org;
- Submit by fax 202-861-1454;
- Mail to:
CAQH re: CORE Compliance Review
601 Pennsylvania Ave, NW
South Building, Suite 500
Washington, DC 20004

Note: All signatures must be hand-written. Electronic signatures will not be accepted.

**Phase I CORE 150: Eligibility and Benefit Batch Acknowledgement Rule
version 1.1.0 March 2011**

BACKGROUND

This rule for use of acknowledgements for batch mode places parallel responsibilities on both submitters of the ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter v5010 270) request (providers) and responders to the ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter v5010 271) responses (health plans or information sources) for sending and accepting the ASC X12 005010X231A1 Implementation Acknowledgement for Health Care Insurance (999) (hereafter v5010 999.) The goal of this approach is to adhere to the principles of EDI in assuring that transactions sent are accurately received and to facilitate health plan correction of errors in their outbound responses.

The rule assumes a successful communication connection has been established and that all parties in the transaction routing path are CORE-certified.

RULE

Section 1: Use of the v5010 999 and v5010 271 Acknowledgements for Batch

Subsection 1.1: Reporting on a Batch v5010 270 or v5010 271 Submission

Functional Group or Transaction Set Acknowledgement

If the v5010 270 batch inquiries or v5010 271 batch responses pass ASC X12 Interchange editing, the receiver of the batch (the provider, clearinghouse, intermediary, health plan or information source) must always return a v5010 999 for each Functional Group of v5010 270 inquiries or v5010 271 responses to indicate that the Functional Group was either accepted, accepted with errors, or rejected and to specify for each included v5010 270 inquiry or v5010 271 response Transaction Set that Transaction Set was either accepted, accepted with errors, or rejected.

Therefore, in batch mode, the receiver (provider, clearinghouse, intermediary, health plan or information source) will always return a v5010 999 acknowledgement indicating either rejection or acceptance of the batch.

If the v5010 270 batch is accepted for processing, a batch of v5010 271 responses is subsequently returned to the submitter by the health plan (or information source). The AAA segments in the v5010 271 responses are used to report business level error situations.

Section 2: Requirements for Return of a v5010 999

The v5010 999 Implementation Acknowledgement must not be returned during the initial communications session in which the v5010 270 batch is submitted. Reference the CORE 153 Eligibility and Benefit Connectivity and CORE 155 Online Eligibility and Benefit Batch Response Time (Section 2: v5010 999 Response Time Requirements) rules for the timing and availability of these two acknowledgements.

CONFORMANCE

Conformance with this rule is considered achieved by receivers of the batch (provider, clearinghouse, intermediary, health plan or information source) if all of the following criteria are achieved:

1. *A v5010 999 is returned to indicate acceptance, rejection or errors in a Functional Group (including the enclosed Transaction Set).*
 - a) *A v5010 999 must always be returned even if there are no errors in the Functional Group and enclosed Transaction Set.*
2. *A v5010 271 response transaction must always be returned for an Interchange, Functional Group and Transaction Set that complies with ASC X12 TR3 implementation guide requirements.*
 - a) *A v5010 271 response transaction may contain either the appropriate AAA Validation Request segment(s) in the case of a business level error or the data segments containing the requested and benefit status details.*

Conformance with this rule must be demonstrated through successful completion of the approved CORE test suite for this rule with a CORE-authorized testing vendor.

Phase I CORE 151: Eligibility and Benefit Real Time Acknowledgement Rule
version 1.1.0 March 2011

BACKGROUND

Rule assumes a successful communication connection has been established and that all parties in the transaction routing path are CORE-certified.

This CORE Phase I rule addresses only acknowledgements for receivers of the ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter v5010 270) for Real Time. It does not address acknowledgements that receivers of the ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter v5010 271) must consider.

RULE

Section 1: Use of the 999 and v5010 271 Acknowledgements for Real Time

Subsection 1.1: Reporting on a Real-Time v5010 270 Submission that is Rejected

Functional Group or Transaction Set Rejection

If the v5010 270 passes ASC X12 Interchange editing, but an error resulting in a rejection is found during the validation of the Functional Group or Transaction Set within a Functional Group, the receiver of the v5010 270 (clearinghouse, intermediary, health plan or information source) must always return an ASC X12 005010X231A1 Implementation Acknowledgement for Health Care Insurance (999) (hereafter v5010 999) for the Functional Group of the v5010 270 to indicate a rejection (negative acknowledgement). If the Functional Group is not rejected, a v5010 999 must not be returned.

Subsection 1.2: Reporting on a Real time v5010 270 Submission that is Accepted

If the v5010 270 complies with the ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (herein v5010 270/270, v5010 270, v5010 271) Technical Report Type 3 (TR3) implementation guide requirements, then the v5010 271 will be returned to the submitter.

The AAA segments in the v5010 271 will be used to report business level error situations.

Subsection 1.3: Summary

Therefore the submitter of a v5010 270 in real-time will receive only one acknowledgement/response from the receiver (clearinghouse, intermediary, health plan or information source): a v5010 999 (rejection); or a v5010 271.

CONFORMANCE

Conformance with this rule is considered achieved by receivers of the 270 request (clearinghouse, intermediary, health plan or information source) if all of the following criteria are achieved:

- 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.
 - a) A v5010 999 must not be returned if there are errors not resulting in the rejection of the Functional Group and enclosed Transaction Set.**
- 2. A v5010 271 must always be returned for an Interchange, Functional Group and Transaction Set that complies with v5010 270 requirements.
 - a) A v5010 271 may contain either the appropriate AAA Validation Request segment(s) in the case of a business level error or the data segments containing the requested eligibility and benefit status details.**

Conformance with this rule must be demonstrated through successful completion of the approved CORE test suite for this rule with a CORE-authorized testing vendor.

Phase I CORE 152: Eligibility and Benefit Real Time Companion Guide Rule version 1.1.0 March 2011

BACKGROUND

Health plans or information sources have the option of creating a "companion guide" that describes the specifics of how they will implement the HIPAA transactions. The companion guide is in addition to and supplements the ASC X12 v5010 Implementation Guide adopted for use under HIPAA.

Currently health plans or information sources have independently created companion guides that vary in format and structure. Such variance can be confusing to trading partners/providers who must review numerous companion guides along with the ASC X12 v5010 Implementation Guides. To address this issue, CORE developed the CORE v5010 Master Companion Guide Template for health plans or information sources. Using this template, health plans or information sources can ensure that the structure of their companion guide is similar to other health plan's documents, making it easier for providers to find information quickly as they consult each health plan's document on these important industry EDI transactions.

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

Although CORE participants believe that a standard template/common structure is desirable, they recognize that different health plans may have different requirements. The CORE v5010 Master Companion Guide Template gives health plans the flexibility to tailor the document to meet their particular needs.

Note: The CORE v5010 Master Companion Guide Template has been adapted from the CAQH/WEDI Best Practices Companion Guide Template originally published January 1, 2003.

RULE

All CORE-certified entities' Companion Guides covering the ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter v5010 270/271) transactions must follow the format/flow as defined in the CORE v5010 Master Companion Guide Template (See CORE v5010 Master Companion Guide Template).

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

CONFORMANCE

Conformance with this rule is considered achieved by health plans (or information sources) if all of the following criteria are achieved:

1. *Publication to its trading partner community of its detailed companion guide specifying all requirements for submitting and processing the v5010 270 and returning the v5010 271 transaction in accordance with this rule.*
2. *Submission to a CORE-authorized testing vendor the following:*
 - a) *A copy of the table of contents of its official v5010 270/271 companion guide.*
 - b) *A copy of a page of its official v5010 270/271 companion guide depicting its conformance with the format for specifying the v5010 270/271 data content requirements.*
 - c) *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 data content requirements of the companion guide is located.*

Conformance with this rule must be demonstrated through successful completion of the approved CORE test suite for this rule with a CORE-authorized testing vendor.

Acme Health Plan

HIPAA Transaction Standard Companion Guide

**Refers to the Implementation Guides
Based on ASC X12 version 005010**

**CORE v5010 Master Companion Guide
Template**

March 2011

Disclosure Statement

This document ...

Preface

This Companion Guide to the v5010 ASC X12N Implementation Guides and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Acme Health Plan. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

EDITOR'S NOTE:

This page is blank because major sections of a book should begin on a right hand page.

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1 INTRODUCTION

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that Acme Health Plan has something additional, over and above, the information in the IGs. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the IGs internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Acme Health Plan

In addition to the row for each segment, one or more additional rows are used to describe Acme Health Plan's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10% and notes or comment about the segment itself goes in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by Acme Health Plan.
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first 3 columns makes it clear that the code value belongs to the row immediately above it
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

SCOPE

This section specifies the appropriate and recommended use of the Companion Guide.

OVERVIEW

This section specifies how to use the various sections of the document in combination with each other.

REFERENCES

This section specifies additional documents useful for the read. For example, the X12N Implementation Guides adopted under HIPAA that this document is a companion to.

ADDITIONAL INFORMATION

This section, completed by the payer, includes other information useful to the reader. For example:

- Assumptions regarding the reader
- Advantages / benefits of EDI

2 GETTING STARTED

WORKING WITH ACME HEALTH PLAN

This section describes how to interact with Acme Health Plan's EDI Department.

TRADING PARTNER REGISTRATION

This section describes how to register as a trading partner with Acme Health Plan.

CERTIFICATION AND TESTING OVERVIEW

This section provides a general overview of what to expect during any certification and testing phases.

3 TESTING WITH THE PAYER

This section contains a detailed description of the testing phase.

4 CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

PROCESS FLOWS

This section contains process flow diagrams and appropriate text.

TRANSMISSION ADMINISTRATIVE PROCEDURES

This section provides Acme Health Plan's specific transmission administrative procedures.

RE-TRANSMISSION PROCEDURE

This section provides Acme Health Plan's specific procedures for re-transmissions.

COMMUNICATION PROTOCOL SPECIFICATIONS

This section describes Acme Health Plan's communication protocol(s).

PASSWORDS

This section describes Acme Health Plan's use of passwords.

5 CONTACT INFORMATION

EDI CUSTOMER SERVICE

This section contains detailed information concerning EDI Customer Service, especially contact numbers.

EDI TECHNICAL ASSISTANCE

This section contains detailed information concerning EDI Technical Assistance, especially contact numbers.

PROVIDER SERVICE NUMBER

This section contains detailed information concerning the payment of claims, especially contact numbers.

APPLICABLE WEBSITES/E-MAIL

This section contains detailed information about useful web sites and email addresses.

6 CONTROL SEGMENTS/ENVELOPES

ISA-IEA

This section describes Acme Health Plan's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

GS-GE

This section describes Acme Health Plan's use of the functional group control segments. It includes a description of expected application sender and receiver codes. Also included in this section is a description concerning how Acme Health Plan expects functional groups to be sent and how Acme Health Plan will send functional groups. These discussions will describe how similar transaction sets will be packaged and Acme Health Plan's use of functional group control numbers.

ST-SE

This section describes Acme Health Plan's use of transaction set control numbers.

7 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

This section describes Acme Health Plan's business rules, for example:

1. Billing for specific services such as DME, Ambulance, Home Health
2. Communicating payer specific edits
3. CORE Level of Certification

8 ACKNOWLEDGEMENTS AND/OR REPORTS

This section contains information and examples on any applicable payer acknowledgements

REPORT INVENTORY

This section contains a listing/inventory of all applicable acknowledgement reports

9 TRADING PARTNER AGREEMENTS

This section contains general information concerning Trading Partner Agreements (TPA). An actual TPA may optionally be included in an appendix.

TRADING PARTNERS

An EDI Trading Partner is defined as any Acme customer (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits to, or receives electronic data from Acme.

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

For example, a Trading Partner Agreement may specify among other things, the roles and responsibilities of each party to the agreement in conducting standard transactions.

10 TRANSACTION SPECIFIC INFORMATION

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that Acme Health Plan has something additional, over and above, the information in the IGs. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the IGs internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Acme Health Plan

In addition to the row for each segment, one or more additional rows are used to describe Acme Health Plan's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

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			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first 3 columns makes it clear that the code value belongs to the row immediately above it
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

APPENDICES

This section contains one or more appendices.

1. Implementation Checklist

This appendix contains all necessary steps for going live with Acme Health Plan.

2. Business Scenarios

This appendix contains free format text descriptions of typical business scenarios. The transmission examples for these scenarios are included in Appendix C.

3. Transmission Examples

This appendix contains actual data streams linked to the business scenarios from Appendix B.

4. Frequently Asked Questions

This appendix contains a compilation of questions and answers relative to Acme Health Plan and its providers. Typical question would involve a discussion about code sets and their effective dates.

5. Change Summary

This section describes the differences between the current Companion Guide and previous guide(s).

Phase I CORE 153: Eligibility and Benefits Connectivity Rule version 1.1.0 March 2011

BACKGROUND

This rule addresses proposed usage patterns for both batch and real time transactions, the exchange of security identifiers, and communications-level errors and acknowledgements. It does not attempt to define the specific content of the message exchanges beyond declaring that the HIPAA-adopted v5010 ASC X12 formats must be used between covered entities and security information must be sent outside of the X12 payload.

This rule is designed to provide a “safe harbor” that application vendors, providers, and health plans (or other information sources) can be assured will be supported by any CORE-certified trading partner. All CORE-certified organizations must demonstrate the ability to implement connectivity as described in this rule. This rule is not intended to require trading partners to remove existing connections that do not match the rule, nor is it intended to require that all CORE trading partners must use this method for all new connections. CORE expects that in some technical circumstances, trading partners may agree to use different communication mechanism(s) and/or security requirements than that described by this rule.

This rule describes some of the specifics for implementing HTTP/S connectivity for healthcare administrative transaction exchange.

RULE

CORE-certified entities must be able to implement HTTP/S Version 1.1 over the public Internet as a transport method for the ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter v5010 270/271) transactions. Information Sources must be able to perform the role of an HTTP/S server, while Information Receivers must be able to perform the role of an HTTP/S client. HTTP/S is a secure, reliable, ubiquitous protocol that has a proven record of support for high-volume transaction exchange and security in healthcare and other industries. In addition, there is wide system-developer and software tools support for HTTP/S, making it a relatively inexpensive transport for information sources and receivers to support.

Section 1: Usage Patterns

HTTP/S supports a request-response message pattern, meaning that the sender submits a message and then waits for a response from the message receiver. This works well for the submission of both batch and real time ASC X12 messages, but the response message from the receiver is different depending on whether the sender’s message is a real time request, batch submission, or batch request pickup.

Section 2: Real Time Requests

Real time requests must include a single inquiry or submission (e.g. one eligibility inquiry to one information source for one patient). In this model the response from the message receiver is either an error response (see below for error reporting) or the corresponding ASC X12 message response (e.g. ASC X12 005010X231A Implementation Acknowledgement for Health Care Insurance (999) [hereafter v5010 999] or v5010 271 if the request was a v5010 270).

Section 3: Batch Submission

Batch requests are sent in the same way as real time requests. In this model the response will differ because message receivers are not required to provide an ASC X12 response in the timeframes specified by CORE for real time. For batch submissions, the response must be only the standard HTTP message indicating whether the request was accepted or rejected (see below for error reporting.) Message receivers must not respond to a batch submission with an ASC X12 response such as an ASC X12 005010X231A1 Implementation Acknowledgement for Health Care (999) as described in the Phase I CORE 150: Eligibility and Benefits Batch Acknowledgement Rule version 1.1.0 in the HTTP response to the batch request, even if their systems’ capabilities allow such a response. (See the Phase I CORE 155: Batch Response Time Rule version 1.1.0 for the response time requirements for v5010 999).

Phase I CORE 153: Eligibility and Benefits Connectivity Rule version 1.1.0 March 2011

For full details of the standard HTTP messages, see [RFC 2616](#).¹ In general a 2xx series response means that the batch submission has been accepted for further processing, while a 4xx or 5xx series response means that the submission has not been accepted and will not be processed by the message receiver.

Subsection 3.1: Batch Response Pickup

Batch responses should be picked up after the message receiver has had a chance to process a batch submission (see the Phase I CORE 155: Batch Response Time Rule version 1.1.0 for details on timing). Under this usage pattern, the message sender connects to the message receiver using HTTP/S and sends a message requesting available files, and the responder then sends back either.

1. The file(s) in the HTTP/S response message (payload), or
2. A list of available file(s), and supports a mechanism to request a particular file from the list.

Section 4: HTTP Data Elements Required and Message Format

Subsection 4.1: Required Data Elements

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. Information Sources must publish their detailed specification for the message format in their publicly available Companion Guide.

In order to comply with the Phase I CORE 155 and 156: Response Time Rules version 1.1.0, message receivers will be required to track the times of any received inbound messages, and respond with the outbound message for that payload ID. In addition, message senders must include the date and time the message was sent in the HTTP Message Header tags.

Subsection 4.2: Date and Time Requirements

This Phase I rule does not define the exact format and attributes for these data elements except that the date must be sent and logged using 8 digits (YYYYMMDD) and time must be sent and logged using a minimum of 6 digits (HHMMSS).

This Rule does not address issues of Batch Response Integrity; those are addressed by the Phase I CORE 150: Batch Acknowledgements Rule version 1.1.0.

Section 5: Security and Authentication Requirements

By using the HTTP/S protocol, all information exchanged between the sender and receiver is encrypted by a session-level private key negotiated at connection time. This approach makes it very difficult for an intruder to decode the encrypted data.

Subsection 5.1: User ID and Password

CORE participants will employ User ID and Password as the default minimum criteria authentication mechanism. Issuance, maintenance and control of password requirements may vary by participant and should be issued in accordance with the organization's HIPAA Security Compliance policies. CORE recommends that the User ID and Password policies and requirements be published in each password issuer's Companion Guide.

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. This allows message receivers to authenticate that the message is from a trusted source before passing it to their ASC X12 parsing engine.

The receiver may also 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.

Due to programming requirements of POSTing over HTTP/S, use of a digital certificate is required to establish communications. CORE-certified participants will make available information on how to obtain the receiver's root public certificate.

¹ The Internet Society. Network Work Group, June 1999. <http://www.ietf.org/rfc/rfc2616.txt>

Phase I CORE 153: Eligibility and Benefits Connectivity Rule version 1.1.0 March 2011

No additional security for file transmissions, such as the separate encryption of the ASC X12 payload data, is required in this Phase I 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.

Section 6: Response Time, Time Out Parameters and Re-transmission

This section of the rule relates to connectivity and telecommunications response times and time outs. The Phase I CORE 150 and 151: Batch and Real Time Acknowledgements Rules version 1.1.0. describe the responsibilities of CORE participants in responding to business messages (e.g. the ASC X12 v5010 270) with the appropriate business response (e.g. the ASC X12 v5010 999, 271, etc.).

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.

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.

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.

Section 7: Response Message Options and Error Notification

This section of the rule addresses only the HTTP Post Message responses. Please refer to Phase I CORE 150 and 151: Eligibility and Benefits Acknowledgement Rules version 1.1.0 for required acknowledgments.

The HTTP Post Message process requires a response (or "reply") to the message that was sent. The response sent back from the message receiver (e.g. the various information sources) can fall into several different categories depending on the type of the request and the capabilities of the message receiver.

Subsection 7.1: Authorization Errors

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.

Subsection 7.2: Batch Submission Acknowledgement

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.

Subsection 7.3: Real Time Response or Response to Batch Response Pickup

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 Phase I CORE 150 and 151: Batch and Real Time Acknowledgements Rules version 1.1.0.

Subsection 7.4: Server Errors

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*. 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.

Phase I CORE 153: Eligibility and Benefits Connectivity Rule
version 1.1.0 March 2011

CONFORMANCE

Conformance with this connectivity rule is considered achieved by information sources if all of the following criteria are achieved:

- 1. The Information Source must publish their detailed HTTP Message format specification in a publicly available Companion Guide.*
- 2. 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.*
- 3. 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. The Information Source's HTTP/S-based connectivity method must be available for use by submitters for 95 percent of the information source's documented system availability as specified in the CORE System Availability rule and measured over a calendar month. Each CORE-certified entity must demonstrate its conformance with this criterion by demonstrating their ability to track and report the times the HTTP/S-based connectivity system was available.*

Conformance with this rule must be demonstrated through successful completion of the approved CORE test suite for this rule with a CORE-authorized testing vendor.

Phase I CORE 154: Eligibility and Benefits 270/271 Data Content Rule
version 1.1.0 March 2011

BACKGROUND

This CORE rule specifies the CORE minimum requirements for using the HIPAA-adopted ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter v5010 270) to inquire about health plan insurance coverage and to respond to such an inquiry using the HIPAA-adopted ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter v5010 271). This Phase I CORE rule covers the following content in the v5010 271.

1. *The required response to an inquiry when the individual is located in the health plan's system under the following conditions:*
 - a) *A generic v5010 270 inquiry*
 - b) *A specific inquiry for a Service Type not supported by the health plan*
 - c) *A specific inquiry for one of the CORE required service types*
2. *The mandated response components include:*
 - a) *the dates of eligibility at the health plan (contract) level for past and future dates and the dates of eligibility at the benefit level if different from the contract level*
 - b) *the patient financial responsibility for each specified benefit at the base contract amounts for both in-network and out-of-network*
 - c) *the name of the health plan when it exists in the health plan's system*

The requirements specified in this CORE rule address certain situational elements and codes and are in addition to requirements contained in the v5010 270/271 implementation guides.

RULE

Section 1: v5010 271 Eligibility Inquiry Response¹

Subsection 1.1: Health Plan Name

When the individual is located in the health plan's (or information source's) system the health plan name must be returned (if one exists within the health plan's or information source's system) in EB05-1204 Plan Coverage Description. Neither the health plan nor the information source is required to obtain such a health plan name from outside its own organization.

Subsection 1.2: Patient Financial Responsibility

The patient financial responsibility for co-insurance, co-payment and deductibles must be returned as specified below by a CORE-certified health plan (or information source) for each of the service type codes returned:

Subsection 1.2.1: To specify the co-insurance responsibility

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.

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.

The health plan (or information source) may, at its discretion, elect not to return co-insurance information for the following services specified in EB03-1365: 1 – Medical Care; 30 – Health Plan Benefit Coverage; 35 – Dental Care; 88 – Pharmacy; AL – Vision (Optometry); MH – Mental Health. This optional reporting does not preempt the health plan's (or information source's) requirement to report patient co-insurance responsibility for the remaining 7 CORE required service types (33 – Chiropractic, 47 – Hospital; 48 – Hospital Inpatient,

¹ This Phase I CORE rule is not intended to be a comprehensive companion document specifying the complete content of either the v5010 270 or v5010 271 transactions. The focus on this Phase I CORE rule is on specifications for the v5010 271 to address the Phase I CORE data requirements for benefit coverage.

**Phase I CORE 154: Eligibility and Benefits 270/271 Data Content Rule
version 1.1.0 March 2011**

50 – Hospital Outpatient, 86 – Emergency Services, 98 – Professional (Physician) Visit – Office, UC – Urgent Care), that must be reported in a generic request for eligibility (Service Type Code 30) or a service type not supported by the health plan.

Subsection 1.2.2: To specify the co-payment responsibility

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.

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.

The health plan (or information source) may, at its discretion, elect not to return co-payment information for the following services specified in EB03-1365: 1 – Medical Care; 30 – Health Plan Benefit Coverage; 35 – Dental Care; 88 – Pharmacy; AL – Vision (Optometry); MH – Mental Health. This optional reporting does not preempt the health plan’s (or information source’s) requirement to report patient co-payment responsibility for the remaining 7 CORE required service types (33 – Chiropractic, 47 – Hospital, 48 – Hospital Inpatient, 50 – Hospital Outpatient, 86 – Emergency Services, 98 – Professional (Physician) Visit – Office, UC – Urgent Care), that must be reported in a generic request for eligibility (Service Type Code 30) or a service type not supported by the health plan.

Subsection 1.2.3: To specify the deductible responsibility

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.

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.

If the deductible amount varies by the benefit coverage level specified in EB02-1207 Coverage Level Code, place the appropriate code in EB02 and use additional occurrences of the EB Eligibility or Benefit Information segment as necessary for each benefit coverage level for each type of service, e.g. individual or family coverage.

The health plan (or information source) may, at its discretion, elect not to return deductible information for the following services specified in EB03-1365: 1 – Medical Care; 30 – Health Plan Benefit Coverage; 35 – Dental Care; 88 – Pharmacy; AL – Vision (Optometry); MH – Mental Health. This optional reporting does not preempt the health plan’s (or information source’s) requirement to report patient deductible responsibility for the remaining 7 CORE required service types (33 – Chiropractic, 47 – Hospital, 48 – Hospital Inpatient, 50 – Hospital Outpatient, 86 – Emergency Services, 98 – Professional (Physician) Visit – Office, UC – Urgent Care), that must be reported in a generic request for eligibility (Service Type Code 30) or a service type not supported by the health plan.

Subsection 1.3: Eligibility Dates

The v5010 270 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 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.

Subsection 1.4: Support for CORE Required Service Types

The health plan (or information source) must support an explicit request for each of the CORE required service types. The CORE required service type codes are: “1”, “33”, “35”, “47”, “48”, “50”, “86”, “88”, “98”, “AL”, “MH”, “UC” submitted in the v5010 270 EQ01 by providing the content identified in subsections 1.1 through 1.3 above for the submitted service type(s).

**Phase I CORE 154: Eligibility and Benefits 270/271 Data Content Rule
version 1.1.0 March 2011**

CONFORMANCE

The CORE test suite for this rule includes the following types of tests:

1. *Receipt by a health plan or information source of a valid generic request for eligibility v5010 270 transaction created using the CORE master test bed data.*
2. *The creation of a v5010 271 transaction generated using the CORE master test bed data.*
 - a) *The CORE master test bed data will contain all of the values necessary to generate a response transaction covering each of the requirements in the following paragraphs of the v5010 271 Eligibility Inquiry Response section of this rule:*
 - i) *Subsection 1.1: health plan name*
 - ii) *Subsection 1.2: patient financial responsibility for co-insurance, co-payment, and deductible, including in-network and out-of-network*

The CORE test suite will not include comprehensive testing requirements to test for all possible permutations of health plan benefit status or patient financial responsibility for all of the CORE required benefits addressed in the v5010 271.

Conformance with this rule must be demonstrated through successful completion of the approved CORE test suite for this rule with a CORE-authorized testing vendor.

**Phase I CORE 155: Eligibility and Benefits Batch Response Time Rule
version 1.1.0 March 2011**

BACKGROUND

When ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter v5010 270) eligibility inquiries submitted in batch processing mode are subsequently converted to real-time processing by any intermediary clearinghouse or switch for further processing by the health plan (or information source) before being returned to the submitter as a batch of ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter v5010 271) responses, the Phase I CORE 155: Eligibility and Benefits Batch Response Time Rule version 1.1.0 shall apply.

RULE

Section 1: v5010 270 Batch Mode Response Time Requirements

Maximum response time when processing in batch mode¹ for the receipt of a v5010 271 to a v5010 270 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 00:00 hours) of each designated day through 11:59 pm (23:59 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. *See Phase I CORE 157: System Availability Rule version 1.1.0 for notification process of holidays.*

Section 2: v5010 999 Batch Mode Response Time Requirements

An ASC X12 005010X231A1 Implementation Acknowledgement for Health Care Insurance (999) (hereafter v5010 999) 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; and to the health plan (or information source) in the case of a batch of v5010 271.²

Section 3: Conformance

Conformance with this maximum response time rule shall be considered achieved if 90 percent of all required responses as specified in the Phase I CORE 150: Eligibility and Benefit Batch Acknowledgement Rule version 1.1.0 are returned within the specified maximum response time as measured within a calendar month.

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.

CONFORMANCE

The CORE test suite for this rule includes the following:

1. *The actual delivery of statistics by a CORE-certified entity will be required only in response to a verified compliance complaint. Otherwise, a CORE-certified entity's compliance with the response time requirements will be based on good faith. Please see Phase I CORE 105: Eligibility and Benefits Enforcement Policy version 1.1.0 for details on filing complaints and who is permitted to file complaints.*
2. *All CORE-certified entities are required to conform to this rule regardless of the connectivity mode and methods used between CORE-certified trading partners.*
3. *This rule assumes that all parties in the transaction routing path are CORE-certified and compliant.*

Conformance with this rule must be demonstrated through successful completion of the approved CORE test suite for this rule with a CORE-authorized testing vendor.

¹ Batch mode is defined in the CORE Glossary of Terms

² See CORE 150: Batch Acknowledgements Rule version 1.1.0, which requires return of a v5010 999 to be sent in all cases indicating rejection/acceptance of the batch.

**Phase I CORE 156: Eligibility and Benefits Real Time Response Time Rule
version 1.1.0 March 2011**

RULE

Section 1: v5010 270 Real Time Mode Response Time Requirements

Maximum response time when processing in real time mode¹ for the receipt of a ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter v5010 271) or in the case of an error, a ASC X12 005010X231A1 Implementation Acknowledgement for Health Care Insurance (999) (hereafter v5010 999) from the time of submission of a v5010 270 must be 20 seconds (or less). V5010 999 errors must be returned within the same response timeframe.² See *Phase I CORE 157: System Availability Rule version 1.1.0 for notification process of holidays.*

Section 2: Conformance

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.

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.

CONFORMANCE

The CORE test suite for this rule includes the following:

1. *The actual delivery of statistics by a CORE-certified entity will be required only in response to a verified compliance complaint. Otherwise, a CORE-certified entity's compliance with the response time requirements will be based on good faith.*
2. *All CORE-certified entities are required to conform to this and other CORE rules regardless of the connectivity mode and methods used between CORE-certified trading partners.*
3. *This rule assumes that all parties in the transaction routing path are CORE-certified and compliant.*
4. *The recommended maximum response time between each participant in the transaction is 4 seconds or less per hop as long as the 20-second total roundtrip requirement is met.*

Conformance with this rule must be demonstrated through successful completion of the approved CORE test suite for this rule with a CORE-authorized testing vendor.

¹ Real time mode is defined in the CORE Glossary of Terms.

² See CORE 151: Real Time Acknowledgements Rule version 1.1.0, which requires return of either a 999 or 271 response.

Phase I CORE 157: Eligibility and Benefits System Availability Rule
version 1.1.0 March 2011

BACKGROUND

Many healthcare providers have a need to determine an individual's health plan coverage at the time and point of patient registration and intake, which may occur on a 24x7x365 basis or outside of the typical business day and business hours. Additionally, many institutional providers are now allocating staff resources to performing patient pre-registration activities on weekends and evenings. As a result, providers have a business need to be able to conduct health plan eligibility transactions at any time.

On the other hand, health plans have a business need to take their eligibility and other systems offline periodically in order to perform the required system maintenance. This typically results in some systems not being available for timely eligibility inquiries and responses certain nights and weekends. The rule was created to address these conflicting needs.

RULE

Section 1: System Availability Requirements

System availability¹ must be no less than 86 percent per calendar week² for both real time and batch processing modes. This will allow for health plan, (or other information source) clearinghouse/switch or other intermediary system updates to take place within a maximum of 24 hours per calendar week for regularly scheduled downtime.

Section 2: Reporting Requirements

Subsection 2.1: Scheduled Downtime

CORE-certified health plans (or information sources), clearinghouses/switches or other intermediaries must publish their regularly scheduled system downtime in an appropriate manner (e.g., on websites or in companion guides) such that the healthcare provider can determine the health plan's system availability and staffing levels can be effectively managed.

Subsection 2.2: Non-Routine Downtime

For non-routine downtime (e.g., system upgrade), an information source must publish the schedule of non-routine downtime at least one week in advance.

Subsection 2.3: Unscheduled Downtime

For unscheduled/emergency downtime (e.g., system crash), an information source will be required to provide information within one hour of realizing downtime will be needed.

Subsection 2.4: No Response Required

No response is required during scheduled downtime(s).

Section 3: Holiday Schedule

Each health plan, (or other information source) clearinghouse/switch or other intermediary will establish its own holiday schedule and publish it in accordance with the rule above.

CONFORMANCE

Each CORE-certified entity must demonstrate its conformance with this system availability rule by publishing the following documentation:

1. *Actual published copies of regularly scheduled downtime schedule, including holidays, and method(s) of publishing*
2. *Sample of non-routine downtime notice and method(s) of publishing*
3. *Sample of unscheduled/emergency downtime notice and method(s) of publishing*

Conformance with this rule must be demonstrated through successful completion of the approved CORE test suite for this rule with a CORE-authorized testing vendor.

¹ System is defined as all necessary components required to process a v5010 270 inquiry and return a response.

² Calendar week is defined as 12:01am Sunday to 12:00am the following Sunday.