CAQH CORE Eligibility & Benefits
CORE Certification Test Suite Version EB.3.0
April 2022

Revision History for Eligibility & Benefits CAQH CORE Certification Test Suite

Version	Revision	Description	Date
1.0.0	Major	Phase I CORE Certification Test Suite balloted and approved by the CAQH CORE Voting Process.	July 2008
2.0.0	Major	Phase II CORE Certification Test Suite balloted and approved by the CAQH CORE Voting Process.	July 2008
1.1.0; 2.1.0	Major	Revised to support v5010	March 2011
EB.1.0	Minor	• Non-substantive adjustments to support re-organization of operating rules into rule sets organized by business transaction (e.g., Eligibility & Benefits, Claim Status, etc.) rather than phase (e.g., Phase I, II, etc.) as approved by the CAQH CORE Board in 2019. • Operating rule naming, versioning and numbering methodologies updated to align with business transaction-based rule sets.	May 2020
EB2.0	Major	Update to align across CAQH CORE Certification Test Suites and include Test Scenarios for the CAQH CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule. Balloted and approved via the CAQH CORE Voting Process.	December 2020
EB3.0	Major	Update to align with enhancements made to the Electronic Delivery of Patient Financial and Benefit Information operating rule requirements to address: • Delivery of Telemedicine Benefits • Expansion CORE-required Service Type Code • Maximum and Remaining Coverage Benefits • Procedure Codes Requests and Responses • Authorization or Certification Determination • Communication of Tiered Benefit	April 2022

Table of Contents

1. Introduction **5**
1.1. CORE Certification Guiding Principles 5
1.2. Eligibility For CORE Certification 6
1.3. Role of CAQH CORE-authorized Testing Vendors 6
1.4. Applicability of This Document 6
2. Guidance for Using This CAQH CORE Certification Test Suite **7**
2.1. Structure of Test Scenarios for the CAQH CORE Eligibility & Benefits Operating Rule Set 7
2.2. Determining CAQH CORE Stakeholder Type for CORE Certification 7
2.3. CORE Certification Provider Stakeholder Type 7
2.4. CORE Certification Health Plan Stakeholder Type 7
2.5. CORE Certification Clearinghouse Stakeholder Type 7
2.6. CORE Certification Vendor Stakeholder Type 8
2.7. Table of CORE Certification Stakeholder Types Examples 8
2.8. User Quick Start Guide 12
2.9. Guidance for Providers and Health Plans Seeking Eligibility & Benefits CORE Certification That Work With Agents 12
2.10. Eligibility & Benefits Master Test Bed Data 13
3. Test Scenarios by Rule **14**
3.1. CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Batch Acknowledgement Requirements Test Scenario 14
3.1.1. Key Rule Requirements 14
3.1.2. Conformance Testing Requirements 14
3.1.3. Test Scripts Assumptions 15
3.1.4. Detailed Step-By-Step Test Script 16
3.2. CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Real Time Acknowledgement Requirements Test Scenario 17
3.2.1. Key Rule Requirements 17
3.2.2. Conformance Testing Requirements 17
3.2.3. Test Scripts Assumptions 17
3.2.4. Detailed Step-By-Step Test Script 19
3.3. CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Companion Guide Requirements Test Scenario 20
3.3.1. Key Rule Requirements 20
3.3.2. Conformance Testing Requirements 20
3.3.3. Test Scripts Assumptions 20
3.3.4. Detailed Step-By-Step Test Script 21
3.4. CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Batch Response Time Requirements Test Scenario 22
3.4.1. Key Rule Requirements 22
3.4.2. Conformance Testing Requirements 22
3.4.3. Test Scripts Assumptions 22
3.4.4. Detailed Step-By-Step Test Script: 24
3.5. CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: Real Time Response Time Requirements Test Scenario 26
3.5.1. Key Rule Requirements 26
3.5.2. Conformance Testing Requirements 26
3.5.3. Test Scripts Assumptions 26
3.5.4. Detailed Step-By-Step Test Script: 27
3.6. CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: System Availability Requirements 29
3.6.1. Key Rule Requirements 29

3.6.2. Conformance Testing Requirements 30
3.6.3. Test Scripts Assumptions 30
3.6.4. Detailed Step-By-Step Test Script 31
3.7. CAQH CORE Eligibility & Benefits (270/271) Data Content Rule: Electronic Delivery of Patient Financial Information Rule Requirements Test Scenario 32
3.7.1. Key Rule Requirements 32
3.7.2. Conformance Testing Requirements: 33
3.7.3. Test Scripts Assumptions 34
3.7.4. Detailed Step-By-Step Test Script 35
3.8. CAQH CORE Eligibility & Benefits (270/271) Data Content Rule: Normalizing Patient Last Name Rule Requirements Test Scenario 49
3.8.1. Key Rule Requirements 49
3.8.2. Conformance Testing Requirements 50
3.8.3. Test Scripts & Assumptions 51
3.8.4. Detailed Step-by-Step Test Scripts 52
3.9. CAQH CORE Eligibility & Benefits (270/271) Data Content Rule: AAA Error Code Reporting Requirements Test Scenario 54
3.9.1. Key Rule Requirements 54
3.9.2. Conformance Testing Requirements 55
3.9.3. Test Scripts Assumptions 56
3.9.4. Detailed Step-by-Step Test Script 57
3.10. CAQH CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule Test Scenario 58
3.10.1. Key Rule Requirements 58
3.10.2. Conformance Testing Requirements 59
3.10.3. Test Scripts Assumptions 59
3.10.4. Detailed Step-By-Step Test Script 60
3.11. CAQH CORE Connectivity Rule v1.1.0 Test Scenario 61
3.11.1. Key Rule Requirements 61
3.11.2. Conformance Testing Requirements 63
3.11.3. Test Scripts Assumptions 63
3.11.4. Detailed Step-By-Step Test Script 64
3.12. CAQH CORE Connectivity Rule vC2.2.0 Test Scenario 65
3.12.1. Key Rule Requirements 65
3.12.2. Conformance Testing Requirements 68
3.12.3. Test Scripts Assumptions 69
3.12.4. Detailed Step-by-Step Test Script 70

1. Introduction

This CAQH CORE Certification Test Suite contains the requirements that must be met by an entity seeking CORE Certification on the CAQH CORE Eligibility & Benefit Operating Rules to be awarded a CORE® Certification Seal. As such, this Test Suite includes:

- Guidance as to the types of stakeholders to which the CAQH CORE Eligibility & Benefits Operating Rule Set apply and how to determine when a specific rule's detailed test script applies to a stakeholder.

- For each CAQH CORE Eligibility & Benefits Operating Rule:
  - High level summary of key rule requirements
  - The specific conformance testing requirements
  - Test script assumptions
  - Detailed step-by-step test scripts

1.1. CORE Certification Guiding Principles

The CAQH CORE Guiding Principles apply to the entire rule set, including the CAQH CORE Certification Test Suite. CORE Certification Testing is not exhaustive and does not use production-level testing. The CAQH CORE Certification Test Suite does not include comprehensive testing requirements to test for all possible permutations of each rule's requirements.

Entities seeking CORE Certification are required to adopt all rules of an operating rule set that apply to their business and are responsible for all their own company-related testing resources. CORE Certification is available for both Real Time and Batch Processing Modes

CORE Certification Testing is required of any entity seeking CORE Certification.

The CORE Certification process has four components:[1]

1. Pre-certification planning and systems evaluation
2. Signing and submitting the CAQH CORE Pledge
3. CAQH CORE Certification Testing
4. Applying for the CORE Certification Seal

After signing the CAQH CORE Pledge, an entity has 180 days to complete CORE Certification Testing and submit its application for CORE Certification. The CAQH CORE testing protocol is scoped only to demonstrate conformance with CAQH CORE Operating Rules, and not overall compliance with HIPAA; each entity applying for CORE Certification signs a statement affirming that it is HIPAA-compliant to the best of its knowledge (signature is from executive-level management.). CORE Certification Testing is not exhaustive, e.g., it does not include production data, volume capacity testing, all specific requirements of each rule, or end-to-end trading partner testing. CAQH CORE does not oversee trading partner relationships; CORE-certified entities may work with non-CORE-certified entities if they so desire. The CORE Certification Testing Policy is used to gain CORE Certification only; it does not outline trading partner implementation interoperability testing activities.

[1] **CORE | CORE Certification Process | CAQH**

1.2. Eligibility for CORE Certification

CAQH CORE certifies all entities that create, transmit or use applicable administrative transactions. CAQH CORE also certifies products or services that facilitate the creation, transmission or use of applicable administrative transactions. CAQH CORE Certification Testing varies based on stakeholder type; entities successfully achieving CORE Certification receive the CORE Certification Seal that corresponds with their stakeholder type.

Associations, medical societies, and the like are not eligible to become CORE-certified; instead, these entities receive a CORE "Endorser" Seal after signing the CAQH CORE Pledge. Endorsers are expected to participate in CAQH CORE public relations campaigns, provide feedback and input to CAQH CORE when requested to do so, and encourage their members to consider participating in CAQH CORE.

1.3. Role of CAQH CORE-authorized Testing Vendors

To obtain a CORE Certification Seal, entities must successfully complete stakeholder-specific detailed step-by-step test scripts in the CAQH CORE Eligibility & Benefits CAQH CORE Certification Test Suite. Successful completion is demonstrated through proper documentation from a CAQH CORE-authorized Testing Vendor.

CAQH CORE-authorized Testing Vendors are companies that have expertise in healthcare transaction testing. They are chosen by CAQH CORE to conduct CAQH CORE Certification Testing for all published CAQH CORE Operating Rules using the CAQH CORE Certification Test Suite specific to each CAQH CORE Operating Rule Set after undergoing a rigorous selection process by CAQH CORE. Alpha and beta testing of their CORE Certification Testing Platform is performed by CAQH CORE Participating Organizations to ensure it aligns with the CAQH CORE Certification Test Suites.

NOTE: CORE Certification and CORE Certification Testing are separate activities. CORE Certification Testing is performed by entities seeking CORE Certification and supported by CAQH CORE-authorized Testing Vendors. CORE Certification is awarded by CAQH CORE after a review of the completed certification testing with a CAQH CORE-authorized Testing Vendor.

1.4. Applicability of This Document

All entities seeking CORE Certification must successfully complete CAQH CORE Eligibility & Benefits CORE Certification Testing from a CAQH CORE-authorized Testing Vendor in accordance with CAQH CORE Eligibility & Benefits CAQH CORE Certification Test Suite. This is required to maintain standard and consistent test results and CAQH CORE Eligibility & Benefits Operating Rule conformance. There are no exceptions to this requirement.

While the CAQH CORE CAQH CORE Eligibility & Benefits Operating Rules applies specifically to HIPAA-covered health plans, HIPAA-covered providers, or their respective agents[2] (see §2.2.5), CORE Certification Seals are awarded to a broader range of entities including non HIPAA-covered entities. In general, all entities that create, transmit or use applicable administrative transactions may seek CORE Certification. CAQH CORE also certifies products or services that facilitate the creation, transmission or use of applicable administrative transactions.

Entities that can obtain CORE Certification Seals are categorized into four CORE Certification stakeholder types: Providers, Health Plans, Clearinghouses, and Vendors. While three of the four CORE Certification stakeholder types share names with HIPAA-covered entities – Health Plans, Providers, and Clearinghouses – for purposes of CORE Certification, these three CORE Certification stakeholder types encompass a broader group of entities than what is included in their respective HIPAA definitions. For instance, the CORE Certification stakeholder type "Health Plan" also includes third party administrators (TPAs) which generally are not defined as HIPAA-covered entities. Other examples of entities that fall into these CORE Certification stakeholder types are described in Section 2.2.5. Throughout the remainder of this document, unless otherwise specified, references to Provider, Health Plan, Clearinghouse, and Vendor are references to the CORE Certification stakeholder type categorizations.

[2] One who agrees and is authorized to act on behalf of another, a principal, to legally bind an individual in particular business transactions with third parties pursuant to an agency relationship. Source: West's Encyclopedia of American Law, edition 2. Copyright 2008 The Gale Group, Inc. All rights reserved.

2. Guidance for Using This CAQH CORE Certification Test Suite

2.1. Structure of Test Scenarios for the CAQH CORE Eligibility & Benefits Operating Rule Set

Each Test Scenario for each rule contains the following sections:

- Key Rule Requirements
  - The CAQH CORE Eligibility & Benefits Operating Rule Set contains the actual rule language and the final authority for all operating rule requirements
- Certification conformance testing requirements by rule
- Test assumptions by rule
- Detailed Step-by-Step Test Scripts addressing each conformance testing requirement by rule for each stakeholder type to which the test script applies

2.2. Determining CAQH CORE Stakeholder Type for CORE Certification

Each test script listed in the Detailed Step-by-Step Test Script section for each Test Scenario is applicable to one or more of the CORE Certification stakeholder types specified in the Stakeholder columns. An entity may indicate that a specific test script does not apply to it. In this case the entity is required to provide a rationale for why a specific test script is not applicable and be prepared for a review of the rationale with CAQH CORE Staff.

The CORE Certification stakeholder types to which the Detailed Step-by-Step Test Scripts apply are Provider, Health Plan, Clearinghouse, and Vendor.

2.3. CORE Certification Provider Stakeholder Type

The CORE Certification stakeholder type "Provider" includes, but is not limited to, a HIPAA-covered provider. The CORE Certification stakeholder type Provider may also include any entity (i.e., an agent) that offers administrative services for a provider or group of providers and may include other agents that take the role of provider in HIPAA-mandated standard transactions. Notwithstanding, HIPAA-covered providers such as physicians, hospitals, dentists, and other providers of medical or health services are included in the CORE Certification Provider stakeholder type. (See §2.2.5 for more detail.)

2.4. CORE Certification Health Plan Stakeholder Type

As noted above, the CORE Certification stakeholder type "Health Plan" includes, but is not limited to, HIPAA-covered health plans. The CORE Certification stakeholder type Health Plan, is more akin to entities that the industry refers to as "payers," and includes third party administrators (TPAs), contractors with administrative services only (ASO) arrangements, utilization management organizations (UMO), and other agents that may conduct some or all elements of the HIPAA transactions on the behalf of a HIPAA-covered health plan. Notwithstanding, HIPAA-covered health plans such as self-insured health plans, health plan issuers, government health plans, and others are included in the CORE Certification Health Plan stakeholder type. (See §2.2.5 for more detail.)

2.5. CORE Certification Clearinghouse Stakeholder Type

The CORE Certification stakeholder type "Clearinghouse" includes, but is not limited to, HIPAA-covered health care clearinghouses. HIPAA defines a health care clearinghouse as an entity that processes health information received in a non-standard format into a standard format, or vice versa[3]. For purposes of CORE Certification, any intermediary between a Provider and a Health Plan CORE Certification stakeholder type that performs some or all aspects of a HIPAA-mandated function or a CAQH CORE Eligibility & Benefits Operating Rule could be considered a CORE Certification Clearinghouse stakeholder type. (See §2.2.5 for more detail.)

[3] See 45 CFR 160.103

2.6. CORE Certification Vendor Stakeholder Type

An entity (hereafter vendor) may offer commercially-available software products or services that enables a provider, a health plan or a clearinghouse to carry out HIPAA-required functions (e.g., standard transactions or a CAQH CORE CAQH CORE Eligibility & Benefits Operating Rule). Such vendor's products or services also are eligible for CORE Certification. In the context of this Eligibility & Benefits CAQH CORE Certification Test Suite, a vendor with commercially-available products can seek CORE Certification for those products/services and must certify each of its specific products/services and product/service versions separately. (See §2.2.5 for more detail.)

2.7. Table of CORE Certification Stakeholder Types Examples

This table includes examples of entities that can obtain CORE Certification Seals. This table is not intended to be comprehensive and exhaustive and may not include all possible entities.

Examples of Entities that are included in the four CORE Certification Stakeholder Types			
Provider	**Health Plan**	**Clearinghouse**	**Vendor**
HIPAA-covered Provider • Any person or organization who furnishes, bills, or is paid for medical or health services in the normal course of business[4] **Provider Agent** • Any entity that performs HIPAA-required functions or services for a provider or group of providers and may include other entities that take the role of provider in HIPAA-mandated standard transactions **Accountable Care Organizations** • Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients[5] • A network of doctors, hospital, specialists, post-acute providers	**HIPAA-covered Health Plan** Includes the following, singly or in combination:[7] • A group health plan • A health insurance issuer • An HMO • Part A or Part B of the Medicare program under title XVIII of the Act • The Medicaid program under title XIX of the Act, 42 U.S.C. 1396, et seq. • An issuer of a Medicare supplemental policy (as defined in section 1882(g)(1) of the Act, 42 U.S.C. 1395ss(g)(1)) • An issuer of a long-term care policy, excluding a nursing home fixed- indemnity policy • An employee welfare benefit plan or any other arrangement that is established or maintained for the	**HIPAA-covered Clearinghouse** A public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that does either of the following functions:[8] • Processes or facilitates the processing of health information received from another entity in a nonstandard format; or containing nonstandard data content into standard data elements or a standard transaction • Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or	**Health Plan Vendor (Product)** • A vendor of commercially-available software solutions for adjudication, claim processing, claim data warehousing, etc., for a health plan or its business associate *Note: A software solution vendor does not hold nor process data on behalf of its customer. This type of vendor is not a business associate of the health plan as defined under HIPAA.* **Health Plan Vendor (Services)** • An entity that holds and processes data on behalf of its health plan customer • An entity to which a health plan has outsourced a business function(s) *Note: This type of vendor holds and processes data on behalf of a health*

[4] Social Security Act, Section 1861 definitions for (u) and (s) are available online at http://www.ssa.gov/OP_Home/ssact/title18/1861.htm
[5] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco and http://innovation.cms.gov/initiatives/aco/
[7] U.S. 45 CFR 160.103
[8] Ibid.

Examples of Entities that are included in the four CORE Certification Stakeholder Types			
Provider	**Health Plan**	**Clearinghouse**	**Vendor**
and even private companies like Walgreens that shares financial and medical responsibility for providing coordinated care to patients in hopes of limiting unnecessary spending[6] • A healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients • A health insurance issuer-formed ACO	purpose of offering or providing health benefits to the employees of two or more employers • The health care program for active military personnel under title 10 of the United States Code • The veterans' health care program under 38 U.S.C. chapter 17 • The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) as defined in 10 U.S.C. 1072(4)) • The Indian Health Service program under the Indian Health Care Improvement Act, 25 U.S.C. 1601, et seq. • The Federal Employees Health Benefits Program under 5 U.S.C. 8902, et seq. • An approved State child health plan under title XXI of the Act, providing benefits for child health assistance that meet the requirements of section 2103 of the Act, 42 U.S.C. 1397, et seq. • The Medicare + Choice program under Part C of title XVIII of the Act, 42 U.S.C. 1395w-21 through 1395w-28 • A high-risk pool that is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals. Any other individual or group plan, or combination of individual or group plans, that	nonstandard data content for the receiving entity **Clearinghouse** • An entity that brokers or mediates connectivity between a provider and a health plan either directly or through another clearinghouse • An entity that receives administrative transactions from either a provider or a health plan and forwards to the intended recipient • An entity that provides other services based on each entity's business model *Note: A clearinghouse is distinct from a health care clearinghouse as defined under HIPAA in that it does NOT transform non-standard data/format into/out of the standard; rather it receives the standard data/format from another entity; then may disaggregate and re-aggregate transactions; and finally, route/forward the transaction to another entity.* **Health Information Exchange (Health Information Service Provider)** • An entity that provides secure transmission of clinical information between providers • An entity that provides secure t transfer of administration information between providers and health plans	*plan e.g., eligibility/membership data; utilization management, health care services review request/response (referral/authorizations.) This type of vendor is defined as a business associate under HIPAA.* **Provider Vendor (Product)** • A vendor of commercially-available software solutions for practice management, patient accounting, etc., to a health care provider or its business associate *Note: A software solution vendor does not hold nor process data on behalf of its customer. This type of vendor is not a business associate of the health plan as defined under HIPAA.* **Provider Vendor (Services)** • A billing/collection or financial services company to which a provider outsources some or all of its financial functions *Note: This type of vendor holds and processes data on behalf of a health care provider, e.g., eligibility verification, billing and collections. This type of vendor is defined as a business associate under HIPAA.* **Web Portal Operator** • As defined in the CAQH CORE Prior Authorization Web Portal Operating Rule, a Web Portal Operator is any organization that makes available to either

[6] http://kaiserhealthnews.org/news/aco-accountable-care-organization-faq/

Examples of Entities that are included in the four CORE Certification Stakeholder Types			
Provider	**Health Plan**	**Clearinghouse**	**Vendor**
	provides or pays for the cost of medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)) **Utilization Management Organization (UMO)[9]** • Provides an independent, unbiased determination of medical necessity beginning with an initial clinical review, then moving to a peer clinical review if needed • Uses evidence-based treatment guidelines to enhance the quality and effectiveness of patient care while eliminating excessive treatment and expense • Understands and adheres to applicable state and federal regulations • Employs drug utilization management mechanisms to address therapeutic appropriateness, over and underutilization, dosage, duration of treatment, duplication, drug allergies, and more • Is prepared to address any risk to patient safety, such as contraindicated treatments, adverse drug interactions, or inappropriate treatment, during the review process **Third Party Administrator (TPA)**	• An entity that provides a "community of trust" for authentication of organizations and end users within an organization • An entity that may manage PKI digital certifications for the "community" • An entity that may transform messages to the form acceptable by the receiver • An entity that forwards clinical information to another HIE for intercommunity information exchange **Health Insurance Marketplaces or Exchanges[10]** • Private exchanges which may predate the Affordable Care Act to facilitate insurance plans for employees of small and medium size businesses • Exchanges are not themselves insurers, so they do not bear risk themselves, but they do determine the insurance companies that are allowed to participate • Health Insurance Exchanges use electronic data interchange to transmit required information between the Exchanges and Carriers (trading partners), in particular enrollment information	providers and their agents, payers and their agents, health plans and their agents, or other organizations a web portal which supports the prior authorization process *Note: A web portal is a specially designed website that brings information from diverse sources together in a uniform way.*[12]

[9] Key functions performed by a UMO listed here are defined by URAC, a Washington DC-based non-profit organization that helps promote health care quality through the accreditation of organizations involved in medical care services.
[10] http://en.wikipedia.org/wiki/Health_insurance_marketplace
[12] https://en.wikipedia.org/wiki/Web_portal

Examples of Entities that are included in the four CORE Certification Stakeholder Types			
Provider	**Health Plan**	**Clearinghouse**	**Vendor**
	• An organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity. This can be viewed as "outsourcing" the administration of the claims processing, since the TPA is performing a task traditionally handled by the company providing the insurance or the company itself. Often, in the case of insurance claims, a TPA handles the claims processing for an employer that self-insures its employees[13] • An insurance company may also use a TPA to manage its claims processing, provider networks, utilization review, or membership functions. While some third-party administrators may operate as units of insurance companies, they are often independent[14] **Administrative Services Only (ASO)** • A contract under which a third-party administrator or an insurer agrees to provide administrative services to an employer in exchange for a fixed fee per employee[15] • An arrangement in which an organization funds its own employee benefit plan such as a pension plan or health insurance	and premium payment information **Value Added Network**[11] • A Value-added Network (VAN) is a hosted service offering that acts as an intermediary between business partners sharing standards based or proprietary data via shared Business Processes	

[13] http://en.wikipedia.org/wiki/Third-party_administrator
[14] Ibid.
[15] http://en.termwiki.com/EN/administrative_services_only_(ASO)_contract
[11] http://en.wikipedia.org/wiki/Value-added_network

Examples of Entities that are included in the four CORE Certification Stakeholder Types			
Provider	**Health Plan**	**Clearinghouse**	**Vendor**
	program but hires an outside firm to perform specific administrative services, e.g., an organization may hire an insurance company to evaluate and process claims under its employee health plan while maintaining the responsibility to pay the claims itself[16] • An arrangement under which an insurance carrier, its subsidiary or an independent organization will handle the administration of claims, benefits, reporting and other administrative functions for a self-insured plan[17] **Health Plan Agent** • Any entity that performs HIPAA-required functions or services for a health plan and may include other entities that take the role of a health plan in HIPAA-mandated standard transactions		

2.8. User Quick Start Guide

An entity can access a User Quick Start Guide specific to the set of CAQH CORE Operating Rules for which it is seeking CORE Certification when it initially establishes its testing profile on the CAQH CORE-authorized Testing Vendor's test site. The User Quick Start Guide is to be used in connection with a CAQH CORE-authorized Testing Vendor's certification testing system. It is meant to serve as an instruction document for the design and general utility of the testing system and is not a step-by-step CORE Certification guide.

2.9. Guidance for Providers and Health Plans Seeking Eligibility & Benefits CORE Certification That Work with Agents

Any Provider or Health Plan seeking CORE Certification must undergo certification testing in accordance with the CAQH CORE Certification Test Suite. However, a Provider or a Health Plan may also be CORE-certified when it outsources various functions to a third party, i.e., a business associate (referenced as an agent in the CAQH CORE Eligibility & Benefits Operating Rules). Thus, the Detailed Step-by-Step Test Scripts recognize that a Provider or a Health Plan may use a

[16] http://www.investopedia.com/terms/a/administrative-services-only.asp
[17] http://www.totalreturnannuities.com/annuity-glossary/a/administrative-services-only-aso-agreement.html

business associate to perform some or all the HIPAA-mandated functions required by the HIPAA-mandated standards and/or the CAQH CORE Operating Eligibility & Benefits Rule Set on its behalf.

When a Provider or a Health Plan outsources some functions to a business associate, both the Provider or Health Plan and its respective business associate to which the functions are outsourced must undergo CORE Certification Testing. The CAQH CORE rule requirements for either a Provider or a Health Plan differ by situation and such variability is dependent on how the Provider or the Health Plan interacts with its business associate and what services (i.e., functions and capabilities) its business associate provides to it. For example, a Health Plan seeking Eligibility & Benefits CORE Certification that uses a Clearinghouse may have some unique circumstances when undergoing certification testing. Because there is a Clearinghouse between the Health Plan's system and the Provider's system, the Clearinghouse acts as a "proxy" for some of the CORE Certification requirements outlined in the Eligibility & Benefits CAQH CORE Certification Test Suite.

Keep in mind that certification testing differs by each test scenario and each detailed step-by-step test script. Dependent upon the agreement between the Provider or the Health Plan and the Clearinghouse, the Provider or the Health Plan may not have to undergo certification testing for some aspects of the rules and their associated test scripts. In such a case, the Provider or the Health Plan must provide a rationale statement which explains the situation to the CAQH CORE-authorized Testing Vendor for each test script for which the N/A option is chosen and the Provider or the Health Plan needs to be prepared for a review of the rationale with CAQH CORE Staff.

2.10. Eligibility & Benefits Master Test Bed Data

The Eligibility & Benefits CAQH CORE Certification Test Suite requires that all organizations seeking Eligibility & Benefits CORE Certification be tested using the same CORE Master Test Bed Data. The scope of the CORE Master Test Bed Data is limited to data needed for entities seeking to become CORE-certified to create and populate their internal files and/or databases. These data are then used for internal pre-certification testing and formal Eligibility & Benefits CORE Certification Testing for the following CAQH CORE Eligibility & Benefits rule requirements:

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

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

The CORE Master Test Bed Data is available at no cost to any entity in Excel spreadsheet format so that organizations may easily extract the key data elements and load them into their internal test databases. CORE Master Test Bed Data does not include all data that an entity may require to load into their internal systems; therefore, entities may need to add other data to the CORE Master Test Bed Data when loading internal systems.

The CAQH CORE-authorized testing vendor uses only the CORE Master Test Bed Data to conduct CORE Certification testing for the CAQH CORE Eligibility and Benefits (270/271) Data Content Rule. The X12 v5010 270/271Transactions created using the CORE Master Test Bed Data must conform to the X12 005010X279A1 Eligibility Benefit Request and Response (270/271) Technical Report Type 3 (TR3) Implementation Guide.

3. Test Scenarios by Rule

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

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

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

3.1.1. Key Rule Requirements

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

Requires that

1. An X12 v5010 999 is returned to indicate either acceptance of the batch or rejection of a Functional Group (including the enclosed Transaction Set) error resulting in the rejection of the entire Functional Group (§3)
2. An X12 v5010 999 must ALWAYS be returned if there are no errors in the Functional Group and enclosed Transaction Set (§3)
3. An X12 v5010 271 eligibility response transaction must ALWAYS be returned for an Interchange, Functional Group and Transaction Set that complies with ASC X12 TR3 implementation guide requirements (§3)
4. An X12 v5010 271 eligibility response transaction may contain either the appropriate AAA Validation Request segment(s) or the data segments containing the requested eligibility and benefit status details. (§3)
5. An X12 v5010 999 must not be returned during the initial communications session in which the 270 batch is submitted (§3)

3.1.2. Conformance Testing Requirements

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

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

3.1.3. Test Scripts Assumptions

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

3.1.4. Detailed Step-By-Step Test Script

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[5]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[6]
1.	An X12 v5010 999 is returned on an invalid Functional Group.	An X12 Interchange containing only a v5010 999 IA.		☐ Pass	☐ Fail	☒	☒	☒	☒	☐
2.	An X12 v5010 999 is returned on a ASC valid ASC X12 Interchange.	An X12 Interchange containing only a v5010 999.		☐ Pass	☐ Fail	☒	☒	☒	☒	☐
3.	An X12 v5010 271 Eligibility Response transaction set is always returned for a valid 270 Eligibility Inquiry Transaction set.	An X12 Interchange is returned containing only a v5010 271 transaction set.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

[5] A checkmark in the box indicates the stakeholder type to which the test applies.
[6] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

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

3.2.1. Key Rule Requirements

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

Requires that

1. An X12 v5010 999 is returned ONLY to indicate a Functional Group (including the enclosed Transaction Set) error resulting in the rejection of the entire Functional Group (§2)
2. An X12 v5010 999 must NOT be returned if there are no errors in the Functional Group and enclosed Transaction Set (§2)
3. An X12 v5010 271 eligibility response transaction must ALWAYS be returned for an Interchange, Functional Group and Transaction Set that complies with ASC X12 TR3 implementation guide requirements (§2)
4. An X12 v5010 271 eligibility response transaction may contain either the appropriate AAA Validation Request segment(s) or the data segments containing the requested eligibility and benefit status details. (§2)

3.2.2. Conformance Testing Requirements

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

1. An X12 v5010 999 is returned ONLY to indicate a Functional Group (including the enclosed Transaction Set) error resulting in the rejection of the entire Functional Group
2. An X12 v5010 999 must NOT be returned if there are no errors in the Functional Group and enclosed Transaction Set
3. An X12 v5010 271 eligibility response transaction must ALWAYS be returned for an Interchange, Functional Group and Transaction Set that complies with X12 v5010 TR3 implementation guide requirements
4. An X12 v5010 271 eligibility response transaction may contain either the appropriate AAA Validation Request segment(s) or the data segments containing the requested eligibility and benefit status details.

3.2.3. Test Scripts Assumptions

1. All communications sessions and logon's are valid; no error conditions are created or encountered.
2. Test scripts will test ONLY for valid and invalid ASC X12 Interchange, Functional Group, Transaction Set and will not test for v5010 271 data content
3. Test scripts will test the following error conditions:
   a. Invalid ASC X12 Interchange (ISA control number match error)
   b. Invalid Functional Group (GS/GE control number match error)

3.2.3. Test Scripts Assumptions
c. Invalid Transaction Set (missing required segment) 4. Test scripts will test the following valid conditions a. Valid ASC X12 Interchange Control Segments b. Valid Functional Group Control Segments c. Valid ASC X12 v5010 Transaction Set 5. The test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

3.2.4. Detailed Step-By-Step Test Script

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[7]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[8]
1.	An X12 v5010 999 is returned on an invalid Functional Group.	An X12 Interchange containing only an X12 v5010 999 IA.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	An X12 v5010 999 is not returned on a valid X12 Interchange.	No X12 v5010 999 is returned.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
3.	An X12 v5010 271 Eligibility Response transaction set is always returned for a valid X12 v5010 270 Eligibility Inquiry Transaction set.	An X12 Interchange is returned containing only an X12 v5010 271 transaction set.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

[7] A checkmark in the box indicates the stakeholder type to which the test applies.
[8] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

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

3.3.1. Key Rule Requirements

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

All CORE-certified entities' Companion Guides covering the X12 v5010 270/271 Eligibility Inquiry and Response transactions must follow the format/flow as defined in the CAQH CORE Master Companion Guide Template for HIPAA Transactions.

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

3.3.2. Conformance Testing Requirements

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

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

1. A copy of the table of contents of its official X12 v5010 270/271 companion document
2. A copy of a page of its official X12 v5010 270/271 companion document depicting its conformance with the format for specifying the X12 v5010 270/271 data content requirements.

Such submission may be in the form of a hard copy paper document, an electronic document, or a URL where the table of contents and an example of the X12 v5010 270/271 content requirements of the companion document is located

3.3.3. Test Scripts Assumptions

1. The detailed content of the X12 v5010 270/271 companion document will not be submitted to the CAQH CORE-authorized Testing Vendor
2. The detailed content of the X12 v5010 270/271 companion document will not be examined nor evaluated
3. Test script will test ONLY that the table of contents of the companion document is
   a. Customized and specific to the entity undergoing this test
   b. Conforms to the flows specified in the Table of Contents of the CAQH CORE Master Companion Document Template
   c. Conforms to the presentation format for depicting segments, data elements and codes as specified in the CAQH CORE Master Companion Document Template
4. The test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

3.3.4. Detailed Step-By-Step Test Script

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[9]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[10]
1.	Companion Document conforms to the flow and format of the CAQH CORE Master Companion Document Template.	Submission of the Table of Contents of the X12 v5010 270/271 companion document, including an example of the X12 v5010 270/271 content requirements.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	Companion Document conforms to the format for presenting each segment, data element and code flow and format of the CAQH CORE Master Companion Document Template.	Submission of a page of the X12 v5010 270/271 companion document depicting the presentation of segments, data elements and codes showing conformance to the required presentation format.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

[9] A checkmark in the box indicates the stakeholder type to which the test applies.
[10] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

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

3.4.1. Key Rule Requirements

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

1. Maximum response time when processing in batch mode for the receipt of an X12 v5010 271 response to an X12 v5010 270 inquiry submitted by a provider or on a provider's behalf by a clearinghouse/switch by 9:00 pm Eastern time of a business day must be returned by 7:00 am Eastern time the following business day. A business day consists of the 24 hours commencing with 12:00 am (Midnight or 0000 hours) of each designated day through 11:59 pm (2359 hours) of that same designated day. The actual calendar day(s) constituting business days are defined by and at the discretion of each health plan or information source. (§5)
2. X12 v5010 999 responses must be available to the submitter within one hour of receipt of the batch: to the provider in the case of a batch of X12 v5010 270 inquiries and to the health plan (or information source) in the case of a batch of v5010 271 responses. (§5)
3. Conformance with this maximum response time rule shall be considered achieved if 90 percent of all required responses as specified in the CORE 150: Eligibility and Benefit Batch Acknowledgement Rule version 1.0.0 are returned within the specified maximum response time as measured within a calendar month. (§5)
4. Each CORE-certified entity must demonstrate its conformance with this maximum response time rule by demonstrating its ability to capture, log, audit, match, and report the date (YYYYMMDD), time (HHMMSS) and control numbers from its own internal systems and the corresponding data received from its trading partners. (§5)

3.4.2. Conformance Testing Requirements

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

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

3.4.3. Test Scripts Assumptions

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

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

3.4.4. Detailed Step-By-Step Test Script:

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

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

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

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

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

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

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

3.5.1. Key Rule Requirements

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

1. Maximum response time when processing in real time mode for the receipt of an X12 v5010 271 (or in the case of an error, a v5010 999 response from the time of submission of an X12 v5010 270 inquiry must be 20 seconds (or less) X12 v5010 999 response errors must be returned within the same response timeframe. (§4)
2. Conformance with this maximum response time rule shall be considered achieved if 90 percent of all required responses are returned within the specified maximum response time as measured within a calendar month. (§4)
3. Each CORE-certified entity must demonstrate its conformance with this maximum response time rule by demonstrating its ability to capture, log, audit, match and report the date (YYYYMMDD), time (HHMMSS) and control numbers from its own internal systems and the corresponding data received from its trading partners. (§4)

3.5.2. Conformance Testing Requirements

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

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

3.5.3. Test Scripts Assumptions

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

3.5.4. Detailed Step-By-Step Test Script:

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[13]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[14]
1)	Verify that outer most communications module(s) transmits all required data elements in the eligibility inquiry message. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the X12 v5010 Transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent.	Output a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
2)	Verify that outer most communications module(s) captures, assigns, logs and links all required data elements from the X12 v5010 271 Interchange to the submitted X12 v5010 270 Interchange. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the ASC X12 v5010	Output a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

[13] A checkmark in the box indicates the stakeholder type to which the test applies.
[14] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[13]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[14]
	Transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent.									
3)	Verify that outer most communications module(s) transmits all required data elements in the eligibility response message. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the X12 v5010 Transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent.	Output a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
4)	Verify that outer most communications module(s) captures, assigns, logs and links all required data elements from the X12 v5010 270 Interchange to the submitted X12 v5010 271 Interchange. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the X12 v5010 Transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent.	Output a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

3.6. CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule: System Availability Requirements

3.6.1. Key Rule Requirements

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

System Availability Requirements

1) System availability must be no less than 90 percent per calendar week for both real-time and batch processing modes. This will allow for health plan, (or other information source) clearinghouse/switch or other intermediary system updates to take place within a maximum of 24 hours per calendar week for regularly scheduled downtime. (§6.2.1) A HIPAA-covered health plan and its agent may choose to use an additional 24 hours of scheduled system downtime per calendar quarter.

Reporting Requirements

1) Scheduled Downtime
   a) 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 so that staffing levels can be effectively managed. (§6.2.2.1)
2) Non-Routine Downtime
   a) 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. (§6.2.2.2)
3) Unscheduled Downtime
   a) 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. (§6.2.2.3)

Other Requirements

4) No response is required during scheduled downtime(s.) (§6.2.2.4)
5) 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. (§6.2.3)

3.6.2. Conformance Testing Requirements

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

Demonstrate its ability to publish to its trading partner community the following schedules:

1) Its regularly scheduled downtime schedule, including holidays.
2) Its notice of non-routine downtime showing schedule of times down.
3) A notice of unscheduled/emergency downtime notice.

3.6.3. Test Scripts Assumptions

1) The entity has implemented in its production environments the necessary policies, procedures and method(s) required to conform to the requirements of the System Availability rule.
2) The CORE test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

3.6.4. Detailed Step-By-Step Test Script

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[15]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[16]
1)	Publication of regularly scheduled downtime, including holidays and method(s) for such publication.	Submission of actual published copies of regularly scheduled downtime including holidays and method(s) of publishing		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2)	Publication of non-routine downtime notice and method(s) for such publication.	Submission of a sample notice of non-routine downtime including scheduled of down time and method(s) of publishing		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
3)	Publication of unscheduled/emergency downtime notice and method(s) for such publication.	Submission of a sample notice of unscheduled/emergency downtime including method(s) of publishing		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

[15] A checkmark in the box indicates the stakeholder type to which the test applies.
[16] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

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

3.7.1. Key Rule Requirements

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

Requirements for X12 v5010 271 Eligibility Inquiry Response

When the individual is located in the system, the health plan must be return the following for CORE-required Service Type Codes:

1. The health plan name (if one exists within the health plan's or information source's system) in EB05-1204 Plan Coverage Description. Neither the health plan or information source is required to obtain such a health plan name from outside its own organization. (§1)
2. The patient financial responsibility for co-insurance, co-payment and deductibles (§1)
3. Benefit information pertaining to telemedicine and remaining coverage
4. Indication if authorization or certification is required

Eligibility Dates

5. The 270 eligibility inquiry may request a benefit coverage date 12 months in the past or up to the end of the current month. If the inquiry is outside of this date range and the health plan (or information source) does not support eligibility inquiries outside of this date range, the v5010 271 response must include the AAA segment with code "62" Date of Service Not Within Allowable Inquiry Period in the AAA03-901 Reject Reason Code data element. (§1)

To specify the co-insurance responsibility

6. Use code "A" Co-Insurance in EB01-1390 Eligibility or Benefit Information data element and use EB08-954 Percent data element for each reported type of service.(§1)
7. If the patient financial responsibility amounts differ for in and out of network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as appropriate.(§1)

To specify the co-payment responsibility

8. Use code "B" Co-Payment in EB01-1390 Eligibility or Benefit Information data element and use EB07-782 Monetary Amount element for each reported type of service. (§1)
9. If the patient financial responsibility amounts differ for in and out of network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as appropriate.(§1)

To specify the deductible responsibility

10. Use code "C" Deductible in EB01-1390 Eligibility or Benefit Information data element and use EB07-782 Monetary Amount to indicate the dollar amount of the deductible for the type of service specified in EB03-1365 service type code.(§1)
11. If the patient financial responsibility amounts differ for in and out of network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as appropriate.(§1)

3.7.1. Key Rule Requirements

12. If the deductible amount varies by the benefit coverage level specified in EB02-1207 Coverage Level Code, place the appropriate code in EB02 and use additional occurrences of the EB Eligibility or Benefit Information segment as necessary for each benefit coverage level for each benefit coverage level for each type of service, e.g., individual or family coverage. (§1)

To specify telemedicine benefits

13. Use the Centers for Medicare and Medicaid Services External Place of Service Codes for Professional Claims Code 02 (Telehealth Provided Other than in Patient's Home) or 10 (Telehealth Provided in Patient's Home) in Segment III (SUBSCRIBER/DEPENDENT ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION), within Data Element III02 (INDUSTRY CODE) to indicate what service or benefit is available for telemedicine for each reported type of service.
14. If telemedicine benefit amounts differ for in and out of network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as appropriate.(§1)

To specify maximum and remaining coverage benefits

15. Use two EB segment occurrences to indicate maximum benefit limitations and remaining benefits for each maximum benefit limitations for each reported typed of service.
16. Use the EB and DTP segment to indicate next eligible date for each reported service type with a date limitation.

To specify authorization/certification

17. Use code "N", "Y", or "U" in EB11- Authorization or Cert Indicator data element to indicate if authorization/certification is required, not required or unknown for a reported service type.

18. If authorization/certification indication differ for in and out of network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as appropriate. (§1)

Requires a receiver of the X12 v5010 271 Response to:

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

3.7.2. Conformance Testing Requirements:

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

1. The creation of an eligibility response X12 v5010 271 transaction generated using the Eligibility & Benefits CORE Master Test Bed Data providing the following information about the individual identified in the X12 v5010 270 eligibility transaction
   a. health plan name if one exists.

3.7.2. Conformance Testing Requirements:
b. patient financial responsibility, including in-network and out-of-network c. health plan benefit coverage dates based on base deductible d. benefit information pertaining to telemedicine and remaining coverages e. indication if authorization or certification is required 2. System receiving the X12 v5010 271 response must demonstrate its capability to detect and extract the data elements addressed in this rule and display such data and appropriate text to the end user.

3.7.3. Test Scripts Assumptions
1. The test scripts do not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

3.7.4. Detailed Step-By-Step Test Script

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[17]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[18]
1.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule indicating the **name of the health plan** covering the individual specified in the X12 v5010 270 eligibility inquiry The health plan is not required to obtain such a health plan name from outside its own organization.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the correct health plan name in EB05-1204.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	Extract from a valid X12 v5010 271 response transaction as defined in the CORE rule the data indicating the **name of the health plan** covering the individual specified in the 270 eligibility inquiry. The health plan is not required to obtain such a health plan name from outside its own organization.	Provide a screen print of the output from Test #2 showing that the required information is displayed to the information requester.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

[17] A checkmark in the box indicates the stakeholder type to which the test applies.
[18] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[17]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[18]
3.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule indicating the patient financial responsibility for each of the benefits covering the individual.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the correct co-insurance, co-payment, and deductible patient financial responsibilities for both in/out of network in either EB08-954 or EB07-782 at either the subscriber loop 2110C or dependent loop 2100D levels.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
4.	Extract from a valid X12 v5010 271 response transaction as defined in the CORE rule the data indicating the patient financial responsibility for each of the benefits covering the individual.	Provide a screen print of the output from Test #4 showing that the required information is displayed to the information requester.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
5.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule specifying the Health Plan remaining deductible amount.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the correct Health Plan remaining deductible amount.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
6.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule specifying a benefit-specific remaining deductible amount different than the Health Plan remaining deductible amount.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the correct benefit-specific remaining deductible amount.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[17]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[18]
7.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule specifying patient liability for a CORE-required explicit service type.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the correct patient liability for the requested service type.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
8.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule indicating the date(s) for the Health Plan base deductible for the health plan covering the individual only if different than the Health Plan Coverage date.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the date(s) applicable to the Health Plan Base deductible only if different than the Health Plan Coverage date.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
9.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule indicating the date(s) for a benefit-specific base deductible only if different than the Health Plan Coverage date.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the date(s) applicable to the benefit-specific base deductible only if different than the Health Plan Coverage date.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
10.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule specifying telemedicine benefit information for a CORE-required explicit service type.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the correct telemedicine benefit information for the requested service type.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[17]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[18]
11.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule specifying maximum and remaining benefit limitations for a CORE-required explicit service type.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the correct maximum and remaining benefit limitations for the requested service type.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
12.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule specifying a remaining benefit with date limitations for a CORE-required explicit service type.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the correct remaining benefit date limitations for the requested service type.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
13.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule specifying that authorization/ certification is required for a CORE-required explicit service type.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the correct authorization /certification indication for the requested service type.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
14.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule specifying that authorization /certification is not required for a CORE-required explicit service type.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the correct authorization /certification indication for the requested service type.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[17]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[18]
15.	Extract from a valid X12 v5010 271 response transaction as defined in the CORE rule the data required to be returned by a health plan in Test Scripts #5 through #14.	Provide a screen print of the output from Tests #5 through #14 showing that the required information is displayed to the end user.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

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

3.8.1. Key Rule Requirements

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

Requirements for X12 v5010 271 Eligibility Inquiry Response

When the individual is located in the system, the health plan must be return the following for CORE-required Categories of Service for Procedure Codes:

1. The health plan name (if one exists within the health plan's or information source's system) in EB05-1204 Plan Coverage Description. Neither the health plan or information source is required to obtain such a health plan name from outside its own organization. (§1)
2. The patient financial responsibility for co-insurance, co-payment and deductibles (§1)
3. Indication if authorization or certification is required

Eligibility Dates

1. The 270 eligibility inquiry may request a benefit coverage date 12 months in the past or up to the end of the current month. If the inquiry is outside of this date range and the health plan (or information source) does not support eligibility inquiries outside of this date range, the v5010 271 response must include the AAA segment with code "62" Date of Service Not Within Allowable Inquiry Period in the AAA03-901 Reject Reason Code data element. (§1)

To specify the co-insurance responsibility

4. Use code "A" Co-Insurance in EB01-1390 Eligibility or Benefit Information data element and use EB08-954 Percent data element for each reported type of service.(§1)
5. If the patient financial responsibility amounts differ for in and out of network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as appropriate.(§1)

To specify the co-payment responsibility

6. Use code "B" Co-Payment in EB01-1390 Eligibility or Benefit Information data element and use EB07-782 Monetary Amount element for each reported type of service. (§1)
7. If the patient financial responsibility amounts differ for in and out of network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as appropriate.(§1)

To specify the deductible responsibility

8. Use code "C" Deductible in EB01-1390 Eligibility or Benefit Information data element and use EB07-782 Monetary Amount to indicate the dollar amount of the deductible for the type of service specified in EB03-1365 service type code.(§1)
9. If the patient financial responsibility amounts differ for in and out of network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as appropriate.(§1)
10. If the deductible amount varies by the benefit coverage level specified in EB02-1207 Coverage Level Code, place the appropriate code in

3.8.1. Key Rule Requirements

EB02 and use additional occurrences of the EB Eligibility or Benefit Information segment as necessary for each benefit coverage level for each benefit coverage level for each type of service, e.g., individual or family coverage. (§1)

To specify authorization/certification

11. Use code "N", "Y", or "U" in EB11- Authorization or Cert Indicator data element to indicate if authorization/certification is required, not required or unknown for a reported service type.

Requires a receiver of the X12 v5010 271 Response to:

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

3.8.2. Conformance Testing Requirements:

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

1. The creation of an eligibility response X12 v5010 271 transaction generated using the Eligibility & Benefits CORE Master Test Bed Data providing the following information about the individual identified in the X12 v5010 270 eligibility transaction
   a. health plan name if one exists.
   b. patient financial responsibility, including in-network and out-of-network
   c. health plan benefit coverage dates based on base deductible
   d. indication if authorization or certification is required
2. System receiving the X12 v5010 271 response must demonstrate its capability to detect and extract the data elements addressed in this rule and display such data and appropriate text to the end user.

3.8.3. Test Scripts Assumptions

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

3.8.4. Detailed Step-By-Step Test Script

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[19]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[20]
1.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule indicating the **name of the health plan** covering the individual specified in the X12 v5010 270 eligibility inquiry The health plan is not required to obtain such a health plan name from outside its own organization.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the correct health plan name in EB05-1204.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	Extract from a valid X12 v5010 271 response transaction as defined in the CORE rule the data indicating the **name of the health plan** covering the individual specified in the 270 eligibility inquiry. The health plan is not required to obtain such a health plan name from outside its own organization.	Provide a screen print of the output from Test #2 showing that the required information is displayed to the information requester.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

[19] A checkmark in the box indicates the stakeholder type to which the test applies.
[20] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[19]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[20]
3.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule indicating the patient financial responsibility for each of the benefits covering the individual.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the correct co-insurance, co-payment, and deductible patient financial responsibilities for both in/out of network in either EB08-954 or EB07-782 at either the subscriber loop 2110C or dependent loop 2100D levels.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
4.	Extract from a valid X12 v5010 271 response transaction as defined in the CORE rule the data indicating the patient financial responsibility for each of the benefits covering the individual.	Provide a screen print of the output from Test #4 showing that the required information is displayed to the information requester.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
5.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule specifying the Health Plan remaining deductible amount.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the correct Health Plan remaining deductible amount.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
6.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule specifying a benefit-specific remaining deductible amount different than the Health Plan remaining deductible amount.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the correct benefit-specific remaining deductible amount.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[19]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[20]
7.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule specifying patient liability for a CORE-required explicit service type.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the correct patient liability for the requested service type.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
8.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule indicating the date(s) for the Health Plan base deductible for the health plan covering the individual only if different than the Health Plan Coverage date.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the date(s) applicable to the Health Plan Base deductible only if different than the Health Plan Coverage date.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
9.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule indicating the date(s) for a benefit-specific base deductible only if different than the Health Plan Coverage date.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the date(s) applicable to the benefit-specific base deductible only if different than the Health Plan Coverage date.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
10.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule specifying that authorization/ certification is required for a CORE-required explicit service type.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the correct authorization /certification indication for the requested service type.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[19]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[20]
11.	Create a valid X12 v5010 271 response transaction as defined in the CORE rule specifying that authorization /certification is not required for a CORE-required explicit service type.	Output a valid fully enveloped X12 v5010 271 eligibility response transaction set with the correct authorization /certification indication for the requested service type.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
12.	Extract from a valid X12 v5010 271 response transaction as defined in the CORE rule the data required to be returned by a health plan in Test Scripts #5 through #11.	Provide a screen print of the output from Tests #5 through #11 showing that the required information is displayed to the end user.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

3.9. CAQH CORE Eligibility & Benefits (270/271) Data Content Rule: Tiered Benefits

3.9.1. Key Rule Requirements

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

Requirements for X12 v5010 271 Eligibility Inquiry Response for Member Tiered Benefit Coverage

1. When the X12 v5010 270 includes a CORE-required service type or procedure code, and it is determined to be a tiered benefit for the patient identified, theX12 v5010 271 must include the following data in EB Loops 2110C/2110D for each applicable tiered benefit:
   - Coverage Status of Benefit
   - Benefit-Specific Base Deductible
   - Benefit-Specific Remaining Deductible
   - Co-Pay Amount
   - Co-Insurance Amount
   - Coverage Level
   - Benefit-specific Base Deductible Dates
   - Remaining Benefit Coverage
   - Authorization or Certification Indication
   - In/Out of Network Indication
2. Each EB loop must also include an MSG segment identifying the benefit tier and the MSG segment content must begin with "MSG*BenefitTier…"
3. If a specific tiered benefit cannot be determined, all tiers must be returned along with the MSG segment with appropriate wording indicating how the provider can determine which tier is applicable to them and the MSG segment content must begin with "MSG*Benefit Tier cannot be determined…"

Requirements for X12 v5010 271 Eligibility Inquiry Response for Provider Tiered Benefit Reimbursement

4. When the health plan and its agent can appropriately identify the provider specified in Loop 2100B NM1/REF/PRV segments the X12 v5010 271 must return the tiered network status of in-network, out-of-network, or exclusive/preferred for the inquiring provider and benefit information only for the patient tier that applies to the inquiring provider if determination can be made.
5. If a patient benefit tier cannot be determined for the provider specified in Loop 2100B, information for all benefit tiers applicable to the patient must be returned in EB Loops 2110C/2110D along with the MSG segment with appropriate wording indicating how the provider can determine which tier is applicable to them.

Requires a receiver of the X12 v5010 271 Response to:

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

3.9.2. Conformance Testing Requirements:

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

1. Health Plans should return tiered benefit information using codified approaches per rule requirements. However, in some cases MSG segments are necessary in or to clearly specify level of benefit detail in a X12 v5010 271 response.
2. System receiving the X12 v5010 271 response must demonstrate its capability to detect and extract the data elements addressed in this rule and display such data and appropriate text to the end user.

3.9.3. Test Scripts Assumptions

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

3.9.4. Detailed Step-By-Step Test Script

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[21]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[22]
1.	Health plans must align its system to codify and return any portion of member benefit tier information in a X12 v5010 271 response.	When submitting testing certification documents to CAQH CORE, a health plan will be asked to sign an attestation form that it has aligned its systems to be able to codify and return of member benefit tier information as allowable.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	Health plans must align its system to codify and return any portion of provider tier benefit information in a X12 v5010 271 response.	When submitting testing certification documents to CAQH CORE, a health plan will be asked to sign an attestation form that it has aligned its systems to be able to codify and return of provider tier benefit information as allowable.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

[21] A checkmark in the box indicates the stakeholder type to which the test applies.
[22] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

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

3.10.1. Key Rule Requirements

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

Requires a health plan (or information source) to:

1. Normalize the last name submitted on the X12 v5010 270 before using submitted last name. (§2.3.2)
2. Normalize internally-stored last name before using internally-stored last name. (§2.3.2)
3. Return the X12 5010 271 response with AAA segment using appropriate error code(s) as required by the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule: AAA Error Code Reporting Requirements when normalized names are not successfully matched or validated. (§2.3.2)
4. Return the un-normalized internally-stored last name when it does not match the un-normalized submitted last name in the NM103-1035 data element and return the INS segment as specified in Table 2.3.3. (§2.3.2.)
5. Return the X12 v5010 271 response as required by the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule when normalized names are successfully matched or validated. (§2.3.2)

Requires a receiver of the v5010 271 response to:

6. Detect all data elements addressed by the rule as returned in the X12 v5010 271 response. (§2.3.4)
7. Display to the end user text uniquely describing the specific error condition(s) and data elements returned in the X12 v5010 271. (§2.3.4)
8. Ensure that displayed text accurately represents the Follow Up Action without changing meaning and intent of the Follow Up Action. (§2.3.4)

Recommendations for submitters of the X12 v5010 270:

9. Submit a person's name suffix in the NM107-1039 data element when submitter's system enables capture and storage of a name suffix in a separate data field. (§2.3.1)
10. Separate a person's name suffix from the last name using either a space, comma or forward slash when the submitter's system does not enable the capture and storage of a name suffix in a separate data field. (§2.3.1)
11. Attempt to identify and parse the last name data element to extract any name suffix and to submit the suffix in the NM107-1039 data element. (§2.3.1)

3.10.2. Conformance Testing Requirements

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

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

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

1. The health plan must demonstrate its system capability to normalize both submitted and internally stored last names and return the required AAA errors when normalized names do not match.
2. The health plan must demonstrate its system has the capability to normalize both submitted and internally stored last names and:
    a. Return the internally stored un-normalized last name when both submitted and internally stored un-normalized last names do not match and the normalized last names do match.
    b. Return the required INS segment.
    c. Return the X12 v5010 271 response required by the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule.
3. The receiver of the X12 v5010 271 response must demonstrate it system has the capability to extract and make available to the end user
    a. The AAA and corresponding AAA Error Code Reporting Rule Error Condition Descriptions.
    b. The INS segment information.
4. The last name returned by the health plan.

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

3.10.4. Detailed Step-by-Step Test Scripts

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

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

Note: The CAQH CORE-authorized Testing Vendors will generate one or more randomly generated X12 v5010 270 inquiries based on the Eligibility & Benefits Master Test Bed Data that will cause the health plan to encounter each of the described error conditions in Test Scripts #1 and #2.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [23]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [24]
1.	Create a valid X12 v5010 271 response transaction indicating that the normalized submitted and internally-stored last names do not match.	Output a valid X12 v5010 271 transaction containing the AAA segment with AAA03=73 Invalid/Missing Subscriber/Insured Name.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	Create a valid X12 v5010 271 response transaction in which the un-normalized internally-stored last name is returned when the normalized submitted and internally-stored last names match.	Output a valid X12 v5010 271 transaction containing the INS segment as required by the CORE Name Normalization rule in which the NM103-1035 in Loop 2100C contains the un-normalized internally-stored last name.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

[23] The checkmark in each box below indicates the stakeholder type to which the test script applies.
[24] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [23]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [24]
3.	Extract from a valid X12 v5010 271 response transaction the patient identification data elements received in the NM1 and DMG segments in Loop 2100C and the information contained in the AAA segment.	Provide a screen print of the output from Test #1 showing that the required information is displayed to the information requester.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
4.	Extract from a valid X12 v5010 271 response transaction the last name as received in the NM103-1035 in Loop 2100C and the information contained in the INS segment.	Provide a screen print of the output from Test #2 showing that the required information is displayed to the information requester.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

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

3.11.1. Key Rule Requirements

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

Requires a health plan (or information source) to:

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

Requires a receiver of the X12 v5010 271 response to:

11. Detect all combinations of error conditions from the AAA segments in the X12 v5010 271 response. (§3.3.2)
12. Detect all data elements addressed by the rule as returned in the X12 v5010 271 response. (§3.3.2)
13. Display to the end user text uniquely describing the specific error condition(s) and data elements returned in the X12 v5010 271. (§3.3.2)
14. Ensure that displayed text accurately represents the AAA03 error code and corresponding Error Condition Description without changing meaning and intent of the Error Condition Description. (§3.3.2)

Defines:

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

3.11.1. Key Rule Requirements

Not Required of health plans:

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

3.11.2. Conformance Testing Requirements

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

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

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

1. The health plan must demonstrate its system capability to detect the various error conditions described and return the required AAA errors and submitted data elements when each error condition is detected.
2. The receiver of the X12 v5010 271 must demonstrate its system capability to appropriately display text to the end user of the AAA errors code, the Error Condition Descriptions and the returned data elements.

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

3.11.4. Detailed Step-by-Step Test Script

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

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

Note: The CAQH CORE-authorized Testing Vendor will generate one or more randomly generated X12 v5010 270 inquiries based on the Eligibility & Benefits Master Test Bed Data that will cause the health plan to encounter each of the described error conditions in Test Scripts #1 and #2.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [25]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [26]
1)	Create a valid X12 v5010 271 response transaction indicating that the v5010 270 inquiry is being rejected because the health plan could not correctly identify the patient.	Output a valid X12 v5010 271 transaction containing the patient identifying data elements submitted and used, the AAA segment with AAA Reject Reason Code corresponding to the error condition detected and other required AAA segment data elements and codes as specified.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2)	Extract from a valid X12 v5010 271 response transaction the patient identification data elements received in Loop 2100C and the information contained in the AAA segment.	Provide a screen print of the output from Test #1 showing that the required information is displayed to the information requester.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

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

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

3.12. CAQH CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule Test Scenario

3.12.1. Key Rule Requirements

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

Requires that

1. All requirements of the CAQH CORE Eligibility and Benefits (270/271) Data Content Rule Version EB 1.0 (and any revised versions) for specifying the following in the X12 271 Response are incorporated into the Single Patient Attribution rule by reference.
    a. status of health benefits coverage
    b. date reporting
    c. health plan coverage dates for the individual for each service type code returned
    d. benefit-specific coverage dates for the individual for each service type code returned
    e. health plan base deductible dates for the individual for each service type code returned
    f. benefit-specific base deductible dates for the individual for each service type code returned
    g. a response to an inquiry for past and future dates
    h. a response to a generic inquiry
    i. a response to an explicit inquiry for a service type not required by a CORE rule
    j. health plan base deductible amounts
    k. health plan remaining deductible amounts
    l. benefit-specific base deductible amounts
    m. benefit-specific remaining deductible amounts
    n. co-payment for each service type code returned
    o. co-insurance amounts for each service type code returned
2. A health plan and its agent must return the health plan name when the individual is located in the health plan's and its agent's systems in the X12 271 Response for each of the CORE service types required by the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule submitted in a X12 270 Request. (§4.2)
3. A health plan and its agent must return explicit attribution status and effective dates of attribution as specified in Table 1 in §3.5 in the X12 271 for each of the CORE service type codes required by the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule submitted in a X12 270 Request.
4. A health plan and its agent must develop and make available to the healthcare provider specific written instructions and guidance for the healthcare provider on its implementation of this operating rule and the definitions of attribution and attribution status. (§4.3)
5. When receiving an X12 271 Response, a product extracting the data from the X12 271 Response for manual processing must make available to the end user text describing the message in the Loop 2110C/Loop 2110D MSG01 Segment included in the X12 271 Response, ensuring that the actual wording of the text displayed accurately represents the corresponding message. (§4.4)

3.12.2. Conformance Testing Requirements

These scenarios test the following conformance requirements of the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule Version EB 1.0. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario.

1. A health plan must return the health plan name when the individual is located in the health plan's system.
2. A health plan must return explicit attribution status and effective dates of attribution as specified in Table 1 in §3.5 to demonstrate that its eligibility system returns the required patient attribution status in response to an explicit inquiry.
3. A system receiving the 271 response must demonstrate its capability to detect and extract the data elements addressed in this rule and display such data and appropriate text to the end user.

3.12.3. Test Scripts Assumptions

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

3.12.4. Detailed Step-By-Step Test Script

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [27]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [28]
1.	Create a valid 271 response transaction as defined in the CORE rule specifying the health plan name for a CORE-required explicit service type (Key Rule Requirement #2)	Output a valid fully enveloped 271 eligibility response transaction set with the correct patient liability for the requested service type		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	Create a valid 271 response specifying the explicit attribution status and effective dates for each CORE-required service type state and effective dates (Key Rule Reference #3)	Output a valid fully enveloped 271 eligibility response transaction set with the correct patient attribution status and effective attribution dates for the service type included in the request		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
3.	Extract from a valid 271 response transaction as defined in the CORE rule the data required to be returned by a health plan in Test Scripts #1 and #2 (Key Rule Requirement #5)	Provide a screen print of the output from Tests #1 and #2 showing that the required information is displayed to the end user		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

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

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

3.13. CAQH CORE Connectivity Rule v1.1.0 Test Scenario

3.13.1. Key Rule Requirements

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

Real time requests

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

Batch requests

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

Batch submissions

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

Batch responses

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

Required Data Elements

6. Certain business data elements: authorization information, a payload identifier, and date and time stamps, must be included in the HTTP message body outside of the ASC X12 data. (§2.4.1)
7. Information Sources must publish their detailed specification for the message format in their publicly available Companion Guide. (§2.4.1)
8. In order to comply with the CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule Section 4: Real Time Response Time Requirements and Section 5: Batch Response Time Requirements message receivers will be required to track the times of any received inbound messages, and respond with the outbound message for that payload ID. (§2.4.1)
9. Message senders must include the date and time the message was sent in the HTTP Message Header tags. (§2.4.1)

Date and Time Requirements

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

Security

12. The HTTP/S protocol, all information exchanged between the sender and receiver is encrypted by a session-level private key negotiated at connection time. (§2.5)

3.13.1. Key Rule Requirements

User ID and Password

13. CORE-certified entity will employ User ID and Password as the default minimum criteria authentication mechanism. (§2.5.1)
14. Issuance, maintenance and control of password requirements may vary by participant and should be issued in accordance with the organizations' HIPAA Security Compliance policies. (§2.5.1)
15. The User ID and Password authentication must be encrypted by the HTTP/S protocol, but passed outside of the ASC X12 payload information as described in the HTTP Message format section. (§2.5.1)
16. The receiver may require the message sender to register the IP address for the host or subnet originating the transaction, and may refuse to process transactions whose source is not registered or does not correspond to the ID used. (§2.5.1)
17. Due to programming requirements of POSTing over HTTP/S, use of a digital certificate is required to establish communications. CORE-certified entities will make available information on how to obtain the receiver's root public certificate. (§2.5.1)
18. No additional security for file transmissions, such as the separate encryption of the X12 payload data, is required in this CORE rule for connectivity. By mutual consent, organizations can implement additional encryption, but HTTP/S provides sufficient security to protect healthcare data as it travels the Internet. (§2.5.1)

Response Time, Time Out Parameters and Re-transmission

19. If the HTTP Post Reply Message is not received within the 60 second response period, the provider's system should send a duplicate transaction no sooner than 90 seconds after the original attempt was sent. (§2.6)
20. If no response is received after the second attempt, the provider's system should submit no more than 5 duplicate transactions within the next 15 minutes. (§2.6)
21. If the additional attempts result in the same timeout termination, the provider's system should notify the provider to contact the health plan or information source directly to determine if system availability problems exist or if there are known Internet traffic constraints causing the delay. (§2.6)

Authorization Errors

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

Batch Submission Acknowledgement

23. At the message acknowledgement level, a message receiver must send back a response with a status code of HTTP 202 Accepted once the message has been received. This does not imply that the X12 content has been validated or approved. (§2.7.2)

Real Time Response or Response to Batch Response Pickup

24. When a message receiver is responding to a real time request or a batch response pickup request, assuming that the message authorization passed, the receiver must respond with an HTTP 200 Ok status code and the X12 data content as specified by the CORE 150 and 151 Eligibility and Benefits Batch and Real Time Acknowledgements Rules version 1.1.0. (§2.7.3)

Server Errors

25. It is possible that the HTTP server is not able to process a real time or batch request. In this case, the message receiver must respond with a standard HTTP 5xx series error such as HTTP 500 Internal Server Error or HTTP 503 Service Unavailable. (§2.7.4)

3.13.1. Key Rule Requirements

26. If a sender receives a response with this error code, they will need to resubmit the request at a later time, because this indicates that the message receiver will never process this message. (§2.7.4)

3.13.2. Conformance Testing Requirements

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

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

3.13.3. Test Scripts Assumptions

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

3.13.4. Detailed Step-By-Step Test Script

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[29]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[30]
1.	Valid Logon Attempt.	HTTP 200 OK		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	Invalid Logon Attempt.	HTTP 403 Forbidden response		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
3.	Verify that communications server/module creates, assigns, logs, links the required data elements to HTTP message payload.	Output a system generated audit log report showing all required data elements		☐ Pass	☐ Fail	☒	☒	☒	☒	☐

[29] A checkmark in the box indicates the stakeholder type to which the test applies.
[30] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

3.14. CAQH CORE Connectivity Rule vC2.2.0 Test Scenario [31]

3.14.1. Key Rule Requirements

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

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

1. Implement Server capability to support both Message Envelope Standards and Message Exchanges specified in the rule for Real Time. (§4.1.1, §4.2, §6.3.1) [32]
2. Implement Server capability to support both Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered. (§4.1.1, §4.2, §6.3.2)
3. Implement Server capability and enforce one of two specified Submitter Authentication Standards for both Real Time and/or Batch. (§4.1.1)
4. Have a capacity plan such that it can receive and process a large number of single concurrent real-time transactions via an equivalent number of concurrent connections. (§4.3.5.1)
5. Have the capability to receive and process large batch transaction files if batch is supported. (§4.3.5.2)
6. Publish detailed specifications in a Connectivity Companion Guide on its public web site as required. (§4.3.7)

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

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

[31] This test scenario, conformance testing requirements, test script assumptions and detailed step-by-step test scripts are applicable to the CAQH Core Connectivity Rule v2.2.0.
[32] Section numbers reference the specific section in the CAQH CORE Connectivity Rule v2.2.0 that specifies the details of this requirement.

3.14.1. Key Rule Requirements

Requires a CAQH CORE Connectivity Rule vC2.2.0 CORE-certified Clearinghouse and other Intermediaries to implement a Server and to:

10. Implement Server capability to support both Message Envelope Standards and Message Exchanges specified in the rule for Real Time. (§4.1.2, §4.2, §6.3.1)
11. Implement Server capability to support both Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered. (§4.1.2, §4.2, §6.3.2)
12. Implement Server capability and enforce one of two specified Submitter Authentication Standards for both Real Time and/or Batch. (§4.1.2)
13. Have a capacity plan such that it can receive and process a large number of single concurrent real-time transactions via an equivalent number of concurrent connections. (§4.3.5.1)
14. Have the capability to receive and process large batch transaction files if batch is supported. (§4.3.5.2)
15. Publish detailed specifications in a Connectivity Companion Guide on its public web site as required. (§4.3.7)

Requires a CAQH CORE Connectivity Rule vC2.2.0 CORE-certified Clearinghouse and other Intermediaries to implement a Client and to:

16. Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified in the rule for Real Time. (§4.1.2, §4.2, §6.3.1)
17. Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered. (§4.1.2, §4.2, §6.3.2)
18. Implement Client capability to support both specified Submitter Authentication Standards for both Real Time and/or Batch. (§4.1.2)

Requires a CAQH CORE Connectivity Rule vC2.2.0 CORE-certified Provider and Provider Vendor to implement a Client and to:

19. Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified in the rule for Real Time. (§4.1.3, §4.2, §6.3.1)
20. Implement Client capability to support one of two Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered. (§4.1.3, §4.2, §6.3.2)
21. Implement Client capability to support both specified Submitter Authentication Standards for both Real Time and/or Batch. (§4.1.3)

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

22. Implement Server capability to support both Message Envelope Standards and Message Exchanges specified in the rule for Real Time. (§4.1.3, §4.2, §6.3.1)
23. Implement Server capability to support one of two Message Envelope Standards and Message Exchanges specified for Batch if Batch is offered. (§4.1.3, §4.2, §6.3.2)
24. Implement Server capability and enforce one of two both specified Submitter Authentication Standards for both Real Time and/or Batch. (§4.1.3)

3.14.1. Key Rule Requirements

Requires all CAQH CORE Connectivity Rule vC2.2.0 CORE-certified Message Receivers to:

25. Track the times of any received inbound messages. (§4.3.4.1)
26. Respond with the outbound message for the received inbound message. (§4.3.4.1)
27. Include the date and time the message was sent in HTTP+MIME or SOAP+WSDL Message Header tags. (§4.3.4.1)

Specifies:

28. Message Enveloping specifications for HTTP MIME Multipart (Envelope Standard A). (§4.2.1)
29. HTTP MIME Multipart payload attachment handling. (§4.2.1.8)
30. Message Enveloping specifications for SOAP+WSDL (Envelope Standard B). (§4.2.2)
31. XML Schema specification for SOAP. (§4.2.2.1)
32. Web Services Definition Language (WSDL) specification. (§4.2.2.2)
33. SOAP payload attachment handling. (§4.2.2.11)
34. Request and response handling for real time, batch, and batch response pickup. (§4.3.1)
35. Submitter authentication and authorization handling. (§4.3.2)
36. Error handling for both Envelope Messaging Standards. (§4.3.3)
37. Envelope metadata fields, including descriptions, intended use syntax and value-sets applicable to both Enveloping Messaging Standards. (§4.4)

3.14.2. Conformance Testing Requirements

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

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

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

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

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

3.14.3. Test Scripts Assumptions

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

3.14.4. Detailed Step-by-Step Test Script

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [33]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [34]
Real Time Connectivity Test Scripts										
1.	Implement and enforce **one of two** Submitter Authentication standards on communications **server**.									
1.1	Implement and enforce use of Username/Password over SSL on communications **server.**	Communications server accepts a valid logon by a client using Username/Password, which is embedded in the message envelope as specified in the CAQH CORE Connectivity Rule v2.2.0.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
1.2	Implement and enforce use of X.509 Certificate over SSL on communications **server.**	Communications server accepts a valid logon by a client using X.509 Certificate over SSL.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	On the authenticated connection as per Test #1, implement capability to support **both** Message Envelope Standards and envelope metadata for Real Time as a communications **server**.									
2.1	Implement SOAP+WSDL Message Envelope Standard and envelope metadata as a communications **server**.	Communications server accepts a valid logon by a client conforming to the SOAP+WSDL envelope and metadata specifications, and successfully completes the Real-time message		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

[33] The checkmark in each box below indicates the stakeholder type to which the test script applies.
[34] If you believe a specific test, or a portion of a specific test, does not apply to your system, check the N/A box and submit a statement describing your rationale.

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [33]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [34]
		interactions as specified in §6.3.1 of the CAQH CORE Connectivity Rule v2.2.0.								
2.2	Implement HTTP MIME Multipart Message Envelope Standard and envelope metadata as a communications **server.**	Communications server accepts a valid logon by a client conforming to the HTTP MIME Multipart envelope and metadata specifications, and successfully completes the Real-time message interactions as specified in §6.3.1 of the CAQH CORE Connectivity Rule v2.2.0.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
3.	Implement capability to support **both** Submitter Authentication standards as a communications **client**.									
3.1	Implement Username/Password submitter authentication method as a communications **client.**	Client successfully logs on to a communications server with Username/Password, which is embedded in the message envelope as specified in the CAQH CORE Connectivity Rule v2.2.0.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
3.2	Implement X.509 certificate submitter authentication method as a communications **client.**	Client successfully logs on to a communications server with X.509 certificate.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
4.	On the authenticated connection as per Test #3, implement capability to support **one of two** Message Envelope Standards and envelope metadata for Real Time as a communications **client**.									

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [33]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [34]
4.1	Implement SOAP+WSDL Message Envelope Standard and envelope metadata as a communications **client.**	Communications client successfully logs on to a communications server using the SOAP+WSDL Message Envelope Standard and envelope metadata specifications, and successfully completes the Real-time message interactions as specified in §6.3.1 of the CAQH CORE Connectivity Rule v2.2.0.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
4.2	Implement HTTP MIME Multipart Message Envelope Standard and envelope metadata as a communications **client**.	Communications client successfully logs on to a communications server using the HTTP MIME Multipart Message Envelope Standard and envelope metadata specifications, and successfully completes the Real-time message interactions as specified in §6.3.1 of the CAQH CORE Connectivity Rule v2.2.0.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
5.	Verify that communications **server** creates, assigns, logs, links the required metadata elements to message payload.	Output a system generated audit log report showing all required data elements		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
6.	Verify that communications **client** creates, assigns, logs, links the required metadata elements to message payload.	Output a system generated audit log report showing all required data elements		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [33]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [34]
Batch Connectivity Test Scripts (Required only if Batch is supported)										
7.	Implement and enforce **one of two** Submitter Authentication standards on communications **server**.									
7.1	Implement and enforce use of Username/Password over SSL on communications **server.**	Communications server accepts a valid logon by a client using Username/Password, which is embedded in the message envelope as specified in the CAQH CORE Connectivity Rule v2.2.0		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
7.2	Implement and enforce use of X.509 Certificate over SSL on communications **server.**	Communications server accepts a valid logon by a client using X.509 Certificate over SSL		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
8.	On the authenticated connection as per Test #7, implement capability to support **both** Message Envelope Standards and envelope metadata for Batch as a communications **server**.									
8.1	Implement SOAP+WSDL Message Envelope Standard and envelope metadata as a communications **server**.	Communications server accepts a valid logon by a client conforming to the SOAP+WSDL envelope and metadata specifications, and successfully completes the Batch message interactions as specified in §6.3.2 of the CAQH CORE Connectivity Rule v2.2.0.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [33]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [34]
8.2	Implement HTTP MIME Multipart Message Envelope Standard and envelope metadata as a communications **server.**	Communications server accepts a valid logon by a client conforming to the HTTP MIME Multipart envelope and metadata specifications, and successfully completes the Batch message interactions as specified in §6.3.2 of the CAQH CORE Connectivity Rule v2.2.0.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
9.	Implement capability to support **both** Submitter Authentication standards as a communications **client**.									
9.1	Implement Username/Password submitter authentication method as a communications **client.**	Client successfully logs on to a communications server with Username/Password, which is embedded in the message envelope as specified in the CAQH CORE Connectivity Rule v2.2.0		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
9.2	Implement X.509 certificate submitter authentication method as a communications **client.**	Client successfully logs on to a communications server with X.509 certificate.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
10.	On the authenticated connection as per Test #9, implement capability to support **one of two** Message Envelope Standards and envelope metadata for Batch as a communications **client**.									

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder [33]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A [34]
10.1	Implement SOAP+WSDL Message Envelope Standard and envelope metadata as a communications **client** .	Communications client successfully logs on to a communications server using the SOAP+WSDL Message Envelope Standard and envelope metadata specifications, and successfully completes the Batch message interactions as specified in §6.3.2 of the CAQH CORE Connectivity Rule v2.2.0.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
10.2	Implement HTTP MIME Multipart Message Envelope Standard and envelope metadata as a communications **client**.	Communications client successfully logs on to a communications server using the HTTP MIME Multipart Message Envelope Standard and envelope metadata specifications, and successfully completes the Batch message interactions as specified in §6.3.2 of the CAQH CORE Connectivity Rule v2.2.0.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
11.	Verify that communications **server** creates, assigns, logs, links the required metadata elements to message payload.	Output a system generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
12.	Verify that communications **client** creates, assigns, logs, links the required metadata elements to message payload.	Output a system generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

4. CAQH CORE SOAP Connectivity Rule vC4.0.0 Test Scenario

4.1. CAQH CORE SOAP Connectivity Rule vC4.0.0 Key Requirements

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

Transport, Security, Authentication and Authorization Requirements (§3.2)

- Use of HTTP Version 1.1 over the public Internet is required as a transport method.
- Transport Layer Security (TLS) Version 1.2 (or higher).
    a. This does not preclude the optional use of TLS 1.3 (or a higher version) for connectivity with trading partners whose security policies require the enhanced security afforded by TLS 1.3 or higher.
- SOAP Version 1.2 or higher
- WSDL Version 1.1 or higher
- X.509 Digital Certification addressing authentication is required.
- OAuth 2.0 or higher addressing authorization is required.

Processing Mode (§3.7.1)

- Required Processing Mode Table specifies the comprehensive and normative processing mode requirements (i.e., Real Time and/or Batch) for the transactions addressed by this rule (§4.4.3)

Payload Type Table (§3.7.2)

- Required Payload Type Table (§4.4.3) specifies the comprehensive and normative identifiers for the CORE Envelope Metadata Payload Type Element as defined in the Table of CORE Envelope Metadata. (§4.4.2.)
- Payload Type identifiers specified in Payload Type Table apply when an entity is exchanging transactions addressed by this rule in conformance with the requirements specified in §4 and subsections.

4.2. CAQH CORE SOAP Connectivity Rule vC4.0.0 Conformance Testing Requirements

These scenarios test the following conformance requirements of the CAQH CORE SOAP Connectivity Rule v4.0.0. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario. Note: Clearinghouses and/or vendors undergoing CORE certification testing should refer to Detailed Step-by-Step Test Scripts for applicable test scripts.

- A HIPAA covered health plan must demonstrate it has implemented the server specifications for SOAP version 1.2.
- A HIPAA covered health plan must demonstrate it has implemented the X.509 authentication requirement.
- A HIPAA covered health plan must demonstrate it has implemented the server specifications for OAuth 2.0
- A HIPAA covered provider must demonstrate it has implemented the client specifications for SOAP version 1.2.
- A HIPAA covered provider must demonstrate it has implemented the X.509 authentication requirement.

4.3. CAQH CORE SOAP Connectivity Rule vC4.0.0 Test Scripts Assumptions

- All tests will be conducted over HTTP/S.
- The message payload is an X12 Interchange.
- No editing or validation of the message payload will be performed.
- Authentication will be tested for successful authentication with a valid certificate, and unsuccessful authentication using an invalid or missing certificate.
- Testing will not be exhaustive for all possible levels of authentication.
- Authorization will be tested for successful authorization with a valid token, and unsuccessful authorization using an invalid or missing token.
- Testing will not be exhaustive for all possible levels of authorization.
- The ability to log, audit, track and report on the required data elements as required by the conformance requirements of the CAQH CORE Infrastructure Rules will be addressed in each rule's test scripts.
- The test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

4.4. CAQH CORE SOAP Connectivity Rule vC4.0.0 Detailed Step-by-Step Test Scripts

CORE Certification Testing is not exhaustive. The CAQH CORE Certification Test Suite does not include comprehensive testing requirements that test for all possible permutations of each rule. An individual test script may be testing for more than one item, and, as noted in the "Stakeholder" column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

The Detailed Step-by-Step Test Scripts below specify the stakeholder type to which each test script applies. A stakeholder may indicate that a specific test script does not apply to it. In this case the stakeholder is required to provide a rationale for why a specific test script is not applicable and be prepared for a review of the rationale with CAQH CORE staff.

When establishing a Certification Test Profile with a CAQH CORE-authorized Testing Vendor a Vendor will be given the option to indicate if the product it is certifying is a Provider-facing product or a Health Plan-facing product. Therefore, the Detailed Step-by-Step Test Scripts applicable to a Provider apply to a Provider-facing product. Similarly, Detailed Step-by-Step Test Scripts applicable to a Health Plan apply to a Health Plan-facing product.

Connectivity										
Test #	Criteria	Expected Result	Actual Result	Pass	Fail	N/A	Stakeholder *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	Health Plan	Clearinghouse	Vendor
1	Implement and enforce use of X.509 Certificate over TLS on communications server	Communications server accepts a valid logon by a client using X.509 Certificate		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
2	Implement and enforce use of OAuth 2.0 over TLS on communications server	Communications server accepts a valid logon by a client using OAuth 2.0		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
3	On the authenticated and authorized connection implement SOAP+WSDL Message Envelope Standard and envelope metadata as a communications server	Communications server accepts a valid logon by a client conforming to the SOAP+WSDL envelope and metadata specifications		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
4	On an authenticated and authorized connection implement the Batch message interaction including receipt of a Batch of transactions, generation of acknowledgements and results	Server successfully receives batch(es) of the transactions and corresponding acknowledgements and responses specified in the respective transaction-specific infrastructure rule being tested		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
5	Implement X.509 certificate authentication method as a communications client	Client successfully logs on to a communications server with X.509 certificate		☐ Pass	☐ Fail	☐	☒	☐	☒	☒

Connectivity										
Test #	**Criteria**	**Expected Result**	**Actual Result**	**Pass**	**Fail**	**N/A**	**Stakeholder** *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	**Health Plan**	**Clearinghouse**	**Vendor**
6	On the authenticated connection implement SOAP+WSDL Message Envelope Standard and envelope metadata as a communications client	Communications client successfully logs on to a communications server using the SOAP+WSDL Message Envelope Standard and envelope metadata specifications		☐ Pass	☐ Fail	☐	☒	☐	☒	☒
7	On an authenticated connection implement the Batch message interaction including submission of a Batch of transactions, pickup of acknowledgements and results and submission of acknowledgement for results	Client successfully completes the submission and retrieval (pick up) of batch(es) of the transactions specified in the respective transaction-specific infrastructure rule being tested		☐ Pass	☐ Fail	☐	☒	☐	☒	☒
8	Verify that communications server creates, assigns, logs, links the required metadata elements to message payload	Output a system generated audit log report showing all required data elements		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
9	Verify that communications client creates, assigns, logs, links the required metadata elements to message payload	Output a system generated audit log report showing all required data elements		☐ Pass	☐ Fail	☐	☒	☐	☒	☒

5. CAQH CORE REST Connectivity Rule vC4.0.0 Test Scenario

5.1. CAQH CORE REST Connectivity Rule vC4.0.0 Key Requirements

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

Transport, Security, Authentication and Authorization Requirements (§3.2)

- Use of HTTP Version 1.1 over the public Internet is required as a transport method.
- Transport Layer Security (TLS) Version 1.2 (or higher).
    a. This does not preclude the optional use of TLS 1.3 (or a higher version) for connectivity with trading partners whose security policies require the enhanced security afforded by TLS 1.3 or higher.
- JavaScript Object Notation (JSON)
- X.509 Digital Certification addressing authentication is required.
- OAuth 2.0 or higher addressing authorization is required.

General Specifications Applicable to REST APIs (§5.2)

- HIPAA-covered entities and their agents must be able to implement HTTP/S Version 1.1 over the public Internet as a transport method. (§5.2.1)
- The rule supports both Synchronous Real-time and Asynchronous Batch Processing for the transport of REST exchanges. (§5.2.2 – §5.2.5)
- If there is an error in processing the message at the HTTP layer the rule requires the use of the appropriate HTTP error or status codes as applicable to the error/status situation. (§5.2.6)
- CAQH CORE recommended best practice is for each trading partner to audit all the REST metadata and payload for each transaction. (§5.2.7)
- Message receivers (servers) are required to track the times of any received inbound messages and respond with the outbound message for a Payload (§5.2.8)
- A HIPAA-covered entity and its agent must have a capacity plan such that it can receive and process a large number of single concurrent Synchronous Real Time transactions via an equivalent number of concurrent connections. (§5.2.9)
- Synchronous Real Time response time must conform to the transaction's corresponding CAQH CORE Infrastructure Rule requirements. (§5.2.10)
- HIPAA-covered entity and its agent's messaging system must have the capability to receive and process large Batch transaction files if the entity supports Asynchronous Batch transactions. (§5.2.11)

Specifications for REST API Uniform Resource Identifiers (URI) Paths (§5.3)

- The rule requires message receivers (servers) to communicate the version of the CAQH CORE Connectivity Rule implemented and version of the REST API through the URI Path. (§5.3.1)
- This rule requires the use of standard naming conventions for REST API endpoints to streamline and support uniform REST implementations as defined in Table 5.3.2. (§5.3.2)

REST HTTP Request Method Requirements (§5.4)

- The rule specifies the use of HTTP Methods POST and GET. However, entities may choose to use additional HTTP Methods (e.g., PUT, PATCH, DELETE, etc.). (§5.4)

5.1. CAQH CORE REST Connectivity Rule vC4.0.0 Key Requirements

REST HTTP Metadata, Descriptions, Intended Use and Values (§5.5)

- The rule specifies metadata that are required to be used for HTTP Requests and HTTP Responses for REST exchange as defined in Table 5.5. (§5.5)

5.2. CAQH CORE REST Connectivity Rule vC4.0.0 Conformance Testing Requirements

These scenarios test the following conformance requirements of the CAQH CORE REST Connectivity Rule v4.0.0. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario. Note: Clearinghouses and/or vendors undergoing CORE certification testing should refer to Detailed Step-by-Step Test Scripts for applicable tests scripts.

- A HIPAA covered health plan must demonstrate it has implemented the server specifications for OAuth 2.0.
- A HIPAA covered health plan must demonstrate it has implemented the X.509 authentication requirement.
- A HIPAA covered provider must demonstrate it has implemented the client specifications for OAuth 2.0.
- A HIPAA covered provider must demonstrate it has implemented the X.509 authentication requirement.

5.3. CAQH CORE REST Connectivity Rule vC4.0.0 Test Scripts Assumptions

- All tests will be conducted over HTTP/S.
- The message payload is an X12 Interchange.
- No editing or validation of the message payload will be performed.
- Authentication will be tested for successful authentication with a valid certificate, and unsuccessful authentication using an invalid or missing certificate.
- Testing will not be exhaustive for all possible levels of authentication.
- Authorization will be tested for successful authorization with a valid token, and unsuccessful authorization using an invalid or missing token.
- Testing will not be exhaustive for all possible levels of authorization.
- The ability to log, audit, track and report on the required data elements as required by the conformance requirements of the CAQH CORE Infrastructure Rules will be addressed in each rule's test scripts.
- The CORE test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

5.4. CAQH CORE REST Connectivity Rule vC4.0.0 Detailed Step-by-Step Test Scripts

CORE Certification Testing is not exhaustive. The CAQH CORE Certification Test Suite does not include comprehensive testing requirements that test for all possible permutations of each rule. An individual test script may be testing for more than one item, and, as noted in the "Stakeholder" column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

The Detailed Step-by-Step Test Scripts below specify the stakeholder type to which each test script applies. A stakeholder may indicate that a specific test script does not apply to it. In this case the stakeholder is required to provide a rationale for why a specific test script is not applicable and be prepared for a review of the rationale with CAQH CORE staff.

When establishing a CORE Certification Test Profile with a CAQH CORE-authorized Testing Vendor a Vendor will be given the option to indicate if the product it is certifying is a Provider-facing product or a Health Plan-facing product. Therefore, the Detailed Step-by-Step Test Scripts applicable to a Provider apply to a Provider-facing product. Similarly, Detailed Step-by-Step Test Scripts applicable to a Health Plan apply to a Health Plan-facing product.

Connectivity										
Test #	**Criteria**	**Expected Result**	**Actual Result**	**Pass**	**Fail**	**N/A**	**Stakeholder** *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	**Health Plan**	**Clearinghouse**	**Vendor**
1	Implement and enforce use of X.509 Certificate over TLS on communications server	Communications server accepts a valid logon by a client using X.509 Certificate		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
2	Implement and enforce use of OAuth 2.0 Token over TLS on communications server	Communications server accepts a valid logon by a client using OAuth 2.0 Token		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
3	On the authenticated and authorized connection implement REST Message and Envelope metadata as a communications server over a valid REST API Uniform Resource Identifiers (URI)	Communications server accepts a valid logon by a client conforming to the REST envelope and metadata specifications		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
4	On an authenticated and authorized connection implement the REST synchronous message interaction including receipt of a Batch of transactions, generation of acknowledgements and results valid REST API Uniform Resource Identifiers (URI)	Server successfully receives batch(es) of the transactions and corresponding acknowledgements and responses specified in the respective transaction-specific infrastructure rule being tested		☐ Pass	☐ Fail	☐	☐	☒	☒	☒

Connectivity										
Test #	**Criteria**	**Expected Result**	**Actual Result**	**Pass**	**Fail**	**N/A**	**Stakeholder** *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	**Health Plan**	**Clearinghouse**	**Vendor**
5	Implement X.509 certificate submitter authentication method as a communications client	Client successfully logs on to a communications server with X.509 certificate		☐ Pass	☐ Fail	☐	☒	☐	☒	☒
6	On the authenticated connection implement OAuth as a communications client	Communications client successfully logs on to a communications server using OAuth		☐ Pass	☐ Fail	☐	☒	☐	☒	☒
7	On an authenticated and authorized connection implement the REST synchronous message interaction including submission of a Batch of transactions, pickup of acknowledgements and results and submission of acknowledgement for results	Client successfully completes the submission and retrieval (pick up) of batch(es) of the transactions specified in the respective transaction-specific infrastructure rule being tested		☐ Pass	☐ Fail	☐	☒	☐	☒	☒
8	Verify that communications server creates, assigns, logs, links the required metadata elements to message payload	Output a system generated audit log report showing all required data elements		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
9	Verify that communications client creates, assigns, logs, links the required metadata elements to message payload	Output a system generated audit log report showing all required data elements		☐ Pass	☐ Fail	☐	☒	☐	☒	☒