



Phase IV CAQH CORE 452 Health Care Services Review – Request  
for Review and Response (278) Infrastructure Rule v4.0.0

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## **1 Background Summary**

Each Phase of CAQH CORE Operating Rules builds on the previous Phases to encourage feasible industry progress. Continuing to build on the Phase I, II, and III CAQH CORE Operating Rules, CAQH CORE determined that Phase IV should be extended to include rules around the health care services request for review and response transactions to allow the industry to leverage its investment in the Phase I, II, and III CAQH CORE infrastructure rules and apply them to conducting the ASC X12N 005010X217 Health Care Services Review – Request for Review and Response (278) transactions (hereafter referenced as ASC X12N v5010 278 Request and Response and referred to as prior authorization in general) as well as the ASC X12C 005010X231 Implementation Acknowledgment for Health Care Insurance (999) and all associated errata hereafter referred to as ASC X12C v5010 999.

The ASC X12N v5010 278 Request and Response supports these key business events<sup>1</sup>:

- Admission certification review request and associated response
- Referral review request and associated response
- Health care services certification review request and associated response
- Extend certification review request and associated response
- Certification appeal review request and associated response
- Reservation of medical services request and associated response
- Cancellations of service reservations request and associated response

Benefits to the industry from applying the CAQH CORE infrastructure rules to prior authorization include:

- Increased consistency and automation across entities
- Increased electronic prior authorizations and a commensurate decrease in phone inquiries
- Reduced administrative costs
- More efficient processes
- Improved customer service to patients/subscribers
- Reduced staff time for phone inquiries
- Enhanced revenue cycle management
- Improved cash flow

The inclusion of this Phase IV CAQH CORE Operating Rule for the ASC X12N v5010 278 Request and Response continues to facilitate the industry’s momentum to increase access to the HIPAA-mandated administrative transactions, and will encourage all HIPAA-covered entities, business associates, intermediaries, and vendors to build on and extend the infrastructure they have established for CAQH CORE Phases I, II, and III.

### ***1.1 Affordable Care Act Mandates***

This CAQH CORE Rule is part of a set of rules that addresses requirements in Section 1104 of the Affordable Care Act (ACA). Section 1104 contains an industry mandate for the use of operating rules to support implementation of the HIPAA standards. Using successful, yet voluntary, national industry efforts as a guide, Section 1104 defines operating rules as “the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation

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<sup>1</sup> ASC X12N 005010X217 Health Care Services Review – Request for Review and Response (278) Technical Report Type 3 Implementation Guide, Section 1.4.1.

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specifications.” As such, operating rules build upon existing healthcare transaction standards. The ACA outlines three sets of healthcare industry operating rules to be approved by the Department of Health and Human Services (HHS) and then implemented by the industry.

The third set of ACA-mandated operating rules address the health care claims or equivalent encounter information transactions, enrollment and disenrollment in a health plan, health plan premium payments, claims attachments, and referral certification and authorization.<sup>2</sup> The ACA requires HHS to adopt a set of operating rules for these five transactions by July 2014.<sup>3</sup> In a letter dated 09/12/12 to the Chairperson of the National Committee on Vital and Health Statistics (NCVHS),<sup>4</sup> the Secretary of HHS designated CAQH CORE as the operating rule authoring entity for the remaining five HIPAA-mandated electronic transactions.

Section 1104 of the ACA also adds the health claims attachment transaction to the list of electronic healthcare transactions for which the HHS Secretary must adopt a standard under HIPAA. The ACA requires the health claims attachment transaction standard to be adopted by 01/01/14, in a manner ensuring that it is effective by 01/01/16.<sup>5</sup>

**NOTE:** HHS has not adopted a standard for health claims attachments or indicated what standard(s) it might consider for the transaction, and an effective date for these operating rules is not included in the ACA. Thus, the immediate focus of the Phase IV CAQH CORE Operating Rules will not include attachments.

## **2 Issue to Be Addressed and Business Requirement Justification**

When the HIPAA transactions were first mandated for use in October 2000<sup>6</sup>, many HIPAA-covered health plan systems were not capable of processing the ASC X12N v4010 278 Request and Response transactions in Real Time. Usually, only Batch transactions were accepted. If Real Time transactions were accepted, the responses would not be returned in Real Time.

Even with the transition to v5010 in 2011, manual reviews still occur depending upon the complexity of the authorization and given many authorizations require supporting documentation. Although Batch processing of the ASC X12N v5010 278 Request facilitates the processing of certifications, referrals, admissions, and authorizations, etc., there is still a heavy reliance on manual processes within the HIPAA-covered health plan systems to generate a response. This manual process hinders broader adoption of the ASC X12N v5010 278 Request and Response transactions as the same information can be obtained more readily via phone or fax options already commonly used. While HIPAA-covered health plans have made much progress in accepting and responding to Real Time ASC X12N v5010 278 Requests and streamlining their manual processes, adoption of the HIPAA-mandated ASC X12N v5010 278 Request and Response still proves to be a challenge for many entities.

In addition to Batch only and manual processing of the ASC X12N v5010 278 Request and Response transactions, lack of product support for the ASC X12N v5010 278 Request and Response transactions also poses a challenge to greater industry adoption. Many vendors do not support this transaction within their practice management and patient accounting systems offerings. As such, providers are required to

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<sup>2</sup> The first set of operating rules under ACA Section 1104 applies to eligibility and claim status transactions; these operating rules were effective 01/01/13. The second set of operating rules applies to EFT and ERA; these operating rules were effective 01/01/14.

<sup>3</sup> This date is statutory language and statutory language can be changed only by Congress.

<sup>4</sup> 09/12/12 HHS [Letter from the Secretary](#) to the Chairperson of NCVHS.

<sup>5</sup> These dates are statutory language and statutory language can be changed only by Congress.

<sup>6</sup> The first set of HIPAA-mandated transaction standards were adopted in the August 2000 HSS Final Rule, [Health Insurance Reform: Standards for Electronic Transactions](#), with an effective date of October 16, 2000. This Final Rule adopted the ASC X12N 278 Health Care Services Review - Request for Review and Response as the standard for the referral certification and authorization transaction.

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use the ASC X12N v5010 278 Request and Response submission tools that each HIPAA-covered health plan offers, often a web tool to submit the request. The development of vendor products for the submission and receipt of the ASC X12N v5010 278 Request and Response transactions is far behind the other HIPAA-mandated transactions and has hindered adoption of the ASC X12N v5010 278 Request and Response transactions across the industry.

By promoting consistent connectivity methods between HIPAA-covered providers and HIPAA-covered health plans, manual processes for requesting and receiving prior authorization can be reduced and electronic transaction usage increased. Defining acceptable acknowledgement response times, appropriate Batch and Real Time acknowledgements, system availability, and requiring entities that publish a Companion Guide do so in a common standard format to ensure that trading partners are informed of the nuances required for successful transaction processing will allow the industry to more easily adopt the ASC X12N v5010 278 Request and Response transactions.

In Phase I several CAQH CORE Infrastructure Operating Rules were approved that are designed to bring consistency and to improve the timely flow of the eligibility transactions. These infrastructure rules require:

- Real Time exchange of eligibility transactions within 20 seconds or less
- The consistent use of the ASC X12C v5010 999<sup>7</sup> for both Real Time and Batch exchanges
- 86% system availability of a HIPAA-covered health plan's eligibility processing system components over a calendar week
- Use of the public internet for connectivity
- Use of a best practices Companion Guide template for format and flow of Companion Guides for entities that issue them

In Phases II and III these CAQH CORE infrastructure rules were applied to the exchange of the HIPAA-mandated ASC X12N 005010X212 Health Care Claim Status Request and Response (276/277) transactions and the HIPAA-mandated ASC X12N 005010X221A1 Health Care Claim Payment/Advice (835) transaction. Phases II and III also included more robust, prescriptive, and comprehensive connectivity requirements.

During the Phase IV CAQH CORE rule development, CAQH CORE used discussion, research, and straw poll results to determine which infrastructure requirements should be applied to the exchange of the ASC X12N v5010 278 Request and Response transactions. Listed below is an overview of the infrastructure requirements incorporated into this rule in §4.

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<sup>7</sup> The use of the ASC X12 TA1 Interchange Acknowledgement is not specifically addressed by the CAQH CORE Operating Rules. The A1 errata to Appendix C.1 of the ASC X12 999 provides industry guidance for the use of the TA1.

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<b>Phase IV Infrastructure Requirements for the ASC X12N v5010 278 Request and Response Transactions</b>	
<b>CAQH CORE Infrastructure Requirement Description</b>	<b>Apply to Phase IV CAQH CORE Infrastructure Rule for the ASC X12N v5010 278 Request and Response</b>
Processing Mode*	<b>Y</b>
Connectivity	<b>Y</b>
System Availability	<b>Y</b>
Real Time Processing Mode Response Time	<b>Y</b>
Batch Processing Mode Response Time	<b>Y</b>
Real Time Acknowledgements	<b>Y</b>
Batch Acknowledgements	<b>Y</b>
Companion Guide	<b>Y</b>
<small>*Note: Beginning with Phase IV CAQH CORE Infrastructure Rules, processing mode requirements will be explicitly clarified. In previous phases this requirement was not as explicit as needed resulting in questions from implementers. The Phase IV CAQH CORE 470 Connectivity Rule v4.0.0 specifies the processing mode(s) that must be supported for each transaction addressed in Phase IV CAQH CORE Operating Rules.</small>	

This Phase IV CAQH CORE Health Care Services Review – Request for Review and Response (278) Infrastructure Rule defines the specific requirements that HIPAA-covered health plans or their agents<sup>8</sup> and HIPAA-covered providers or their agents must satisfy. As with all CAQH CORE Operating Rules, these requirements are intended as a base or minimum set of requirements, and it is expected that many entities will go beyond these requirements as they work towards the goal of administrative interoperability. This Phase IV CAQH CORE Health Care Services Review - Request for Review and Response (278) Infrastructure Rule requires that HIPAA-covered health plans or their agents make appropriate use of the standard acknowledgements, support the CAQH CORE Connectivity requirements, and use the CAQH CORE v5010 Master Companion Guide Template when publishing their ASC X12N v5010 278 Companion Guide.

By applying these CAQH CORE infrastructure requirements to the conduct of the ASC X12N v5010 278 Request and Response transactions, this Phase IV CAQH CORE Health Care Services Review - Request for Review and Response (278) Infrastructure Rule helps provide the information that is necessary to electronically process a prior authorization request and thus reduce the current cost of today’s manual transaction processes.

It is understood that applying the CAQH CORE infrastructure requirements to the exchange of the ASC X12N v5010 278 Request and Response transactions does not address the industry’s transaction data content needs but rather establishes an electronic “highway”. Subsequent phases of CAQH CORE rule-making may use the industry’s experience and lessons learned from implementing the ASC X12N v5010 278 Request and Response transactions to develop a CAQH CORE Operating Rule addressing the data content of these transactions as various entities are testing content approaches.

### **3 Scope**

#### **3.1 What the Rule Applies To**

This Phase IV CAQH CORE Health Care Services Review – Request for Review and Response (278) Infrastructure Rule applies to the:

<sup>8</sup> 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.

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- ASC X12N 005010X217 Health Care Services Review – Request for Review and Response (278) Technical Report Type 3 and associated errata

And

- ASC X12C 005010X231 Implementation Acknowledgement for Health Care Insurance (999) Technical Report Type 3 and associated errata.

### ***3.2 When the Rule Applies***

This Phase IV CAQH CORE Infrastructure Rule applies when any HIPAA-covered entity or its agent uses, conducts, or processes the ASC X12N v5010 278 Request and Response transactions.

### ***3.3 What the Rule Does Not Require***

This rule does not require any entity or its agent to:

- Conduct, use, or process the ASC X12N v5010 278 Request and Response transactions if it currently does not do so or is not required by Federal or state regulation to do so.

### ***3.4 Outside the Scope of This Rule***

This rule does not address any data content requirements of the ASC X12N v5010 278 Request and Response transactions. This Phase IV CAQH CORE Infrastructure Rule applicable to health care services review requests and responses is related to improving access to the transaction and **not to** addressing content requirements. Retail pharmacy prior authorizations are out of scope for this rule, i.e., pharmacist initiated prior authorization for drug/biologics and prescriber initiated prior authorization for drugs/biologics.

### ***3.5 Maintenance of This Rule***

Should implementation of this rule be required via Federal regulation, any substantive updates to the rule (i.e., change to rule requirements) will be made in alignment with Federal processes for updating versions of the operating rules.

### ***3.6 How the Rule Relates to CAQH CORE Phases I, II, and III***

The Phase I CAQH CORE Eligibility and Benefits Operating Rules focused on improving Real Time electronic eligibility and benefits verification as eligibility is the first transaction in the claims process. The Phase II CAQH CORE Eligibility/Benefits & Claim Status Operating Rules focused on extending the value of electronic eligibility by adding additional data content requirements that deliver more robust patient financial liability information, including remaining deductibles, and adding more service type codes that must be supported. Building on this, CAQH CORE also determined that Phase II should be extended to include infrastructure rules around the claim status transaction to allow providers to check electronically, in Real Time, the status of a claim, without manual intervention, or to confirm receipt of claims. Phase III was extended to include rules around the health care claim payment/advice transaction to allow the industry to leverage its investment in the Phase I and Phase II CAQH CORE Infrastructure Operating Rules.

This Phase IV rule adds to the Phase I, II, and III CAQH CORE infrastructure rule requirements by specifying the use of the ASC X12C v5010 999 and the CAQH CORE infrastructure requirements when conducting the ASC X12N v5010 278 Request and Response transactions.

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As with other CAQH CORE Operating Rules, general CAQH CORE policies also apply to Phase IV CAQH CORE Operating Rules and will be outlined in the Phase IV CAQH CORE Operating Rule Set.

This rule supports the CAQH CORE Guiding Principles that CAQH CORE Operating Rules will not be based on the least common denominator but rather will encourage feasible progress, and that CAQH CORE Operating Rules are a floor and not a ceiling, i.e., entities can go beyond the Phase IV CAQH CORE Operating Rules.

### **3.7 Assumptions**

A goal of this rule is to adhere to the principles of electronic data interchange (EDI) in assuring that transactions sent are accurately received and to facilitate correction of errors for electronically submitted prior authorization requests.

The following assumptions apply to this rule:

- A successful communication connection has been established.
- This rule is a component of the larger set of Phase IV CAQH CORE Operating Rules; as such, all the CAQH CORE Guiding Principles apply to this rule and all other rules.
- This rule is not a comprehensive companion document addressing any content requirements of the ASC X12N v5010 278 Request and Response transactions or the ASC X12C v5010 999.
- Compliance with all CAQH CORE Operating Rules is a minimum requirement; any HIPAA-covered entity is free to offer more than what is required in the rule.

### **3.8 Abbreviations and Definitions Used in This Rule**

**Batch (Batch Mode, Batch Processing Mode)**<sup>9</sup>: Batch Mode is when the initial (first) communications session is established and maintained open and active only for the time required to transfer a Batch file of one or more transactions. A separate (second) communications session is later established and maintained open and active for the time required to acknowledge that the initial file was successfully received and/or to retrieve transaction responses.

Batch Mode/Batch Processing Mode is also considered to be an asynchronous processing mode, whereby the associated messages are chronologically and procedurally decoupled. In a request-response interaction, the client agent can process the response at some indeterminate point in the future when its existence is discovered. Mechanisms to implement this capability may include: polling, notification by receipt of another message, receipt of related responses (as when the request receiver "pushes" the corresponding responses back to the requestor), etc.

Batch Mode/Batch Processing Mode is from the perspective of both the request initiator and the request responder. If a Batch (asynchronous) request is sent via intermediaries, then such intermediaries may, or may not, use Batch Processing Mode to further process the request.

**Processing Mode**: Refers to when the payload of the connectivity message envelope is processed by the receiving system, i.e., in Real Time or in Batch mode.

**Real Time (Real Time Mode, Real Time Processing Mode)**<sup>10</sup>: Real Time Mode is when an entity is required to send a transaction and receive a related response within a single communications session,

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<sup>9</sup> See Phase I CAQH CORE Glossary: <http://www.caqh.org/sites/default/files/core/phase-i/reference/PIGlossary.pdf>.

<sup>10</sup> Ibid.

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which is established and maintained open and active until the required response is received by the entity initiating that session. Communication is complete when the session is closed.

Real Time Mode/Real Time Processing Mode is also considered to be a synchronous processing mode.

Real Time Mode/Real Time Processing Mode is from the perspective of both the request initiator and the request responder.

**Safe Harbor:** A “Safe Harbor” is generally defined as a statutory or regulatory provision that provides protection from a penalty or liability.<sup>11</sup>

In many IT-related initiatives, a safe harbor describes a set of standards/guidelines that allow for an “adequate” level of assurance when business partners are transacting business electronically.

The CAQH CORE Connectivity Safe Harbor requires the implementation of the CAQH CORE Connectivity Rule so that application vendors, HIPAA-covered providers, HIPAA-covered health plans or their respective agents can be assured the CAQH CORE Connectivity Rule will be supported by any trading partner. All entities must demonstrate the ability to implement connectivity as described in Phase IV CAQH CORE 470 Connectivity Rule v4.0.0.

## **4 Rule Requirements**

### ***4.1 Health Care Services Review – Request and Response Processing Mode Requirements***

A HIPAA-covered health plan or its agent must implement the server requirements for either Real Time Processing Mode **OR** Batch Processing Mode for the ASC X12N v5010 278 Request and Response transactions as specified in the Phase IV CAQH CORE 470 Connectivity Rule v4.0.0. Optionally, a HIPAA-covered health plan or its agent may elect to implement both Real Time and Batch Processing Modes.

The Phase IV CAQH CORE 470 Connectivity Rule v4.0.0 Real Time Processing Mode requirements are applicable when Real Time Processing Mode is offered for these transactions. The Phase IV CAQH CORE 470 Connectivity Rule v4.0.0 Batch Processing Mode requirements are applicable when Batch Processing Mode is offered for these transactions.

A HIPAA-covered health plan or its agent conducting the ASC X12N v5010 278 Request and Response transactions is required to conform to the processing mode requirements specified in this section regardless of any other connectivity modes and methods used between trading partners.

### ***4.2 Health Care Services Review – Request and Response Connectivity Requirements***

A HIPAA-covered entity or its agent must be able to support the Phase IV CAQH CORE 470 Connectivity Rule v4.0.0.

This connectivity rule addresses usage patterns for Real Time and Batch Processing Modes, the exchange of security identifiers, and communications-level errors and acknowledgements. It does not attempt to define the specific content of the message payload exchanges beyond declaring the formats that must be used between entities and that security information must be sent outside of the message envelope payload.

All HIPAA-covered entities must demonstrate the ability to implement connectivity as described in the Phase IV CAQH CORE 470 Connectivity Rule v4.0.0. The Phase IV CAQH CORE 470 Connectivity Rule v4.0.0 is designed to provide a “Safe Harbor” that application vendors, HIPAA-covered providers

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<sup>11</sup> Merriam-Webster’s Dictionary of Law. Merriam-Webster, Inc., 28 May, 2007. <Dictionary.com  
<http://dictionary.reference.com/browse/safeharbor>>

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and HIPAA-covered health plans (or other information sources) can be assured will be supported by any trading partner. Supported means that the entity is capable and ready at the time of the request by a trading partner to exchange data using the Phase IV CAQH CORE 470 Connectivity Rule v4.0.0. These requirements are not intended to require trading partners to remove existing connections that do not match the rule, nor are they intended to require that all trading partners must use this method for all new connections. CAQH CORE expects that in some technical circumstances, trading partners may agree to use different communication mechanism(s) and/or security requirements than those described by these requirements.

### **4.3 Health Care Services Review – Request and Response System Availability**

Many healthcare providers have a need to request prior authorizations outside of the typical business day and business hours. Additionally, many institutional providers are now allocating staff resources to performing administrative and financial back-office activities on weekends and evenings. As a result, providers have a business need to be able to conduct prior authorization transactions at any time.

On the other hand, HIPAA-covered health plans have a business need to periodically take their prior authorization processing and other systems offline in order to perform required system maintenance. This typically results in some systems not being available for timely processing of ASC X12N v5010 278 Request and Response and ASC X12C v5010 999 transactions on certain nights and weekends. This rule requirement addresses these conflicting needs.

#### **4.3.1 System Availability Requirements**

System availability must be no less than 86 percent per calendar week for both Real Time and Batch Processing Modes. System is defined as all necessary components required to process an ASC X12N v5010 278 Request and Response and an ASC X12C v5010 999 transaction. Calendar week is defined as 12:01 a.m. Sunday to 12:00 a.m. the following Sunday. This will allow for a HIPAA-covered health plan or its agent to schedule system updates to take place within a *maximum* of 24 hours per calendar week for regularly scheduled downtime.

#### **4.3.2 Reporting Requirements**

##### **4.3.2.1 Scheduled Downtime**

A HIPAA-covered health plan or its agent must publish its regularly scheduled system downtime in an appropriate manner (e.g., on websites or in Companion Guides) such that the HIPAA-covered health plan's trading partners can determine the health plan's system availability so that staffing levels can be effectively managed.

##### **4.3.2.2 Non-Routine Downtime**

For non-routine downtime (e.g., system upgrade), a HIPAA-covered health plan or its agent must publish the schedule of non-routine downtime at least one week in advance.

##### **4.3.2.3 Unscheduled Downtime**

For unscheduled/emergency downtime (e.g., system crash), a HIPAA-covered health plan or its agent are required to provide information within one hour of realizing downtime will be needed.

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**4.3.2.4 No Response Required**

No response is required during scheduled, non-routine, or unscheduled downtime(s).

**4.3.2.5 Holiday Schedule**

Each HIPAA-covered health plan or its agent will establish its own holiday schedule and publish it in accordance with the rule requirements above.

**4.4 Health Care Services Review – Request and Response Real Time Processing Mode Response Time Requirements**

*Maximum* response time for the receipt of an ASC X12N v5010 278 Response from the time of submission of an ASC X12N v5010 278 Request must be 20 seconds when processing in Real Time Processing Mode. ASC X12C v5010 999 response errors must be returned within the same response timeframe. While *there could be a subsequent ASC X12N v5010 278 Response made available to the submitter for pick up at a later time this rule does not address that scenario.*

Each HIPAA-covered entity or its agent must support this *maximum* response time requirement to ensure that at least 90 percent of all required responses are returned within the specified maximum response time as measured within a calendar month.

Each HIPAA-covered entity or its agent must 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.

The recommended maximum response time between each participant in the transaction routing path is 4 seconds or less per hop as long as the 20-second total roundtrip *maximum* requirement is met.

Each HIPAA-covered entity or its agent must support these response time requirements in this section and other CAQH CORE Operating Rules regardless of the connectivity mode and methods used between trading partners.

**4.5 Health Care Services Review – Request and Response Batch Processing Mode Response Time Requirements**

*Maximum* response time for availability of ASC X12N v5010 278 Responses when processing ASC X12N v5010 278 Requests submitted in Batch Processing Mode by 9:00 pm Eastern Time of a business day by a provider or on a provider's behalf by a clearinghouse/switch must be no later than 7:00 am Eastern Time the third business day following submission. While *there could be a subsequent ASC X12N v5010 278 Response made available to the submitter for pick up at a later time this rule does not address that scenario.*

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 HIPAA-covered health plan or its agent.

Each HIPAA-covered entity or its agent must support this *maximum* response time requirement to ensure that at least 90 percent of all required responses are returned within the specified maximum response time as measured within a calendar month.

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Each HIPAA-covered entity or its agent must 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.

Each HIPAA-covered entity or its agent must support these response time requirements in this section and other CAQH CORE Operating Rules regardless of the connectivity mode and methods used between trading partners.

#### **4.5.1 ASC X12C v5010 999 Batch Processing Mode Response Time Requirements**

ASC X12C v5010 999 must be available to the submitter within one hour of receipt of the Batch:

- To the requester in the case of a Batch of ASC X12N v5010 278 Requests

And

- To the HIPAA-covered health plan or its agent in the case of a Batch of ASC X12N v5010 278 Responses.

Each HIPAA-covered entity or its agent must support this response time requirement to ensure that at least 90 percent of all required responses are returned within the specified maximum response time as measured within a calendar month.

Each HIPAA-covered entity or its agent must 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.

Each HIPAA-covered entity or its agent must support these response time requirements in this section and other CAQH CORE Operating Rules regardless of the connectivity mode and methods used between trading partners.

The HIPAA-covered health plan or its agent must not return the ASC X12C v5010 999 during the initial communications session in which the ASC X12N v5010 278 request is submitted.

#### **4.6 *Health Care Services Review – Request and Response Real Time Acknowledgement Requirements***

##### **4.6.1 Use of the ASC X12C v5010 999 Implementation Acknowledgements for Real Time Processing Mode**

A HIPAA-covered health plan or its agent must return:

- An ASC X12C v5010 999 to indicate that a Functional Group(s) or Transaction Set(s) is rejected.

A HIPAA-covered health plan or its agent must not return:

- An ASC X12C v5010 999 to indicate that a Functional Group(s) or Transaction Set(s) is accepted or accepted with errors.

Therefore, the submitter of an ASC X12N v5010 278 Request in Real Time will receive only one response from the HIPAA-covered health plan or its agent: *an ASC X12C v5010 999 rejection or an ASC X12N v5010 278 Response.*

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**4.7 Health Care Services Review – Request and Response Batch Acknowledgement Requirements**

**4.7.1 Use of the ASC X12C v5010 999 Implementation Acknowledgements for Batch Processing Mode**

*These requirements for use of the ASC X12C v5010 999 for Batch Processing Mode place parallel responsibilities on both requesters submitting the ASC X12N v5010 278 Request (i.e., providers or their agents) and responders returning the ASC X12N v5010 278 Response (i.e., HIPAA-covered health plans or their agents) for sending and accepting the ASC X12C v5010 999. The goal of this approach is to adhere to the principles of EDI in assuring that transactions sent are accurately received and to facilitate correction of errors in Functional Groups of ASC X12N v5010 278 Requests and Functional Groups of ASC X12N v5010 278 Responses.*

This rule assumes a successful communication connection has been established.

A HIPAA-covered entity or its agent must return an ASC X12C v5010 999 for each Functional Group of ASC X12N v5010 278 Request or ASC X12N v5010 278 Response transactions:

- To indicate that the Functional Group(s) was either accepted, accepted with errors, or rejected
- And
- To specify for each included ASC X12N v5010 278 Request or ASC X12N v5010 278 Response Transaction Set that the transaction set was either accepted, accepted with errors, or rejected.

When a Functional Group of ASC X12N v5010 278 Request or a Functional Group of ASC X12N v5010 278 Response transactions is either accepted with errors or rejected, the ASC X12C v5010 999 must report each error detected to the most specific level of detail supported by the ASC X12C v5010 999.

**4.8 Health Care Services Review – Request and Response Companion Guide**

A HIPAA-covered health plan or its agent have the option of creating a “Companion Guide” that describes the specifics of how it will implement the HIPAA transactions. The Companion Guide is in addition to and supplements the ASC X12 TR3 Implementation Guide adopted for use under HIPAA.

Currently HIPAA-covered health plans or their agents have independently created Companion Guides that vary in format and structure. Such variance can be confusing to trading partners/providers who must review numerous Companion Guides along with the ASC X12 TR3 Implementation Guides. To address this issue, CAQH CORE developed the CAQH CORE v5010 Master Companion Guide Template for health plans or information sources. Using this template, health plans and information sources can ensure that the structure of their Companion Guide is similar to other health plan’s documents, making it easier for providers to find information quickly as they consult each health plan’s document on these important industry EDI transactions.

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

Although CAQH CORE believes that a standard template/common structure is desirable, it recognizes that different HIPAA-covered health plans may have different requirements. The CAQH CORE v5010 Master Companion Guide template gives health plans the flexibility to tailor the document to meet their particular needs.

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The requirements specified in this section do not currently apply to retail pharmacy.

#### **4.8.1 Health Care Services Review – Request and Response Companion Guide Requirements**

If a HIPAA-covered entity or its agent publishes a Companion Guide covering the ASC X12N v5010 278 Request and Response transactions, the Companion Guide must follow the format/flow as defined in the CAQH CORE v5010 Master Companion Guide Template for HIPAA Transactions (CAQH CORE v5010 Master Companion Guide Template available [HERE](#)).

**NOTE:** This rule does not require any HIPAA-covered entity to modify any other existing Companion Guides that cover other HIPAA-mandated transaction implementation guides.

### **5 Conformance Requirements**

**Conformance** with this CAQH CORE Operating Rule can be voluntarily demonstrated and certified through successful completion of the Phase IV CAQH CORE Voluntary Certification Test Suite with a third party CAQH CORE-authorized Testing Vendor, followed by the entity's successful application for a CORE Certification Seal. A CORE Certification Seal demonstrates that an entity has successfully tested for conformity with all of the Phase IV CAQH CORE Operating Rules, and the entity or its product has fulfilled all relevant conformance requirements.

Only the Department of Health and Human Services (HHS) can decide whether a particular HIPAA-covered entity's system is **compliant** or **noncompliant** with the HIPAA Administrative Simplification requirements (which include HIPAA-adopted CAQH CORE Operating Rules). HHS may adjudicate on a HIPAA-covered entity's compliance and assess civil money penalties or penalty fees for noncompliance under the following HIPAA Administrative Simplification mandates:

- HIPAA regulations mandate that the Secretary “will impose a civil money penalty upon a covered entity or business associate if the Secretary determines that the covered entity or business associate has violated an administrative simplification provision.” ([47 CFR 160.402](#))
- Under the ACA, HIPAA mandates a certification process for HIPAA-covered health plans only, under which HIPAA-covered health plans are required to file a statement with HHS certifying that their data and information systems are in compliance with applicable standards and associated operating rules. ([Social Security Act, Title XI, Section 1173\(h\)](#)) HIPAA also mandates that a HIPAA-covered health plan must “ensure that any entities that provide services pursuant to a contact with such health plan shall comply with any applicable certification and compliance requirements.” ([Social Security Act, Title XI, Section 1173\(h\)\(3\)](#))
- Under the ACA, HIPAA also mandates that HHS is to “conduct periodic audits to ensure that health plans...are in compliance with any standards and operating rules.” ([Social Security Act, Title XI, Section 1173\(h\)](#))

### **6 Appendix**

#### **6.1 Appendix 1: Reference**

- ASC X12C 005010X231 Implementation Acknowledgement for Health Care Insurance (999) Technical Report Type 3 and associated errata
- ASC X12N 005010X217 Health Care Services Review – Request for Review and Response (278) Technical Report Type 3 Implementation Guide and associated errata