



Phase V CAQH CORE Certification Test Suite v.5.0.0

Draft for Final CAQH CORE Vote Ballot

March 2019

**CAQH Committee on Operating Rules for Information Exchange (CORE)
Draft Phase V CAQH CORE Certification Test Suite v5.0.0
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1 INTRODUCTION

This Phase V CAQH CORE Certification Test Suite contains the requirements that must be met by an entity seeking CORE Certification on the Phase V CAQH CORE Operating Rule Set to be awarded a CORE® Certification Seal. As such, this test suite includes:

- Guidance as to the types of stakeholders to which the Phase V CAQH CORE Operating Rule Set apply and how to determine when a specific detailed test script applies to a stakeholder.
- For each Phase V CAQH CORE Prior Authorization 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 Phase V CAQH CORE Certification Test Suite. CAQH CORE Certification Testing is not exhaustive and does not use production-level testing. The Phase V CAQH CORE Certification Test Suite does not include comprehensive testing requirements to test for all possible permutations of each rule requirement.

Entities seeking CORE Certification are required to adopt all rules of a phase that apply to their business and are responsible for all their own company-related testing resources, e.g., certain entities only support the prior authorization request and/or response transactions and would only adopt rules pertaining to those transactions. CORE Certification is available for both Real Time and Batch Processing Modes.

CAQH CORE Certification Testing is required of any entity seeking CORE Certification. Health Plans and Providers seeking certification for the Phase V CAQH CORE Operating Rule Set must first be CORE-certified for Phases I, II, III and IV of the CAQH CORE Operating Rules. Clearinghouses and Vendors seeking to certify their products or services for the Phase V CAQH CORE Operating Rules must first be CORE-certified for Phases I, II, III and IV of the CAQH CORE Operating Rules to the extent that these products or services involve prior authorization. An entity undergoing CAQH CORE Certification Testing may also choose to undergo combined CAQH CORE Certification Testing for all five phases concurrently.

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24 The CORE Certification process has four components:¹

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

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

36 **1.2 ELIGIBILITY FOR CORE CERTIFICATION**

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

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

43 **1.3 ROLE OF CAQH CORE-AUTHORIZED TESTING VENDORS**

44 To obtain a stakeholder-specific CORE Certification Seal, entities must successfully complete stakeholder-specific Detailed Step-by-Step Test Scripts in
45 the Phase V CAQH CORE Certification Test Suite. Successful completion is demonstrated through proper documentation from a CAQH CORE-authorized
46 Testing Vendor.

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

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

¹ [CORE Certification: A Step-By-Step Process for Phases I-IV](#), CAQH.

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54 **1.4 APPLICABILITY OF THIS DOCUMENT**

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

58 While the Phase V CAQH CORE Operating Rule Set applies specifically to HIPAA-covered health plans, HIPAA-covered providers or their respective
59 agents² (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
60 create, transmit or use applicable administrative transactions may seek CORE Certification. CAQH CORE also certifies products or services that facilitate
61 the creation, transmission or use of applicable administrative transactions.

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

69 **2 GUIDANCE FOR USING THIS CERTIFICATION TEST SUITE**

70 **2.1 STRUCTURE OF TEST SCENARIOS FOR THE CAQH CORE PHASE V RULE SET**

71 Each test scenario for each rule contains the following sections:

- 72 • Key Rule Requirements
 - 73 ○ The Phase V CAQH CORE Operating Rule Set contain the actual rule language and are the final authority for all operating rule
 - 74 requirements
- 75 • Certification conformance testing requirements by rule
- 76 • Test assumptions by rule
- 77 • Detailed Step-by-Step Test Scripts addressing each conformance testing requirement by rule for each stakeholder type to which the test script
- 78 applies

² “Agents” Defined As: 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. West's Encyclopedia of American Law, edition 2. Copyright 2008 The Gale Group, Inc. All rights reserved.

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79 **2.2 DETERMINING CAQH CORE STAKEHOLDER TYPE FOR CORE CERTIFICATION**

80 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
81 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
82 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.

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

84 **2.2.1 CORE Certification Provider Stakeholder Type**

85 The CORE Certification stakeholder type “Provider” includes, but is not limited to, a HIPAA-covered provider. The CORE Certification stakeholder type
86 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
87 that take the role of provider in HIPAA-mandated standard transactions. Notwithstanding, HIPAA-covered providers such as physicians, hospitals, dentists,
88 and other providers of medical or health services are included in the CORE Certification Provider stakeholder type. (See §2.2.5 for more detail.)

89 **2.2.2 CORE Certification Health Plan Stakeholder Type**

90 As noted above, the CORE Certification stakeholder type “Health Plan” includes, but is not limited to, HIPAA-covered health plans. The CORE Certification
91 stakeholder type Health Plan is more akin to entities that the industry refers to as “payers,” and includes third party administrators (TPAs), contractors with
92 administrative services only (ASO) arrangements, utilization management organizations (UMO), and other agents that may conduct some or all elements
93 of the HIPAA transactions on the behalf of a HIPAA-covered health plan. Notwithstanding, HIPAA-covered health plans such as self-insured health plans,
94 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.)

95 **2.2.3 CORE Certification Clearinghouse Stakeholder Type**

96 The CORE Certification stakeholder type “Clearinghouse” includes, but is not limited to, HIPAA-covered health care clearinghouses. HIPAA defines a
97 health care clearinghouse as an entity that processes health information received in a non-standard format into a standard format, or vice versa³. For
98 purposes of CORE Certification, any intermediary between a Provider and a Health Plan CORE Certification stakeholder type that performs some or all
99 aspects of a HIPAA-mandated function or a Phase V CAQH CORE Operating Rule could be considered a CORE Certification Clearinghouse stakeholder
100 type. (See §2.2.5 for more detail.)

101 **2.2.4 CORE Certification Vendor Stakeholder Type**

102 An entity (hereafter vendor) may offer commercially-available software products or services that enables a provider, a health plan or a clearinghouse to
103 carry out HIPAA-required functions (e.g., standard transactions or a Phase V CAQH CORE Operating Rule). Such products or services also are eligible for
104 CORE Certification. In the context of this Phase V CAQH CORE Certification Test Suite, a vendor with commercially-available products can seek CORE

³ [45 CFR § 160.103](#)

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105 Certification for those products/services and must certify each of its specific products/services and product/service versions separately. (See §2.2.5 for
106 more detail.)

107 **2.2.5 Table of CORE Certification Stakeholder Types Examples**

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

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| Examples of Entities that are Included in the Four CORE Certification Stakeholder Types | | | |
|---|---|--|---|
| Provider | Health Plan | Clearinghouse | Vendor |
| <p><u>HIPAA-covered Provider</u></p> <ul style="list-style-type: none"> Any person or organization who furnishes, bills, or is paid for medical or health services in the normal course of business⁴ <p><u>Provider Agent</u></p> <ul style="list-style-type: none"> 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 <p><u>Accountable Care Organizations</u></p> <ul style="list-style-type: none"> Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients⁵ A network of doctors, hospital, specialists, post-acute providers and even private companies, like Walgreens, that share financial and medical responsibility for providing coordinated care to patients in hopes of limiting unnecessary spending⁶ 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 | <p><u>HIPAA-covered Health Plan</u> Includes the following, singly or in combination:⁷</p> <ul style="list-style-type: none"> 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 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 | <p><u>HIPAA-covered Clearinghouse</u> 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</p> <ul style="list-style-type: none"> 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 nonstandard data content for the receiving entity <p><u>Clearinghouse</u></p> <ul style="list-style-type: none"> 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 | <p><u>Health Plan Vendor (Product)</u></p> <ul style="list-style-type: none"> A vendor of commercially-available software solutions for adjudication, claim processing, claim data warehousing, etc., for a health plan or its business associate <p><i>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.</i></p> <p><u>Health Plan Vendor (Services)</u></p> <ul style="list-style-type: none"> 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) <p><i>Note: This type of vendor holds and processes data on behalf of a health 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.</i></p> <p><u>Provider Vendor (Product)</u></p> <ul style="list-style-type: none"> A vendor of commercially-available software solutions for practice management, patient accounting, |

⁴ Definitions of (u) and (s) under the [Social Security Act, Section 1861](#).

⁵ [Accountable Care Organizations \(ACOs\): General Information](#). Centers for Medicare & Medicaid Services.

⁶ [Accountable Care Organizations, Explained](#). Kaiser Health News. September 14, 2015.

⁷ [45 CFR § 160.103](#)

⁸ Ibid.

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| <p>cost of care for an assigned population of patients</p> <ul style="list-style-type: none"> • A health insurance issuer-formed ACO | <p>(CHAMPUS) as defined in 10 U.S.C. 1072(4))</p> <ul style="list-style-type: none"> • 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 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)) <p><u>Utilization Management Organization (UMO)</u>⁹</p> <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • An entity that provides other services based on each entity’s business model <p><i>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.</i></p> <p><u>Health Information Exchange (Health Information Service Provider)</u></p> <ul style="list-style-type: none"> • An entity that provides secure transmission of clinical information between providers • An entity that provides secure transfer of administration information between providers and health plans • 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 | <p>etc., to a health care provider or its business associate</p> <p><i>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.</i></p> <p><u>Provider Vendor (Services)</u></p> <ul style="list-style-type: none"> • A billing/collection or financial services company to which a provider outsources some or all its financial functions <p><i>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.</i></p> <p><u>Web Portal Operator</u></p> <ul style="list-style-type: none"> • As defined in the Phase V CAQH CORE Prior Authorization Web Portal Operating Rule, a Web Portal Operator is any organization that makes available to either 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 <p><i>Note: A web portal is a specially designed website that brings information from diverse sources together in a uniform way.</i>¹⁰</p> |
|---|--|--|---|

⁹ <https://www.urac.org/programs/health-utilization-management-accreditation>

¹⁰ https://en.wikipedia.org/wiki/Web_portal

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| | <p>effectiveness of patient care while eliminating excessive treatment and expense</p> <ul style="list-style-type: none"> • 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 <p><u>Third Party Administrator (TPA)</u></p> <ul style="list-style-type: none"> • 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 employees¹¹ • 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 | <p><u>Health Insurance Marketplaces or Exchanges</u>¹²</p> <ul style="list-style-type: none"> • Private exchanges which may predate the ACA 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 and premium payment information <p><u>Value Added Network</u>¹³</p> <ul style="list-style-type: none"> • 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 | |
|--|--|---|--|

¹¹ http://en.wikipedia.org/wiki/Third-party_administrator

¹² http://en.wikipedia.org/wiki/Health_insurance_marketplace

¹³ http://en.wikipedia.org/wiki/Value-added_network

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| | <p>of insurance companies, they are often independent¹⁴</p> <p><u>Administrative Services Only (ASO)</u></p> <ul style="list-style-type: none"> • 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 employee¹⁵ • An arrangement in which an organization funds its own employee benefit plan such as a pension plan or health insurance 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 itself¹⁶ • 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 plan¹⁷ <p><u>Health Plan Agent</u></p> <ul style="list-style-type: none"> • 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 | | |
|--|--|--|--|

¹⁴ Ibid.

¹⁵ [http://en.termwiki.com/EN/administrative_services_only_\(ASO\)_contract](http://en.termwiki.com/EN/administrative_services_only_(ASO)_contract)

¹⁶ [Administrative Services Only \(ASO\)](#). Investopedia [online]. March 7, 2019.

¹⁷ <http://www.totalreturnannuities.com/annuity-glossary/a/administrative-services-only-aso-agreement.html>

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110 **2.3 USER QUICK START GUIDE**

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

115 **2.4 GUIDANCE FOR PROVIDERS AND HEALTH PLANS SEEKING PHASE V CAQH CORE CERTIFICATION THAT WORK WITH AGENTS**

116 Any Provider or Health Plan seeking CORE Certification must undergo certification testing in accordance with the Phase V CAQH CORE Certification Test
117 Suite. However, a Provider or Health Plan may also be CORE-certified when it outsources various functions to a third party, i.e., a business associate
118 (referenced as an agent in the Phase V CAQH CORE Operating Rules). Thus, the Detailed Step-by-Step Test Scripts recognize that a Provider or Health
119 Plan may use a business associate to perform some or all the HIPAA-mandated functions required by the HIPAA-mandated standards and/or the Phase V
120 CAQH CORE Operating Rule Set on its behalf.

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

128 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
129 Provider or Health Plan and the Clearinghouse, the Provider or the Health Plan may not have to undergo certification testing for some aspects of the rules
130 and their associated test scripts. In such a case, the Provider or Health Plan must provide a rationale statement, which explains the situation to the CAQH
131 CORE-authorized Testing Vendor for each test script for which the “N/A” option is chosen and the Provider or Health Plan needs to be prepared for a
132 review of the rationale with CAQH CORE Staff.

133 **2.5 PHASE V MASTER TEST BED DATA**

134 The Phase V CAQH CORE Certification Test Suite requires that all organizations seeking Phase V CORE Certification be tested using the same Phase
135 V CORE Master Test Bed Data. While the Phase V Master Test Bed Data builds and elaborates on the [Phase II CORE Certification Testing Master Test
136 Bed Data](#), the scope of the Phase V Master Test Bed Data is limited to data needed for entities seeking to become Phase V CORE-certified to create
137 and populate their internal files and/or databases addressing prior authorization only. These data are then used for internal pre-certification testing and
138 formal Phase V CORE Certification Testing for the Phase V CAQH CORE rule requirements:

- 139 • Phase V CAQH CORE Prior Authorization (278) Request/Response Data Content Rule
- 140 • Phase V CAQH CORE Prior Authorization Web Portal Rule

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141 The Phase V CORE Master Test Bed Data is available for free to any entity in Excel spreadsheet format, so organizations may easily extract the key data
142 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
143 their internal systems; therefore, entities may need to add other data to the CORE Master Test Bed Data when loading internal systems.

144 Thus, the CAQH CORE-authorized Testing Vendor uses only the Phase V CORE Master Test Bed Data to conduct Phase V CORE Certification testing for
145 the Phase V CAQH CORE Prior Authorization (278) Request/Response Data Content and Phase V CAQH CORE Prior Authorization Web Portal rules.
146 However, the 5010X217 278 Transactions created using the Phase V CORE Master Test Bed Data must conform to the X12/005010X217 Health Care
147 Services Review – Request for Review and Response (278) Technical Report Type 3.¹⁸

¹⁸ The X12 Technical Report Type 3 that details the full requirements for this transaction along with the license for its use is available at <http://store.x12.org/store/>. Note: Permission to use X12 copyrighted materials within this document has been granted.

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3 PHASE V CAQH CORE PRIOR AUTHORIZATION (278) REQUEST / RESPONSE DATA CONTENT RULE TEST SCENARIO

3.1 PHASE V CAQH CORE PRIOR AUTHORIZATION (278) REQUEST/RESPONSE DATA CONTENT RULE KEY REQUIREMENTS

Note: This section identifies at a high-level the key requirements of this rule. Refer to the Phase V CAQH CORE Operating Rule Set 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.

Provider Submission Requirements (§4.1)

- When the patient is the subscriber, the provider must submit the Patient Last Name, First Name and Date-of-Birth in Loop ID 2010C Subscriber Name NM1 and DMG segments.
- When the patient is the dependent, the provider must submit Subscriber Last Name, First Name and Date-of-Birth in Loop ID 2010C Subscriber Name NM1 and DMG segments and Dependent Last Name, First Name and Date-of-Birth in Loop ID 2010D Dependent Name NM1 and DMG segments.

Normalizing Last Name Requirements (§4.2.1, §4.2.1.1, §4.2.1.2)

- Requires a Phase V CORE-Certified health plan (or information source) to normalize the last name submitted on the 5010X217 278 and internally-stored last name prior to using submitted last name for matching or verification.

Consistent and Uniform Use of AAA Error and Action Codes Requirements (§4.2.2)

- When the health plan detects an error in data submitted in the following Loops:
 - Loop ID 2000A Request
 - Loop ID 2010A Utilization Management Organization (UMO) Name
 - Loop ID 2010B Requester Request
 - Loop ID 2010C Subscriber Request
 - Loop ID 2010D Dependent Request
 - Loop ID 2000E Patient Event Request
 - Loop ID 2010EA Patient Event Provider Request
 - Loop ID 2010EC Patient Event Transport Location Request
 - Loop ID 2000F Service Request
 - Loop ID 2010FA Service Provider Request
- The most specific AAA Error Code AAA03 901 Reject Reason Code permitted in the respective loops AAA Segment code set must be returned.

Out-of-network Requester, Service Provider or Specialty Entity (§4.2.2.1)

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3.1 PHASE V CAQH CORE PRIOR AUTHORIZATION (278) REQUEST/RESPONSE DATA CONTENT RULE KEY REQUIREMENTS

- When the requester provider, service provider or specialty entity submitted on the 5010X217 278 Request is determined to be out-of-network in the following Loops:
 - LOOP ID - 2010B AAA - Requester Request
 - LOOP ID - 2010EA AAA Patient Event Provider Request
 - LOOP ID - 2010FA AAA - Service Provider Request
- Error Code 35-Out of Network must be returned in AAA03 901 Reject Reason Code Data Element in addition to any other AAA03 901 Reject Reason Code.

Requesting Additional Documentation for a Pended Response (§4.2.3.1)

- When the 5010X217 278 Request includes one or more Diagnosis Code(s) in Loop 2000E Patient Event Level HI Patient Diagnosis Health Care Information Codes that can be categorized by the health plan and its agent into one or more of the following types of events:
 - General Outpatient
 - Inpatient
 - Surgery
 - Oncology
 - Cardiology
 - Imaging
 - Laboratory
 - Physical Therapy
 - Occupational Therapy
 - Speech-Language Pathology
- and
- [When/If] additional medical information is required, the health plan and its agent must return data element HCR01 306 Action Code=A4 Pended and HCR03 Industry Code 0V-Requires Medical Review or HCR03 Industry Code 0P-Requested Information Not Received or HCR03 Industry Code 0U-Additional Patient Information Required in Loop ID 2000E HCR Health Care Services Review Segment to indicate that the review outcome is pended for additional medical information and either:
 - The appropriate PWK01 Attachment Report Type Code in Loop ID 2000E PWK – Additional Patient Information Segment.
- or

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3.1 PHASE V CAQH CORE PRIOR AUTHORIZATION (278) REQUEST/RESPONSE DATA CONTENT RULE KEY REQUIREMENTS

- One or more appropriate Logical Observation Identifier Names and Codes (LOINC) Code from the HL7 CDA® R2 Attachment Implementation Guide: Exchange of C-CDA Based Documents, Release 1 (Universal Realm) Standard for Trial Use August 2017⁵ in Loop ID 2000E HI – Patient Diagnosis Health Care Information Codes Segment.

and

- The appropriate PWK01 Attachment Report Type Code in Loop ID 2000E PWK – Additional Patient Information Segment.

Requesting Additional Documentation for a Pended Response (§4.2.3.2)

- When the 5010X217 278 Request transaction includes one or more Procedure or Revenue Code(s) in Loop 2000F Service Level SV1, SV2, or SV3 segments¹⁸ that can be placed by the health plan and its agent into one or more of the following types of service:
 - General Outpatient
 - Inpatient
 - Surgery
 - Oncology
 - Cardiology
 - Imaging
 - Laboratory
 - Physical Therapy
 - Occupational Therapy
 - Speech-Language Pathology

and

- [When/If] additional medical information is required, the health plan and its agent must return data element HCR01 306 Action Code=A4 Pended and HCR03 Industry Code 0V-Requires Medical Review or HCR03 Industry Code 0P-Requested Information Not Received or HCR03 Industry Code 0U-Additional Patient Information Required in Loop ID 2000F HCR Health Care Services Review Segment to indicate that the review outcome is pended for additional medical information and either:
 - The appropriate PWK01 Attachment Report Type Code in Loop ID 2000F PWK – Additional Patient Information Segment.

or

⁵ See Appendix – Section 5.3 for further description of Logical Observation Identifier Names and Codes.

¹⁸ The 5010X217 278 Request requires the submission of a procedure or revenue code when known by the provider (requester) in Loop 2000F SV1, SV2, or SV3 Service Level Segments. When the provider needs to submit more than one procedure or revenue code Loop 2000F must be repeated for each additional code.

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3.1 PHASE V CAQH CORE PRIOR AUTHORIZATION (278) REQUEST/RESPONSE DATA CONTENT RULE KEY REQUIREMENTS

- One or more appropriate Logical Observation Identifier Names and Codes (LOINC) Code from the HL7 CDA® R2 Attachment Implementation Guide: Exchange of C-CDA Based Documents, Release 1 (Universal Realm) Standard for Trial Use August 2017 in Loop ID 2000F HI – Request for Additional Information Health Care Information Codes Segment.

and

- The appropriate PWK01 Attachment Report Type Code in Loop ID 2000F PWK – Additional Patient Information Segment.

Using Health Care Service Decision Reason Codes (HCSDRC) (§4.2.4)

- When the health plan and its agent use the Health Care Service Decision Reason Code (HCSDRC) in Loop ID 2000E Patient Event Detail HCR Segment, if appropriate, one or more additional Health Care Service Decision Reason Codes (HCSDRC) should be returned in the HCR Segment in addition to the required code to provide the most comprehensive information to the submitter.
- When the health plan and its agent use the Health Care Service Decision Reason Code (HCSDRC) in Loop ID 2000F Service Level Detail HCR Segment, if appropriate, one or more Health Care Service Decision Reason Codes (HCSDRC) should be returned in the HCR Segment in addition to the required code to provide the most comprehensive information back to the provider.

Detection and Display of 278 Response Data Elements (§4.3)

- The receiver of a 5010X217 278 Response is required to detect and extract all data elements, data element codes and corresponding code definitions to which this rule applies as returned by the health plan and its agent in the 278 Response must display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the 5010X217 278 Response data content.

3.2 PHASE V CAQH CORE PRIOR AUTHORIZATION (278) REQUEST / RESPONSE DATA CONTENT RULE CONFORMANCE TESTING REQUIREMENTS

These scenarios test the following conformance requirements of the Phase V CAQH CORE Prior Authorization (278) Request/Response Data Content 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. Note: Clearinghouses and/or vendors undergoing CAQH CORE Certification Testing should refer to the Detailed Step-by-Step Test Scripts for applicable test scripts.

Provider Submission

The provider must submit the Patient Last Name, First Name and Date-of-Birth in Loop ID 2010C Subscriber Name NM1 and DMG segments.

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3.2 PHASE V CAQH CORE PRIOR AUTHORIZATION (278) REQUEST / RESPONSE DATA CONTENT RULE CONFORMANCE TESTING REQUIREMENTS

The provider must submit Subscriber Last Name, First Name and Date-of-Birth in Loop ID 2010C Subscriber Name NM1 and DMG segments and Dependent Last Name, First Name and Date-of-Birth in Loop ID 2010D Dependent Name NM1 and DMG segments.

Uniform Use of AAA Error and Action Codes Requirements

The most specific AAA Error Code AAA03 901 Reject Reason Code permitted in the respective loops AAA Segment code set must be returned for errors detected in data submitted in the following Loops:

- Loop ID 2010B Requester Request
- Loop ID 2010C Subscriber Request
- Loop ID 2010D Dependent Request
- Loop ID 2000E Patient Event Request
- Loop ID 2000F Service Request

Requesting Additional Documentation for a Pended Patient Event Response

- To indicate that the review outcome is pended for additional medical information for a Laboratory Diagnosis Code submitted in the 5010X217 Request Loop 2000E Patient Event Level HI Patient Diagnosis Health Care Information Code the 5010X217 278 Response must include:
 - HCR01 306 Action Code=A4 Pended and HCR03 Industry Code 0V-Requires Medical Review in Loop ID 2000E HCR Health Care Services Review Segmentand
 - the appropriate PWK01 Attachment Report Type Code in Loop ID 2000E PWK – Additional Patient Information Segment.
- To indicate that the review outcome is pended for additional medical information for an Imaging Diagnosis Code submitted in the 5010X217 Request Loop 2000E Patient Event Level HI Patient Diagnosis Health Care Information Code the 5010X217 278 Response must include
 - HCR01 306 Action Code=A4 Pended and HCR03 Industry Code 0V-Requires Medical Review in Loop ID 2000E HCR Health Care Services Review Segmentand
 - The appropriate PWK01 Attachment Report Type Code in Loop ID 2000E PWK – Additional Patient Information Segment.
- To indicate that the review outcome is pended for additional medical information for a Cardiology Diagnosis Code submitted in the 5010X217 278 Request Loop 2000E Patient Event Level HI Patient Diagnosis Health Care Information Code the 5010X217 278 Response must include:

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3.2 PHASE V CAQH CORE PRIOR AUTHORIZATION (278) REQUEST / RESPONSE DATA CONTENT RULE CONFORMANCE TESTING REQUIREMENTS

- HCR01 306 Action Code=A4 Pended and HCR03 Industry Code 0V-Requires Medical Review in Loop ID 2000E HCR Health Care Services Review Segment

and

- One appropriate Logical Observation Identifier Names and Codes (LOINC) Code in data element 2017 in Loop ID 2000E HI – Patient Diagnosis Health Care Information Codes Segment

and

- The appropriate PWK01 Attachment Report Type Code in Loop ID 2000E PWK – Additional Patient Information Segment.

Requesting Additional Documentation for a Pended Service Level Response

- To indicate that the review outcome is pended for additional medical information for an Imaging Procedure or Revenue Code submitted in Loop 2000F Service Level SV1 segment in the 5010X217 278 Request the 5010X217 278 Response Loop ID 2000F HCR Health Care Services Review Segment must include:
 - HCR01 306 Action Code=A4 Pended and HCR03 Industry Code 0V-Requires Medical Review in Loop ID 2000F HCR Health Care Services Review Segment

and

 - The appropriate PWK01 Attachment Report Type Code in Loop ID 2000F PWK – Additional Patient Information Segment.
- To indicate that the review outcome is pended for additional medical information for an Oncology Procedure or Revenue Code submitted in Loop 2000F Service Level SV2 segment in the 5010X217 278 Request the 5010X217 278 Response Loop ID 2000F HCR Health Care Services Review Segment must include:
 - HCR01 306 Action Code=A4 Pended and HCR03 Industry Code 0V-Requires Medical Review in Loop ID 2000F HCR Health Care Services Review Segment

and

 - The appropriate PWK01 Attachment Report Type Code in Loop ID 2000F PWK – Additional Patient Information Segment.
- To indicate that the review outcome is pended for additional medical information for a Laboratory Procedure or Revenue Code submitted in Loop 2000F Service Level SV1 segment in the 5010X217 278 Request the 5010X217 278 Response must include:
 - HCR01 306 Action Code=A4 Pended and HCR03 Industry Code 0V-Requires Medical Review in Loop ID 2000F HCR Health Care Services Review Segment

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3.2 PHASE V CAQH CORE PRIOR AUTHORIZATION (278) REQUEST / RESPONSE DATA CONTENT RULE CONFORMANCE TESTING REQUIREMENTS

and

- One appropriate Logical Observation Identifier Names and Codes (LOINC) Code in data element 2017 in Loop ID 2000F HI – Request for Additional Information Health Care Information Codes Segment

and

- The appropriate PWK01 Attachment Report Type Code in Loop ID 2000F PWK – Additional Patient Information Segment.
- To indicate that the review outcome is pended for additional medical information for a Cardiology Procedure or Revenue Code submitted in Loop 2000F Service Level SV2 segment in the 5010X217 278 Request the 5010X217 278 Response must include:
 - HCR01 306 Action Code=A4 Pended and HCR03 Industry Code 0V-Requires Medical Review in Loop ID 2000E HCR Health Care Services Review Segment

and

- One appropriate Logical Observation Identifier Names and Codes (LOINC) Code in data element 2017 in Loop ID 2000E HI – Patient Diagnosis Health Care Information Codes Segment

and

- The appropriate PWK01 Attachment Report Type Code in Loop ID 2000F PWK – Additional Patient Information Segment.

Detection and Display of 278 Response Data Elements

The receiver of a 5010X217 278 Response must detect, extract and display all data elements, data element codes and corresponding code definitions as returned in the 278 Response.

3.3 PHASE V CAQH CORE PRIOR AUTHORIZATION (278) REQUEST / RESPONSE DATA CONTENT RULE TEST SCRIPTS ASSUMPTIONS

If applicable, entity is Phase I, II, III and IV CORE-certified.

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

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3.4 PHASE V CAQH CORE PRIOR AUTHORIZATION (278) REQUEST / RESPONSE DATA CONTENT RULE DETAILED STEP-BY-STEP TEST SCRIPTS

CAQH 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 is 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, the Detailed Step-by-Step Test Scripts applicable to a Health Plan apply to a health plan-facing product.

| Test # | Criteria | Expected Result | Actual Result | Pass | Fail | N/A | Stakeholder | | | |
|--|---|--|---------------|-------------------------------|-------------------------------|--------------------------|---|--------------------------|-------------------------------------|-------------------------------------|
| | | | | | | | <i>An X in the box indicates the stakeholder type to which the test applies</i> | | | |
| | | | | | | | Provider | Health Plan | Clearinghouse | Vendor |
| Provider Request Submission & Response Processing | | | | | | | | | | |
| 1. | Create a valid 5010X217 278 request transaction as defined in the CAQH CORE rule requesting a prior authorization for an Oncology service in Loop 2000F Service Level for one of the dependents listed in the Phase V Master Test Bed Data. | Output a valid fully enveloped 5010X217 278 request transaction set with complete subscriber and dependent names. | | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. | Detect, extract and display data elements from a valid 5010X217 278 response transaction as defined in the CAQH CORE rule using data from Test Scripts #3 through #14. | Submission of a screen print of the output from Test Scripts #3 through #14, showing that the required information is displayed to the end user. | | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| AAA Error and Action Codes | | | | | | | | | | |

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| Test # | Criteria | Expected Result | Actual Result | Pass | Fail | N/A | Stakeholder | | | |
|--------|--|--|---------------|-------------------------------|-------------------------------|--------------------------|---|-------------------------------------|-------------------------------------|-------------------------------------|
| | | | | | | | <i>An X in the box indicates the stakeholder type to which the test applies</i> | | | |
| | | | | | | | Provider | Health Plan | Clearinghouse | Vendor |
| 3. | Create a valid 5010X217 278 response transaction as defined in the CAQH CORE rule specifying the errors detected in Loop ID 2010B Requester transaction the AAA Segment error codes. | Output a valid fully enveloped 5010X217 278 response transaction set with the appropriate AAA Segment error codes. | | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. | Create a valid 5010X217 278 response transaction as defined in the CAQH CORE rule specifying the errors detected in Loop ID 2010C Subscriber Request transaction the AAA Segment error codes. | Output a valid fully enveloped 5010X217 278 response transaction set with the appropriate AAA Segment error codes. | | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. | Create a valid 5010X217 278 response transaction as defined in the CAQH CORE rule specifying the errors detected in Loop ID 2010D Dependent Request transaction the AAA Segment error codes. | Output a valid fully enveloped 5010X217 278 response transaction set with the appropriate AAA Segment error codes. | | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. | Create a valid 5010X217 278 response transaction as defined in the CAQH CORE rule specifying the errors detected in Loop ID 2010E Patient Event Request transaction the AAA Segment error codes. | Output a valid fully enveloped 5010X217 278 response transaction set with the appropriate AAA Segment error codes. | | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |

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| Test # | Criteria | Expected Result | Actual Result | Pass | Fail | N/A | Stakeholder | | | |
|------------------------|--|--|---------------|-------------------------------|-------------------------------|--------------------------|---|-------------------------------------|-------------------------------------|-------------------------------------|
| | | | | | | | <i>An X in the box indicates the stakeholder type to which the test applies</i> | | | |
| | | | | | | | Provider | Health Plan | Clearinghouse | Vendor |
| 7. | Create a valid 5010X217 278 response transaction as defined in the CAQH CORE rule specifying the errors detected in Loop ID 2010F Service Request transaction the AAA Segment error codes. | Output a valid fully enveloped 5010X217 278 response transaction set with the appropriate AAA Segment error codes. | | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Pended Response | | | | | | | | | | |
| 8. | Create a valid 5010X217 278 response transaction as defined in the CAQH CORE rule specifying that the Patient Event request for Laboratory services submitted in Loop 2000E Patient Event Level is pended for additional medical information using the specified HCR segment codes and the PWK Segment to identify the medical information needed. | Output a valid fully enveloped 5010X217 278 response transaction set with the appropriate HCR Segment and PWK Segment codes. | | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9. | Create a valid 5010X217 278 response transaction as defined in the CAQH CORE rule specifying that the Patient Event request for Imaging services submitted in Loop 2000E Patient Event Level is pended for additional medical information using the specified HCR segment codes and the PWK Segment to identify the medical information needed. | Output a valid fully enveloped 5010X217 278 response transaction set with the appropriate HCR Segment and PWK Segment codes. | | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |

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| Test # | Criteria | Expected Result | Actual Result | Pass | Fail | N/A | Stakeholder | | | |
|--------|--|--|---------------|-------------------------------|-------------------------------|--------------------------|---|-------------------------------------|-------------------------------------|-------------------------------------|
| | | | | | | | <i>An X in the box indicates the stakeholder type to which the test applies</i> | | | |
| | | | | | | | Provider | Health Plan | Clearinghouse | Vendor |
| 10. | Create a valid 5010X217 278 response transaction as defined in the CAQH CORE rule specifying that the Patient Event request for Cardiology submitted in Loop 2000E Patient Event Level is pended for additional medical information using the specified HCR segment codes and a LOINC and the PWK Segment to identify the medical information needed to identify the medical information needed. | Output a valid fully enveloped 5010X217 278 response transaction set with the appropriate HCR Segment codes and a LOINC. | | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 11. | Create a valid 5010X217 278 response transaction as defined in the CAQH CORE rule specifying that the Service Level request for Imaging services in Loop 2000F Services Level SV1 Segment is pended for additional medical information using the specified HCR segment codes and the PWK Segment to identify the medical information needed. | Output a valid fully enveloped 5010X217 278 response transaction set with the appropriate HCR Segment and PWK Segment codes. | | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |

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| Test # | Criteria | Expected Result | Actual Result | Pass | Fail | N/A | Stakeholder | | | |
|--------|--|---|---------------|-------------------------------|-------------------------------|--------------------------|---|-------------------------------------|-------------------------------------|-------------------------------------|
| | | | | | | | <i>An X in the box indicates the stakeholder type to which the test applies</i> | | | |
| | | | | | | | Provider | Health Plan | Clearinghouse | Vendor |
| 12. | Create a valid 5010X217 278 response transaction as defined in the CAQH CORE rule specifying that the Service Level request for Oncology services in Loop 2000F Services Level SV2 Segment is pended for additional medical information using the specified HCR segment codes and the PWK Segment to identify the medical information needed. | Output a valid fully enveloped 5010X217 278 response transaction set with the appropriate HCR Segment and PWK Segment codes. | | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 13. | Create a valid 5010X217 278 response transaction as defined in the CAQH CORE rule specifying that the Service Level request for Laboratory services submitted in Loop 2000F Services Level SV1 Segment is pended for additional medical information using the specified HCR segment codes and a LOINC and the PWK Segment to identify the medical information needed to identify the medical information needed. | Output a valid fully enveloped 5010X217 278 response transaction set with the appropriate HCR Segment codes, LOINC and PWK Segment codes. | | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |

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| Test # | Criteria | Expected Result | Actual Result | Pass | Fail | N/A | Stakeholder | | | |
|--------|--|---|---------------|-------------------------------|-------------------------------|--------------------------|---|-------------------------------------|-------------------------------------|-------------------------------------|
| | | | | | | | <i>An X in the box indicates the stakeholder type to which the test applies</i> | | | |
| | | | | | | | Provider | Health Plan | Clearinghouse | Vendor |
| 14. | Create a valid 5010X217 278 response transaction as defined in the CAQH CORE rule specifying that the Service Level request for Cardiology services in Loop 2000F Services Level SV2 Segment is pended for additional medical information using the specified HCR segment codes and a LOINC and the PWK Segment to identify the medical information needed to identify the medical information needed. | Output a valid fully enveloped 5010X217 278 response transaction set with the appropriate HCR Segment codes, LOINC and PWK Segment codes. | | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |

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4 PHASE V CAQH CORE PRIOR AUTHORIZATION WEB PORTAL RULE TEST SCENARIO

4.1 PHASE V CAQH CORE PRIOR AUTHORIZATION WEB PORTAL RULE KEY REQUIREMENTS

Note: This section identifies at a high level the key requirements of this rule. Refer to the Phase V CAQH CORE Operating Rule Set 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 (§4.1)

- A HIPAA-covered health plan or its agent system availability must be no less than 86 percent per calendar week.
- A HIPAA-covered health plan or its agent must publish their regularly scheduled system downtime in an appropriate manner.
- A HIPAA-covered health plan or its agent must publish the schedule of non-routine downtime at least one week in advance.
- A HIPAA-covered health plan or its agent must provide information within one hour of realizing downtime will be needed in the event of unscheduled/emergency downtime.
- No response is required during scheduled or unscheduled/emergency downtime(s).
- A HIPAA-covered health plan or its agent must establish and publish its own holiday schedule.

Web Form Data Request Field Labels (§4.2.1)

- The web portal operator of prior authorization submissions must apply the corresponding Loop, segment and data element name from the 5010X217 278 Request and Response to all web form data fields using the:
 - IMPLEMENTATION NAME for each corresponding loop, segment and data element where an IMPLEMENTATION NAME exists
 - or
 - Use the ALIAS if it is available and identified as such in the 5010X217 278 when an IMPLEMENTATION NAME does not exist or is considered less common.
- When an IMPLEMENTATION NAME or ALIAS for a corresponding Loop, segment and data element does not exist the X12 base standard Loop, segment and data element names must be used for the web form data field, when available.

Web Form Data Response Field Labels (§4.2.2)

- The web portal operator receiving a 5010X217 278 Response transaction to a previously submitted prior authorization request must apply the corresponding Loop, segment and data element name from the 5010X217 278 Response transaction to all web form data fields using the:

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- IMPLEMENTATION NAME for each corresponding Loop, segment and data element where an IMPLEMENTATION NAME exists
or
- Use the ALIAS if it is available and identified as such in the 5010X217 278 when an IMPLEMENTATION NAME does not exist.
- When an IMPLEMENTATION NAME or ALIAS for a corresponding Loop, segment and data element does not exist the X12 base standard Loop, segment and data element names must be used for the web form data field, when available.

Use of the X12/005010X217 Health Care Services Review Request for Review and Response (278) Technical Report 3 (§4.3)

- The data collected from the web form and mapped to the X12/005010X217 Health Care Services Review – Request for Review and Response (278) transaction must comply with the Phase V CAQH CORE Prior Authorization 278 Request/Response Data Content Rule.

Confirmation of Receipt of Web Form Submission (§4.4)

- A submission receipt indicating to the provider that the completed prior authorization request form was successfully received, and the next steps of the web portal operator must be returned when the submitter clicks a “submit” or similar button, along with information about the “next steps” for the web portal operator. Examples of such information include:
 - Submitter is notified if the web portal operator requires additional documentation to process the request;
 - Submitter has the option to print and save a PDF;
 - Submitter may view the authorization status;
 - Submitter may check the status, or an update of a previously submitted request, for the prior authorization request via hypertext that includes a navigation bar or a sidebar menu linking to other web pages via hyperlinks, often referred to as links;
 - Submitter is provided information about the assignment of a transaction or reference control number;
 - Submitter is provided a detailed timestamp including time zone for the submission.

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4.2 PHASE V CAQH CORE PRIOR AUTHORIZATION WEB PORTAL RULE CONFORMANCE TESTING REQUIREMENTS

These scenarios test the following conformance requirements of the Phase V CAQH CORE Prior Authorization Web Portal 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. Note: Clearinghouses and/or vendors undergoing CORE Certification Testing should refer to the Detailed Step-by-Step Test Scripts for applicable test scripts.

System Availability

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

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

Web Form Data Field Labels

Display the application of the IMPLEMENTATION NAME or ALIAS to the corresponding Loop, segment and data element name from the 5010X217 278 Request and Response to all web form submission data fields, when available.

Use of the 005010X217 278 TR3

Demonstrate compliance with the Phase V CAQH CORE Prior Authorization 278 Request/Response Data Content Rule.

Confirmation of Web Form Submission

Demonstrate submission receipt indicating to the provider that the completed prior authorization request form was successfully received.

4.3 PHASE V CAQH CORE PRIOR AUTHORIZATION WEB PORTAL RULE TEST SCRIPTS ASSUMPTIONS

If applicable, entity is Phase I, II, III and IV CORE-certified.

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

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4.4 PHASE V CAQH CORE PRIOR AUTHORIZATION WEB PORTAL RULE DETAILED STEP-BY-STEP TEST SCRIPTS

CAQH 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 is 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, the Detailed Step-by-Step Test Scripts applicable to a Health Plan apply to a health plan-facing product.

| Test # | Criteria | Expected Result | Actual Result | Pass | Fail | N/A | Stakeholder | | | |
|----------------------------|---|--|---------------|-------------------------------|-------------------------------|--------------------------|---|-------------------------------------|-------------------------------------|-------------------------------------|
| | | | | | | | <i>An X in the box indicates the stakeholder type to which the test applies</i> | | | |
| | | | | | | | Provider | Health Plan | Clearinghouse | Vendor |
| System Availability | | | | | | | | | | |
| 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. | | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2 | Publication of non-routine downtime notice and method(s) for such publication. | Submission of a sample notice of non-routine downtime, including schedule of downtime and method(s) of publishing. | | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |

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| Test # | Criteria | Expected Result | Actual Result | Pass | Fail | N/A | Stakeholder | | | |
|--|--|---|---------------|-------------------------------|-------------------------------|--------------------------|--|-------------------------------------|-------------------------------------|-------------------------------------|
| | | | | | | | An X in the box indicates the stakeholder type to which the test applies | | | |
| | | | | | | | Provider | Health Plan | Clearinghouse | Vendor |
| 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. | | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Web Form Data Field Labels | | | | | | | | | | |
| 4 | Display the application of the IMPLEMENTATION NAME or ALIAS to the corresponding Loop, segment, data element name from the 5010X217 278 Request and Response to all web form submission data fields. | Submission of actual web form showing use of IMPLEMENTATION NAME or ALIAS. | | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| CORE Prior Authorization 278 Request/Response Data Content Rule | | | | | | | | | | |
| 5 | Web portal operator must comply with CAQH CORE 278 Data Content Rule when mapping web form data collected to the 005010X217 278 transaction. | Output a valid fully enveloped 5010X217 278 request transaction set. | | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Confirmation of Web Form Submission | | | | | | | | | | |
| 6 | Display the submission receipt of the web form submission data fields. | Submission of actual web page confirming successful receipt of the request. | | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |