Analysis & Planning Guide for Implementing the CORE Health Care Claims Operating Rules
March 2024

CAQH Committee on Operating Rules for Information Exchange (CORE)
Analysis & Planning Guide for Implementing CORE Health Care Claims Operating Rules

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1. Introduction: Analysis & Planning for CORE Health Care Claims Operating Rule Implementation

This CORE Health Care Claims Analysis & Planning Guide is a resource for entities preparing to implement the CORE Health Care Claims Operating Rules. A solid understanding of the CORE Health Care Claims Operating Rules, combined with an effective planning effort, is the basis for a successful implementation project.

This document provides guidance for project managers, business analysts, system analysts, architects, and other project staff to complete the first step of a typical systems development life cycle: Systems Analysis & Planning. The purpose of this guide is to enable project managers and other staff to:

- Understand the applicability of the CORE Health Care Claims Operating Rules requirements to your organization's systems and business processes that support the following transactions and their respective errata:
    - X12 v5010X222 Health Care Claim (837) Professional, the X12 v5010X223 Health Care Claim (837) Institutional, X12 v5010X224 837 Health Care Claim Dental (hereafter collectively referenced as the X12 v5010 837); the X12 v5010X214 Claim Acknowledgment (277CA) (hereafter referenced as X12 v5010 277CA); the X12 v6020X314 Attachments (275) (hereafter referenced as the X12 v6020 275); and attachments sent via non-X12 transactions.
- Identify and inventory all impacted internal systems, business processes (manual and automated) and functions/processes outsourced to an agent[1] (e.g., Business Associate) that process the transactions or perform other requirements of the CORE Health Care Claims Operating Rules
- Perform a detailed rule requirements gap analysis to identify system(s) that may require remediation in order to conform to the CORE Health Care Claims Operating Rule requirements and to identify business processes which may be impacted by the CORE Health Care Claims Operating Rules (e.g., need for internal testing, project management, additional resources, etc.)

The appendices of this Analysis & Planning Guide include the following:

- **Stakeholder & Business Type Evaluation**: Use to determine your stakeholder type(s) and understand the role of your agents (Business Associates) that process the transactions and will be affected by connectivity requirements.
- **Systems Inventory & Impact Assessment Worksheet**: Use to perform a high-level inventory of all internal systems, business processes (manual and automated) and functions/processes outsourced to an agent that process the transactions and are impacted by the CORE Health Care Claims Operating Rules
- **Gap Analysis Worksheet**: Use to determine the level of system(s) remediation necessary for implementing the business requirements of the CORE Health Care Claims Operating Rules

NOTES:

- This document is for educational purposes only. In the case of a question between this document and CORE Operating Rule text or Federal regulations, the latter takes precedence.
- This Analysis & Planning Guide is scoped to general implementation planning of the CORE Health Care Claims Operating Rules and can assist with compliance with a potential Federal Regulation pursuant to ACA Section 1104 or CORE Certification; these are, however, separate projects requiring analysis and planning beyond that described in this document.[2]
- The CORE Operating Rules reference three stakeholder categories: HIPAA-covered Provider and/or its agent; HIPAA-covered Health Plan or its agent; HIPAA-covered Entity or its agent. This document references examples of these stakeholder categories to assist with applicability and implementation; these examples include clearinghouses and vendors. Please note that some stakeholder types are not necessarily HIPAA-covered entities (e.g., software or service vendors) and may not be directly required to implement the rule requirements but may need to because of being an agent of a HIPAA-covered entity.

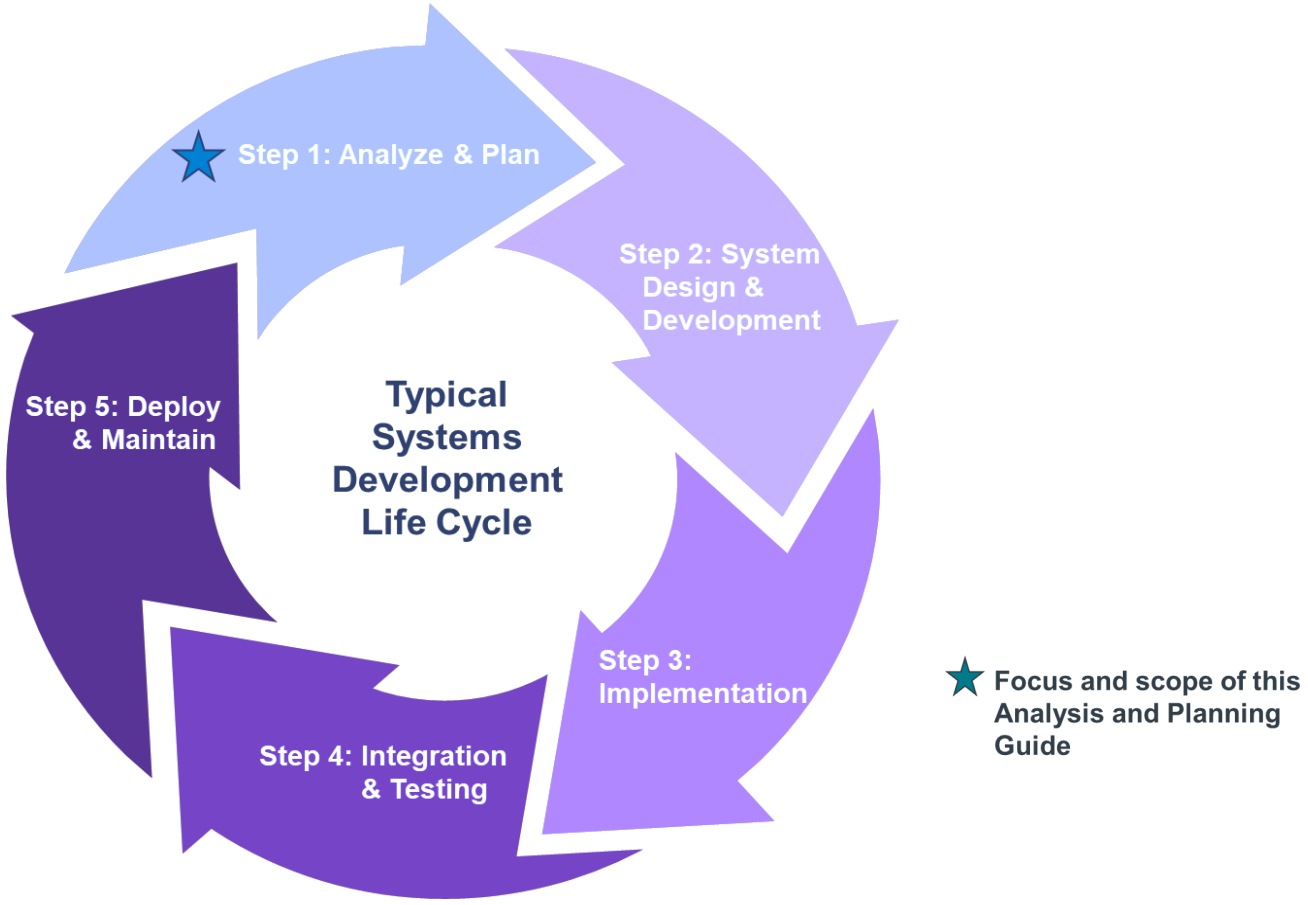
[1] One who agrees and is authorized to act on behalf of another, a principal, to legally bind an individual in particular business transactions with third parties pursuant to an agency relationship. Source: West's Encyclopedia of American Law, edition 2. Copyright 2008 The Gale Group, Inc. All rights reserved. The term "agent" as used in this document describes entities that provide outsourced functions/activities on behalf of HIPAA-covered health plans or providers, (e.g., Business Associate). The full definition of Business Associate can be found in the **Electronic Code of Federal Regulations** (Title 45, Subtitle A, Subchapter C, Part 160.103).

[2] The CORE Health Care Claims Operating Rules have not been mandated by HHS at the time of publishing of this guide.

2. Systems Development Life Cycle

The diagram below illustrates a typical systems development life cycle (SDLC) for developing or remediating information systems. SDLC includes five key steps, beginning with analysis and planning through deployment and ongoing maintenance. This Analysis & Planning Guide is scoped to assist your organization in the first step of an SDLC for the implementation of the CORE Health Care Claims Operating Rules given Step 1 sets the stage for all other steps. Note: The impacted system(s) may include an in-house developed system, commercial off the shelf (COTS)/cloud-based system, or a solution outsourced to a third party. The "system" in certain cases may also be a manual process or even include activities performed on your behalf by one or more agents.

Typical Systems Development Life Cycle



3. Analysis & Planning for the Health Care Claims CORE Operating Rules: Key Tasks

The following table outlines the key tasks necessary to complete Step 1: Analyze & Plan a Systems Development Life Cycle. When the analysis and planning is completed, you will have created a high-level systems impact analysis and developed a detailed project plan for adopting the CORE Health Care Claims Operating Rules requirements.

Analysis and Planning: Key Tasks	
Task	**Activity**
Task A – Complete Staff Education and Training on the CORE Health Care Claims Operating Rules	• Thoroughly review and understand the CORE Health Care Claims Operating Rules. • Conduct general education and awareness of the CORE Health Care Claims. Operating Rules for the impacted areas in your organization (see Section 4 of this document for additional resources available to educate staff on the CORE Operating Rules).
Task B – Determine Your Organization's Stakeholder & Business Type(s) (Stakeholder & Business Type Evaluation) *CORE Health Care Claims Operating Rule requirements are tied to applicable stakeholder type(s): HIPAA-covered provider, HIPAA-covered health plan, a HIPAA-covered entity, or their respective agents.* *Please note that some stakeholder types are not necessarily HIPAA-covered entities (e.g., software or service vendors) and may not be directly required to implement the rule requirements but may need to because of being an agent of a HIPAA-covered entity.*	• Determine your stakeholder and business type(s) to understand which CORE Health Care Claims Operating Rules apply to your organization. • Understand the role of agents that provide services or process the transactions on your behalf. • Consider the following based on your stakeholder type(s):
	• If your organization is a health plan that receives X12 v5010 837 Claim: – The majority of the CORE Health Care Claims Operating Rule requirements apply to you. – Health plans that outsource a portion or all the CORE Health Care Claim Operating Rules requirements to an agent to process may have some unique implementation considerations. Depending on the scenario between the health plan and its agent(s), the health plan may not need to implement some rule requirements directly while the agent will need to implement them on behalf of the health plan. For other transactions, agents may include other types of entities not involved in the implementation of the existing ACA-mandated CORE Operating Rules and the CORE Health Care Claims Operating Rules. The health plan, therefore, might have a different agent(s) to consider when implementing the Health Care Claims CORE Operating Rules. (See Appendix D for a diagram of potential stakeholders involved in the transactions addressed in the CORE Health Care Claims Operating Rules that may assist with identifying all entities involved.)
	• If your organization is a <u>provider</u>: – You likely are outsourcing some of the CORE Health Care Claims Operating Rule requirements to an agent. Provider organizations using a clearinghouse, a software vendor, or a third-party billing/collection service to process the transactions with health plans may have some unique implementation considerations, as the clearinghouse/software vendor/billing/collection services is performing some functions on behalf of the provider as an agent.

Analysis and Planning: Key Tasks	
Task	**Activity**
	• If your organization is a clearinghouse: – If a health plan and/or provider outsource(s) certain functions to you to perform on their behalf, you are responsible for implementing all CORE Health Care Claims Operating Rule requirements which have been outsourced to you. In this scenario, your organization will need to work with your business partners to determine applicable rule requirements.
	• If your organization is a <u>software or services vendor</u>: – You may be responsible for incorporating many of the CORE Health Care Claims Operating Rule requirements into your services or software as a result of providing software or services solutions to a HIPAA-covered entity even though you are not considered an agent of a HIPAA-covered entity. A review of the CORE Health Care Claims Certification Test Suite Section 2.2.4 may provide some insight. – Note: If your services or software are provider-facing, you will have a unique set of requirements to implement that are different than health plan-facing services or software.
Task C – Conduct a Systems Inventory (Systems Inventory & Impact Assessment Worksheet)	*Relative to your stakeholder type(s):* • Identify and inventory <u>all</u> impacted internal systems, business processes (manual and automated) and functions/processes outsourced to an agent that processes the transactions. • Determine which functions for each identified impacted system and business process are in-house developed and maintained, commercial-off-the-shelf (COTS)/cloud-based system or outsourced to an agent. • Determine potential options for addressing the CORE Health Care Claims Operating Rule requirements applicable to your stakeholder type(s) (e.g., remediate an in- house developed system, replace or upgrade any COTS/cloud-based system, or work with the vendor to ensure they meet CORE Health Care Claims Operating Rule requirements).
Task D – Conduct Detailed Rule Requirements Gap Analysis (Gap Analysis Worksheet)	• Identify the impacted systems (identified via the Systems Inventory & Impact Assessment Worksheet) responsible for satisfying each requirement of the CORE Health Care Claims Operating Rules. • Identify and document any gaps between the existing system's capability and each rule requirement. • Identify and document any business process which may also be impacted by each CORE Health Care Claims Operating Rule requirement and to what extent the process is impacted.

Analysis and Planning: Key Tasks	
Task	**Activity**
Task E – Develop a Detailed Project Plan	• A detailed project plan typically outlines steps for completion of the following key activities as Steps 2 - 5 of the System Development Life Cycle: – Determine required resources to complete the project (i.e., estimate resources, time, system release schedules, and money) – Develop a detailed Functional Requirements Document – Create a detailed Systems Design Document describing, in detail, the required functions and capabilities necessary to implement the CORE Health Care Claims Operating Rules – Implement necessary system(s) enhancements – Test impacted systems to ensure conformance to the requirements set forth in the Functional Requirements Document – Deploy (i.e., implement system(s) into production environment) – Conduct trading partners implementation testing
Other Considerations – CORE Certification	• Consider CORE Certification as part of your project plan[3] – CORE offers CORE Certification to the four stakeholder types that create, transmit or use the transactions: health plans, providers, software/services vendors, and clearinghouses. – Key benefits to completing CORE Certification include: ▪ Certification testing provides an online mechanism for a stakeholder to test its system's ability to exchange eligibility and claim status data with its trading partners using the CORE Health Care Claims Operating Rules. ▪ Demonstrates via a recognized industry "Seal" your organization's adoption of the CORE Health Care Claims Operating Rules to the industry. ▪ Encourages trading partners to work together on transaction data content, infrastructure and connectivity needs. ▪ Promotes maximum ROI when all stakeholders in the information exchange are known to conform with the CORE Health Care Claims Operating Rules. • More information on the CORE Certification process is available on the CAQH website.

[3] **NOTE:** A CORE Certification Program is offered by CORE. Information on the CMS compliance program regarding standards and operating rules is under development and can be found HERE.

4. Additional Resources

Beyond the information provided in this CORE Analysis & Planning Guide, there are additional resources for entities preparing to implement the CORE Health Care Claims Operating Rules:

- **CORE Health Care Claims Operating Rules**
- **Operating Rule Implementation Resources** from CORE and its partners to help you implement the CORE Operating Rules (developed for CORE Certification but same concepts, e.g., role of trading partners, apply for general adoption of the CORE Operating Rules).
- CORE FAQs address typical questions regarding the CORE Operating Rules.
  - If your question is not answered by the FAQ, email question to **CORE@caqh.org** to have it entered into the formal CORE Request Process.
- Upcoming CORE **Education Sessions** (as well as presentations and recordings from previous sessions) for further clarification on rule requirements.
- **CMS FAQs** (FAQs on a wide range of other topics, as well)
- **X12 Requests for Interpretation** provide Information related to the meaning, use, and interpretation of X12 Standards, Guidelines, and Technical Reports, including implementation guidelines for the transactions can be obtained from X12.

Entities seeking to implement the CORE Health Care Claims Operating Rules are encouraged to note the following:

- The CORE Health Care Claims Operating Rules assume that any HIPAA-covered entity implementing the operating rules is compliant with HIPAA; HIPAA compliance is not defined by CORE.
- The CORE Health Care Claims Operating Rule requirements are specific to either a HIPAA-covered entity or its respective agent(s). The applicability of a specific CORE Health Care Claims Operating Rule requirement may vary according to trading partner relationship, contracted services, and other arrangements. If you have specific questions concerning applicability, please **contact CORE Staff**.
- CORE staff is available to assist with questions about understanding the requirements of the CORE Health Care Claims Operating Rules in regard to your stakeholder type(s); gap analysis and systems remediation are the responsibility of the implementing entities.

5. Appendix

Appendix A: CORE Stakeholder & Business Type Evaluation

Purpose: After becoming educated on the CORE Health Care Claims Operating Rules, you will need to determine your stakeholder type(s). The *CORE Health Care Claims Stakeholder & Business Type Evaluation* below will assist you in determining which CORE Health Care Claims Operating Rules apply to your organization and to generally consider which trading partners you need to work with on planning and implementation. Knowing your stakeholder type(s) will help you complete the *Systems Inventory & Assessment Worksheet.*

NOTE: Applicability of a specific rule requirement may vary according to trading partner relationship, contracted services, and other arrangements.[4] Some example business models include:

- Provider direct-to-Health plan connection:
  - Health plan implements all requirements of the CORE Health Care Claims Rule Set.
  - Provider receives and processes acknowledgements as required by the CORE Health Care Claim Rules.
- Provider-to-agent connection:
  - Provider outsources X12 v5010 837 Claim to an agent (e.g., clearinghouse/financial services organization).
  - Agent (e.g., provider-facing clearinghouse or billing company) acts as a proxy for provider's CORE conformance for the contracted services.
- Health plan-to-agent connection:
  - Health plan outsources the return or elements of X12 v5010 837 Claim to an agent (e.g., clearinghouse, business associate, or utilization management organization).
  - Health plan agent acts as a proxy for health plan's CORE Health Care Claims conformance for the contracted services.
- Single/dual clearinghouse-to-health plan connection:
  - Health plan outsources infrastructure and connectivity functions to a clearinghouse.
  - Health plan-facing clearinghouse acts as a proxy for health plan's CORE Health Care Claims conformance for the contracted services.

Key Takeaway: Understand what aspects of your business and/or outsourced functions are impacted by the CORE Health Care Claims Operating Rules (e.g. products, business lines, etc.).

[4] The CORE Health Care Claims Operating Rule Set requirements are tied to applicable stakeholder type(s): HIPAA-covered provider, HIPAA-covered health plan, a HIPAA-covered entity, or their respective agents. This document references examples of these stakeholder categories to assist with applicability and implementation. Please note that some stakeholder types that are part of the entities involved in exchanging the Health Care Claims transaction are not necessarily a HIPAA-covered entity. Some stakeholders (software or service vendors) may not be directly required to implement the rule requirements but may need to as a result of being an agent of a HIPAA-covered entity.

Stakeholder & Business Type Evaluation		
Question	**Points for Consideration**	**Your Response**
1. What is your stakeholder type(s): health plan, provider, vendor, clearinghouse? (See question 3 for more information on other trading partners)	The Health Care Claims CORE Certification Test Suite defines four stakeholder types that implement the operating rules: health plan, clearinghouse, provider, and vendor; the applicability of specific CORE Health Care Claims Operating Rule requirements vary according to stakeholder type. Please reference Section 2 of the Health Care Claims CORE Certification Test Suite for further information.	
2. What role and responsibilities does my organization have for implementing the CORE Health Care Claims Operating Rules, given our stakeholder type(s)?	The CORE Health Care Claims Operating Rules outline the specific roles and responsibilities for each stakeholder type; review CORE Health Care Claims Operating Rule text for more detail.	
3. Does my organization rely on other organizations (e.g., software vendors, clearinghouses, business associates) to assist with X12 v5010 837 processing?	The applicability of a specific CORE Health Care Claims Operating Rule requirements may vary according to trading partner relationship, contracted services, and other arrangements. If your organization relies on a software vendor or a clearinghouse or other business associate to meet any of the CORE Health Care Claims Operating Rule requirements, you will need to coordinate with that entity as part of your pre-implementation planning and outline applicability of each requirement to the vendor, clearinghouse or business associate. See section 4 of this document (above) for additional resources. Ensure appropriate business associate agreements are in place with necessary stakeholders.	

Appendix B: CORE Systems Inventory & Impact Assessment Worksheet
Purpose: After you complete the *Stakeholder & Business Type Evaluation,* your next step is to complete the *CORE Systems Inventory & Impact Assessment Worksheet* which enables you to identify and inventory all impacted systems that process the X12 v5010 837 Health Care Claims transaction.

This assessment worksheet will help you identify your systems impacted by the implementation of the CORE Health Care Claims Operating Rules, including in-house developed and maintained systems, COTS/cloud-based systems, and those functions outsourced to a third party. While completing this analysis you should also consider potential options for addressing applicable CORE Health Care Claims Operating Rule requirements (e.g., remediate an in-house developed system, replace or upgrade any COTS/cloud-based system, or work with third-party vendor).

Instructions:
1. In the second column of the worksheet, note if one of your system(s) is impacted by each rule and list the name of the impacted system(s)
    - **NOTE**: The impacted system(s) may include an in-house developed system, COTS/cloud-based system, or a capability outsourced to a third party. The "system" in certain cases may also be a manual process.
2. In the third column, identify potential options for addressing the rule requirements for each impacted system(s).
3. Use the worksheet findings to inform completion of the *Gap Analysis Worksheet* for any identified system impacted by the rule requirements.

Key Takeaway: Understand how many of your systems/products are impacted by each CORE Health Care Claims Operating Rule and understand with which vendors you will need to coordinate.

CORE Systems Inventory & Impact Assessment Worksheet			
CORE Operating Rule Requirements	**Are One or More Systems/Processes Impacted?** *(Yes/No; Name of Impacted System/Process)*	**Is the System/Process In-House, COTS/Cloud-based, or Outsourced to a Third Party?**	**Potential Options to Address Rule Requirements** *(e.g. remediate an in-house developed system, replace or upgrade any COTS/cloud-based system, work with third party vendor to ensure they meet CORE Operating Rule requirements, or update manual processes)*
CORE Health Care Claims Rules			
CORE Health Care Claim (837) Infrastructure Rule vHC.2.0			
CORE Health Care Claims (837) Data Content Rule vHC.1.0			
CORE Claim Acknowledgment (277CA) Data Content Rule vCA.1.0			
CORE Attachments Health Care Claims Rules			
CORE Attachments Health Care Claims (275) Infrastructure Rule vHC.1.0			
CORE Attachments Health Care Claims Data Content Rule vHC.1.0			
CORE Connectivity Rule			
CORE Connectivity Rule vC.4.0.0 (HTTPS Safe Harbor; continued support for SOAP and added support for REST; authorization: OAuth 2.0.; security: TLS 1.2)			

Appendix C: CORE Gap Analysis Worksheet

Purpose: After the *Systems Inventory & Impact Assessment*, the next task is for entities to determine the level of system(s) remediation necessary for adopting the business and technical requirements of the CORE Health Care Claims Operating Rules using the *CORE Gap Analysis Worksheet*. Each rule requirement in the *Gap Analysis Worksheet* includes a section reference for the corresponding operating rule for more detail.

NOTES:

- For more detail on rule requirements refer to the actual CORE Operating Rule text which takes precedence over this worksheet.
- If your entity has identified more than one impacted system you may need to complete a *Gap Analysis Worksheet* for each system.

Instructions:

1. The *Gap Analysis Worksheet* contains each CORE Health Care Claims Operating Rule Requirement in the first column by CORE Health Care Claims Operating Rule. In the second column, enter the system(s) impacted by the CORE Health Care Claims Operating Rule Requirement. If there is no system impacted by the requirement, enter N/A.
    - **NOTE**: The impacted system(s) may include an in-house developed system, a COTS/cloud-based system, or a capability outsourced to a third party or business associate.
2. In the third column note if the system currently meets the CORE Health Care Claims Operating Rule Requirement or not.
3. In the fourth column, briefly describe any gap between the CORE Health Care Claims Operating Rule Requirement and the system under evaluation, if applicable. The high level findings from the *Systems Inventory & Impact Assessment* inform the input in this column.
4. In the fifth column estimate the effort required to remediate the impacted system(s). This can include the type of skilled resource required, the number of such resources, and the potential hours required to fill the gap identified.
5. In the sixth column identify and describe any impacted business process. These often include potential training and education of staff, clients, and other users of the system's new capabilities.
6. In the seventh column estimate and describe the effort required to revise the impacted business process. This can include the type of skilled resources required, the number of such resources, and the potential hours required to fill the gap identified.
7. The results of the completed *Gap Analysis Worksheet* will allow for the development of a detailed project plan.

Key Takeaway: Understand the level of system(s) remediation necessary for adopting each CORE Health Care Claims Operating Rule requirement.

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
CORE Health Care Claim (837) Infrastructure Rule vHC.2.0							
	Processing Mode Requirements (§4.1)						
1	HIPAA-covered health plan or its agent must implement the server requirements for Batch Processing mode.						
	Connectivity Requirements (§4.2)						
2	A HIPAA-covered entity must be able to support the most recently published CORE Connectivity Rule.						
	System Availability Requirements (§4.3.1.1)						
3	System availability must be no less than 90 percent per calendar week for both Real Time and Batch Processing Modes.						
	Reporting Requirements (§4.3.2.1, §4.3.2.2, §4.3.2.3, §4.3.2.5)						
4	Publication of regularly scheduled downtime in an appropriate manner.						
5	Publication of non-routine downtime notice and method(s) at least one week in advance.						
6	Publication of unscheduled/emergency downtime notice and method(s) for such publication within one hour of realizing downtime will be needed.						
7	Establish and publish its own holiday schedule in an appropriate manner.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	Acknowledgement Requirements (§4.4.1.1.1., §4.4.1.1.2)						
8	HIPAA-covered health plan or its agent must return an X12 v5010 999 transaction when any Functional Group of any X12 v5010 837 Claim Transaction Set is accepted, accepted with errors, or rejected. The X12 v5010 999 transaction must report each error detected to the most specific level of detail supported by the X12 v5010 999 transaction.						
9	A HIPAA-covered health plan or its agent must acknowledge each claim received in any Functional Group of any X12 v5010 837 Claim Transaction Set using the X12 v5010 277CA transaction only when X12 v5010 837 Claim Transaction Set is not rejected.						
10	When any Functional Group of any X12 v5010 837 Claim Transaction Set is rejected the HIPAA-covered health plan or its agent must return an X12 v5010 999 transaction. The X12 v5010 999 transaction must report each error detected to the most specific level of detail supported by the X12 v5010 999 transaction.						
11	An X12 v5010 999 transaction must not be returned when the Functional Group of any X12 v5010 837 Claim Transaction Set is not rejected.						
12	A HIPAA-covered health plan or its agent must acknowledge each claim received in any Functional Group of any X12 v5010 837 Claim Transaction Set using the X12 v5010 277CA transaction only when X12 v5010 837 Claim Transaction Set is accepted.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	Response Requirements (§4.4.2)						
13	The maximum elapsed time for the availability of an X12 v5010 999 transaction or X12 v5010 277CA transaction to any X12 v5010 837 Claim transaction that is submitted by a provider, or on a provider's behalf by a clearinghouse/switch, by 9:00 pm Eastern Time of a business day must be no later than 7:00 am Eastern Time the second business day following submission. Ensure that at least 90 percent of required responses are returned within specified maximum response time as measured within a calendar month.						
14	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.						
15	HIPAA-covered provider or its agent receiving an X12 v5010 999 transaction and an X12 v5010 277CA transaction are required: • To process any X12 v5010 999 transaction within one business day of its receipt And • To process any X12 v5010 277CA transaction within one business day of its receipt And • To recognize all error conditions that can be						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	specified using all standard acknowledgements named in this rule And • To pass all such error conditions to the end user as appropriate Or • To display to the end user text that uniquely describes the specific error condition(s), ensuring that the actual wording of the text displayed accurately represents the error code and the corresponding error description specified in the related X12 acknowledgement specification without changing the meaning and intent of the error condition description.						
	Companion Guide Requirements (§4.5.1)						
16	Companion guide conforms to the flow and format of the CORE Master Companion Guide Template.						
17	Companion guide conforms to the format for presenting each segment, data element and code flow and format of the CORE Master Companion Guide Template.						
CORE Health Care Claim (837) Data Content Rule vHC.1.0							
	Requirements for Providers - Remote Delivery Claims (§4.1.1)						
1	A provider and its agent must submit appropriate CORE-defined combinations of corresponding POS + modifier codes when billing a telehealth claim with						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	POS 02 or 10 for the X12 v5010 837 Professional.						
	Requirements for Providers - Coordination of Benefits (§4.1.2)						
2	A provider and its agent involved in Provider to Health Plan COB Interactions must submit appropriate data content from the X12 v5010 837 transaction for coordination of benefits as defined in Table 3 and Table 4 of §3.5 if known, when submitting claims to subsequent health plans.						
3	A provider and its agent must submit the following information to the primary health plan in the X12 v5010 837 transaction to support Health Plan to Health COB Interactions: • Data for the subscriber holding the policy with the primary health plan in the Subscriber loop (Loop ID-2000B). • Details about the secondary health plan and associated subscriber in Loop ID-2320. • Relevant data from Table 3 and Table 4 of §3.5 if known to the secondary plan.						
	Requirements for Providers - Matching Information Between an Initial and Supplementary Claim to Submit Additional Diagnoses for a Single Encounter (§4.1.3)						
4	A provider and its agent must match the information included in an initial claim and the information included in a supplementary claim consistent with the data elements indicated in §4.1.3 for the X12 v5010 837 Professional or X12 v5010 837 Institutional.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	Requirements for Health Plans - Remote Delivery Claims (§4.2.1)						
5	A health plans and its agent must accept CORE-defined combinations of corresponding POS + modifier codes for qualifying categories of service covered for telemedicine when a X12 v5010 837 Professional is received with POS 02 or 10.						
	Requirements for Health Plans - Coordination of Benefits (§4.2.2)						
6	A primary health plan and its agent must accept the information and return appropriate data back to a provider in a X12 v5010 837 transaction as specified in §4.2.2.1 for Provider to Health Plan COB Interactions.						
7	A secondary health plan and its agent must accept the information and return appropriate data back to provider in a X12 v5010 837 transaction as specified in §4.2.2.1 for Provider to Health Plan COB Interactions.						
8	A tertiary health plan and its agent must accept the information and return appropriate data back to a provider in a X12 v5010 837 transaction as specified in §4.2.2.1 for Provider to Health Plan COB Interactions.						
9	A primary health plan and its agent must submit the information specified §4.2.2.2 to a secondary health plan in a X12 v5010 837 transaction for Health Plan to Health Plan COB Interactions.						
10	A secondary health plan and its agent must accept information received as specified in §4.2.2.2 from a						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	primary health plan in a X12 v5010 837 transaction for Health Plan to Health Plan COB Interactions.						
11	A primary health plan and its agent must submit the information specified §4.2.2.1 to a secondary health plan in a X12 v5010 837 transaction for Health Plan to Health Plan COB Interactions.						
12	A Companion Guide covering the X12 v5010 837 for COB published by a health plan or its agent must follow the format/flow as defined in the CORE Master Companion Guide Template. Minimum data content requirements for COB shall be organized in section 10 of the CORE Master Companion Guide Template – "10. Transaction Specific Information.						
	Requirements for Health Plans - Matching Information Between an Initial and Supplementary Claim to Submit Additional Diagnoses for a Single Encounter (§4.2.3)						
13	When a health plan or its agent accepts the submission of additional claims for a single encounter, they must require the following information to match between the initial claim and supplementary claim. • Rendering Provider NPI • Billing Provider NPI • Member Identification Number • Dates of Service						
	Detection and Display of X12 v5010 837 Claim Transaction Data Elements (§4.3)						
14	The receiver of an X12 v5010 837 is required to detect and extract all data elements to which the rule applies.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
15	The receiver of an X12 v5010 837 must display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the data content.						
	Electronic Policy Access Requirements (§4.4)						
16	A health plan and its agent must make these data requirements easily accessible to submitters of an X12 v5010 837 transaction, either on the plan website or in the transaction-specific companion guide.						
	Electronic Policy Access Requirements – Remote Delivery Claims (§4.4.1)						
17	A health plan must provide electronic access to the POS and modifiers that are required by the plan for remote care delivery claims.						
	Electronic Policy Access Requirements – Coordination of Benefits (§4.4.2)						
18	To support a coordination of benefit claims request by any trading partner (e.g., a healthcare provider), such information must be accurate and current and must clearly communicate to providers what information is needed						
	Electronic Policy Access Requirements – Matching Information Between an Initial and Supplementary Claim to Submit Additional Diagnoses for a Single Encounter (§4.4.3)						
19	A health plan and its agent is not required to indicate the attendant loops and segments required by the X12 v5010 837 Professional and X12 v5010 837 Institutional to successfully submit the information indicated in §4.2.3 for *Matching Information Between an Initial and Supplementary Claim to Submit*						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	Additional Diagnoses for a Single Encounter.						
CORE Claim Acknowledgment (277CA) Data Content Rule vHC.1.0							
	Association of the X12 v5010 277CA with Its Corresponding Health Care Claim (§4.1.2)						
1	A health plan and its agent must return any data elements from Table 2 of §3.5 that were included in the X12 v5010 837 Professional, X12 v5010 837 Institutional, and X12 v5010 837 Dental submissions from providers along with the X12 v5010 277CA data elements from Table 3 of §3.5 to support association of the X12 v5010 277CA transaction with its corresponding X12 v5010 837 Claim transaction.						
	Alignment of Claim Category Status Codes and Claim Status Codes to Health Care Claim Line Items (Services) (§4.1.3)						
2	A health plan and its agent must receive and process X12 v5010 837 Professional, X12 v5010 837 Institutional, or X12 v5010 837 Dental transactions from providers containing the data content in the loops and segments indicated in Table 4 of §3.5.						
3	A health plan and its agent must return any data elements from Table 4 of §3.5 that were included in the X12 v5010 837 Professional, X12 v5010 837 Institutional, and X12 v5010 837 Dental submissions from providers along with the X12 v5010 277CA data elements from Table 5 of §3.5 to support aligning error codes on a X12 v5010 277CA to line items (services) on its corresponding X12 v5010 837 Claim transaction.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
4	When a health plan and its agent return X12 v5010 277CA transactions with claim-level (2200D-STC) CSCCs and CSCs to providers, they must include the data content in the claim-level loops and segments indicated in Table 3 of §3.5, when the data is submitted on the X12 v5010 837 Claim transaction.						
5	When a health plan and its agent return X12 v5010 277CA transactions with line level (2220D-STC) CSCCs and CSCs to providers, they must include the data content in the line level loops and segments indicated in Table 5 of §3.5, when the data is submitted on the X12 v5010 837 Claim transaction.						
	Uniform Use of Claim Status Category Codes & Claim Status Codes (§4.1.5)						
6	A health plan or its agent must align its internal codes and corresponding business scenarios to the CORE-defined Claim Rejection Business Scenarios specified in §4.1.4 and the CSCC + CSC code combinations specified in the CORE-required Code Combinations for CORE-defined Claim Rejection Business Scenarios.xlsx.						
7	A health plan or its agent must support the maximum CORE-required CSCC + CSC combinations in the X12 v5010 277CA as specified in CORE-required Code Combinations for CORE-defined Claim Rejection Business Scenarios.xlsx.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	Claim Acknowledgment Response Scenarios (§4.1.6)						
8	When a health plan and its agent detect an error related to the unit of work, the most specific CSCC + CSC code combination must be returned in Loop ID 2200B STC segment.						
9	When a health plan and its agent detect an error related to a billing provider's group of claims, the most specific CSCC + CSC code combination must be returned in Loop ID 2200C STC segment.						
10	When a health plan and its agent detect an error related to any other error related to the claim, the most specific CSCC + CSC code combination must be returned in Loop ID 2200D STC segment.						
11	When a health plans and its agent detect an error related to the line item (service), the most specific CSCC + CSC code combination must be returned in Loop ID 2220D STC segment.						
	Detection and Display of 277CA Data Elements (§4.2.2)						
12	The receiver of an X12 v5010 277CA is required to detect and extract all data elements to which the rule applies.						
	Detection and Display of CORE-required Code Combinations for CORE-defined Claim Rejection Business Scenarios (§4.2.2)						
13	When receiving a X12 v5010 277CA, a product extracting the data (e.g., a vendor's provider-facing system or solution) from the X12 v5010 277CA for manual processing must make available to the end user:						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	• Text describing the CSCC + CSC reject error codes included in the transaction, ensuring that the actual wording of the text displayed accurately represents the corresponding code description specified in the code lists without changing the meaning and intent of the description. AND • Text describing the corresponding CORE-defined Claim Rejection Business Scenario.						
CORE Attachments Health Care Claims (837) Infrastructure Rule vHC.1.0							
Infrastructure Rule Requirements for Attachments Using the X12 275 Transaction							
	Processing Mode Requirements (§4.1)						
1	A HIPAA covered health plan and its agent must support the server requirements for Batch Processing mode.						
	Connectivity Requirements (§4.2)						
2	A HIPAA-covered entity and its agent must be able to support the most recent published and CORE adopted version of the CORE Connectivity Rule.						
	System Availability Requirements (§4.3.1)						
3	System availability must be no less than 90 percent per calendar week for both Real Time and Batch Processing Modes.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	Reporting Requirements (§4.3.2)						
4	A HIPAA covered health plan and its agent must publish regularly scheduled downtime, including holidays and method(s).						
5	A HIPAA covered health plan and its agent must publish non-routine downtime notice and method(s).						
6	A HIPAA covered health plan and its agent must publish unscheduled/emergency downtime notice and method(s).						
7	A HIPAA covered health plan and its agent must establish and publish its own holiday schedule.						
	Payload Acknowledgements for X12 275 Attachments (§4.4.1.1)						
8	A HIPAA covered health plan and its agent must return an X12 v5010X231 999 when any Functional Group of an X12 v6020X314 275 Attachment Transaction Set is accepted, accepted with errors, or rejected.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	Batch Mode Response Time Requirements (§4.4.1.3)						
9	Support maximum response time requirement specifying that an X12 v6020X290 999 must be available for pick up by 7:00 am Eastern Time on the second business day following submission when an X12 v6020X314 275 has been submitted by a HIPAA covered provider and its agent in Batch Processing Mode, by 9:00 pm Eastern Time of a business day. Ensure that at least 90 percent of required responses are returned within specified maximum response time as measured within a calendar month.						
	Real Time Response Time Requirement (§4.4.1.3)						
10	Support maximum response time requirement specifying that an X12 v6020X290 999 Response must be received within 20 seconds from the time of submissions of an X12 v6020X314 275 when processing in Real Time Processing Mode. Ensure that at least 90 percent of required responses are returned within specified maximum response time as measured within a calendar month.						
	Basic Requirements for Receivers of Acknowledgements (§4.4.1.5)						
11	The receiver of an X12 v6020X290 999 must • Process any X12 v6020X290 999 within one business day of its receipt, And						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	• Recognize all error conditions that can be specified using all standard acknowledgements named in this rule And • Pass all such error conditions to the end user as appropriate Or • Display to the end user text that uniquely describes the specific error condition(s)						
	Data Error Handling Requirements for Attachments using the X12 275 Transaction (§4.5, §4.5.1)						
12	The receiver of an X12 v6020X314 275 must return an X12 v6020X290 999 to notify providers and their agents (submitter/client) of the acceptance, acceptance with error, or rejection.						
13	If the receiver (server) responds at the Initial Data Content Processing Layer, it must also return an X12 v6020X257 824 to notify providers and their agents (submitter/client) of the acceptance, acceptance with error, or rejection of the X12 v6020X314 275 transaction and the content of the Binary Data Segment (BDS) segment in the X12 v6020X314 275 transaction in addition to the X12 v6020X290 999.						
14	The receiver of an X12 v6020X257 824 transaction must return an X12 v6020X290 999 for each Functional Group of X12 v6020X257 824 transactions to indicate that the that it was either accepted, accepted with errors or rejected.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	File Size Requirements for X12 275 Attachments (§4.6.1, §4.6.2, §4.6.3)						
15	Each HIPAA-covered entity and its agent must be able to accept a minimum 64MB of Base64 encoded data by their front-end servers when the encoded data received is exchanged via the X12 v6020X316 275 transaction.						
16	A HIPAA-covered entity and its agent must be able to accept a *minimum* of 64MB of Base64 encoded data by their front-end servers when the encoded data received is exchanged via the X12 v6020X314 275 transaction.						
17	A HIPAA-covered entity and its agent must be able to accept a *minimum* of 64MB file size document by their internal document management systems used for holding and processing attachments.						
18	The receiver (server) must support the capability to receive multiple LX loops per X12 v6020X314 275 when the submitter (client) chooses to send multiple LX loops for one Health Care Claim submission.						
	Companion Guide Requirements (§4.7)						
19	A guide covering the X12 v6020X314 275 published by a HIPAA covered health plan and its agent must follow the format defined in the CORE Master Companion Guide Template.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	Electronic Policy Access of Required Information (§4.8)						
20	A health plan and its agent must offer a readily accessible electronic method to be determined by health plan and its agent for identifying the attachment-specific data needed to support a claim adjudication request by any trading partner (e.g., a healthcare provider). The information must be accurate and current and must clearly communicate to providers what supporting documentation is needed.						
Infrastructure Rule Requirements for Additional Documentation Using the Non-X12 275 Method							
	Connectivity Requirements using CORE Connectivity (§5.1)						
21	If a HIPAA-covered entity and its agent elect to use CORE Connectivity as their non-X12 method of additional documentation submission, the most recent published and CORE adopted version of the CORE Connectivity Rule must be supported.						
	System Availability and Reporting Requirements for Additional Documentation – Non-X12 Method (§5.2.1.1, §5.2.2.1, §5.2.2.2, §5.2.2.3, §5.2.2.5)						
22	A HIPAA covered health plan and its agent's system availability must be no less than 90 percent per calendar week for both Real Time and Batch Processing Modes.						
23	A HIPAA covered health plan and its agent must publish regularly scheduled system downtime in an appropriate manner.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
24	A HIPAA covered health plan and its agent must publish the schedule of non-routine downtime at least one week in advance.						
25	A HIPAA covered health plan and its agent must provide information within one hour of realizing downtime will be needed in the event of unscheduled/emergency downtime.						
26	A HIPAA covered health plan and its agent must establish and publish its own holiday schedule.						
	File Size Requirements – Non-X12 Method (§5.3, §5.3.1, §5.3.2)						
27	A HIPAA-covered entity and its agent must support the receipt and processing of the minimum file size requirements to ensure attachments can be processed across varying systems.						
28	A HIPAA-covered entity and its agent must be able to accept a *minimum* of 64MB of Base64 encoded data by their front-end servers when the encoded data received is exchanged via a non-X12 method.						
29	A HIPAA-covered entity and its agent must be able to accept a *minimum* of 64MB file size document by their internal document management systems.						
	Electronic Policy Access of Required Information (§5.4)						
30	A health plan and its agent must offer an electronic method to be determined by health plan and its agent for identifying the attachment-specific data needed to support a claim adjudication request by any trading partner (e.g., a healthcare provider).						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
CORE Attachments Health Care Claims Data Content Rule vHC.1.0							
Data Content Rule Requirements for Attachments using the X12 275 Transaction							
	Requirements to Support Reassociation (§4.1.1)						
1	PWK02 Code EL in Loop 2300/ Loop 2400 in the X12 v5010 837 Health Care Claim must be used to notify a HIPAA-covered health plan and its agent that additional documentation is being transmitted electronically using the Binary Data Segment (BDS) in X12 v6020X314 275 when a HIPAA-covered provider and its agent send an unsolicited X12 v6020X314 275 in support of an X12 v5010 837 Health Care Claim submission.						
Data Content Rule Requirements for Attachments using the Non-X12 Method							
	Requirements to Support Reassociation (§5.1.1)						
2	HIPAA-covered providers and their agents using the most recent version of CORE Connectivity to transmit a non-X12 payload must follow the appropriate header requirements to notify health plans and their agents that additional documentation is being transmitted electronically.						

Rule Req. #	**CORE Operating Rule Requirement**	**System/Process Impacted** *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	**System/ Process Currently Meets the Requirement** *(Yes/No)*	**Gap** *(Briefly describe gap)*	**Estimated System/ Process Remediation Effort** *(Required number, type of skilled resource, person hours required)*	**Business Processes Impacted** *(Briefly describe)*	**Business Processes/ Documentation Revisions Required & Effort Estimates**
3	A provider and its agent must include all available Attachment Data Elements as part of the attachment payload when sending additional information. Table 1. Attachment Data Elements for Reassociation using Non-X12 Attachment Methods identifies the data elements necessary for successful reassociation of the non-X12 attachment payload and the X12 v5010 837 Claim Submission.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
CORE SOAP Connectivity Rule vC4.0.0							
	Message Envelope Requirement (§4.1)						
1	Requires the use of SOAP+WSDL.						
	Submitter Authentication Requirement (§4.1.1)						
2	Requires the use of X.509 Client Authentication (mutual authentication) over TLS 1.2 or higher.						
	Submitter Authorization Requirements (§4.1.2)						
3	Requires support for OAuth 2.0 Client Authorization over TLS 1.2 or higher.						
	Real Time and Batch Payload Attachment Handling (§4.1.4)						
4	Payload must be sent as an MTOM encapsulated object.						
	Required Transport Method (§4.2.1)						
5	HIPAA-covered entities or their agents must implement HTTP/S Version 1.1 over the public Internet.						
6	Receivers must perform the role of an HTTP/S server; Senders must perform the role of an HTTP/S client.						
7	All information exchanged between the client and server is encrypted by a session-level private key negotiated at connection time.						

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	Real Time Requests (§4.2.3)						
8	Real Time requests must include a single inquiry or submission as specified in the transaction's corresponding CORE Infrastructure Rule.						
	Batch Submission (§4.2.4)						
9	Batch requests are sent in the same way as Real Time requests.						
10	Response must be only the standard HTTP message indicating whether the request was accepted or rejected.						
11	Message receivers must not respond to a batch submission with an X12 response such as a 5010 X12 999 in the HTTP response to the batch request, even if their systems' capabilities allow such a response.						
12	All X12 responses must be available for pick up by the message sender (client) in accordance with the respective CORE Infrastructure Rule for the transaction.						
	Batch Response Pickup (§4.2.5)						
13	Batch responses must be picked up after the message receiver has had a chance to process a Batch submission in the timeframes specified in the transaction's corresponding CORE Infrastructure Rule.						
	Error Handling (§4.2.6)						
14	The appropriate HTTP error or status codes and SOAP Faults as applicable to the error/status situation must be used.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	Tracking of Date and Time and Payload ID (§4.2.8)						
15	Servers are required to track the times of any received inbound messages, and respond with the outbound message for that Payload ID.						
16	Clients must include the date and time the message was sent in the CORE metadata element Time Stamp.						
	Capacity Plan (§4.2.9.1, §4.2.9.2)						
17	A HIPAA-covered entity or its agent's messaging system must have a capacity plan such that it can receive and process a large number of single concurrent Real Time transactions via an equivalent number of concurrent connections which must be received, processed and the appropriate response provided within response time requirements specified in the transaction's corresponding CORE Operating Rule.						
18	A HIPAA-covered entity or its agent's messaging system must have the capability to receive and process large Batch transaction files which must be received, processed and the appropriate response provided within the time specified in the applicable CORE Operating Rule.						
	Response Time, Time Out Parameters, and Re-transmission (§4.2.10)						
19	If the HTTP Post Reply Message is not received within the 60 second response period, the client system should send a duplicate transaction no sooner than 90 seconds after the original attempt was sent.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
20	Client system should submit no more than 5 duplicate transactions within the next 15 minutes if no response is received after the second attempt.						
21	If the additional attempts result in the same timeout termination, the client system should notify the submitter to contact the receiver directly to determine if system availability problems exist or if there are known Internet traffic constraints causing the delay.						
	Publication of Entity-Specific Connectivity Companion Document (§4.3)						
22	Servers must publish detailed specifications in a Connectivity Companion Document on the entity's public web site.						
	Envelope Metadata (§4.4.2)						
23	The Envelope Metadata specified in Table 4.4.2 pertains to the Message Envelope SOAP+WSDL. With the exception of *ErrorCode* and *ErrorMessage* fields, which are only sent in the response, the CORE required envelope metadata for the request and response are required to be identical.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	Processing Mode (§4.4.3.1)						
24	A HIPAA-covered entity or its agent must support the transaction processing mode requirements specified in the *COREProcessingModePayloadTypeTables.docx* companion document when exchanging transactions in conformance with this CORE Connectivity Rule vC4.0.0.						
25	The Processing Mode requirements specified also apply when a HIPAA-covered entity or its agent are exchanging the transactions addressed by this rule using any other connectivity method as permitted by the CORE Safe Harbor.						
	Enumeration of Payload Type Fields (§4.4.3.2)						
26	A HIPAA-covered entity or its agent must support the requirements for identifying the payload (*PayloadType)* carried within the content of the Message Envelope as specified in the *COREProcessingModePayloadTypeTables.docx* companion document to this CORE Connectivity Rule v4.0.0.						
CORE REST Connectivity Rule vC4.0.0							
	API Interface Format Requirement (§5.1.1)						
1	HIPAA-covered entities and their agent must use Java script Object Notation (JSON) for REST Interfaces.						

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	Authentication Requirement (§5.1.2)						
2	Requires the use of X.509 Client Authentication (mutual authentication) over TLS 1.2 or higher.						
	Submitter Authorization Requirements (§4.1.2)						
3	Requires support for OAuth 2.0 Client Authorization over TLS 1.2 or higher.						
	Transport Method (§5.2.1)						
4	HIPAA-covered entities and their agents must be able to implement HTTP/S Version 1.1 over the public internet.						
	Request and Response Handling (§5.2.2)						
5	Request and response handling for both Synchronous Real-time and Asynchronous Batch Process.						
	Error Handling (§5.2.6)						
6	Message receiver must notify the message sender if the request was successfully handled during the processing of HTTP headers and processing of the payload.						
	Tracking of Date and Time and Payload (§5.2.8)						
7	Servers are required to track the times of any received inbound messages and respond with the outbound message for that Payload.						
8	Clients must include the date and time the message was last modified.						

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	Capacity Plan (§5.2.9., §5.2.11)						
9	A HIPAA-covered entity or its agent's messaging system must have a capacity plan such that it can receive and process a large number of single concurrent Synchronous Real Time transactions via an equivalent number of concurrent connections which must be received, processed and the appropriate response provided within response time requirements specified in the transaction's corresponding CORE Operating Rule.						
10	A HIPAA-covered entity or its agent's messaging system must have the capability to receive and process large Batch transaction files which must be received, processed and the appropriate response provided within the time specified in the applicable CORE Operating Rule.						
	Specifications for REST API Uniform Resource Identifiers (URI) Paths (§5.3.1, §5.3.2)						
11	Servers are required to communicate the version of the CORE Connectivity Rule implemented and version of the REST API through the URI Path, per Table 5.3.1.						
12	Requires entities to use standard naming conventions for REST API endpoints to streamline and support uniform REST implementations.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	REST HTTP Request Method Requirements (§5.4)						
13	Entities are required to use the metadata specified in Table 5.5 for HTTP Requests and HTTP Responses for REST Exchanges.						
	Publication of Entity-Specific Connectivity Companion Document (§5.7)						
14	Servers must publish detailed specifications in a Connectivity Companion Document on the entity's website.						