Phase I CORE Certification Test Suite

Version 1.1.0

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1 INTRODUCTION TO CORE PHASE I CERTIFICATION TEST SUITE

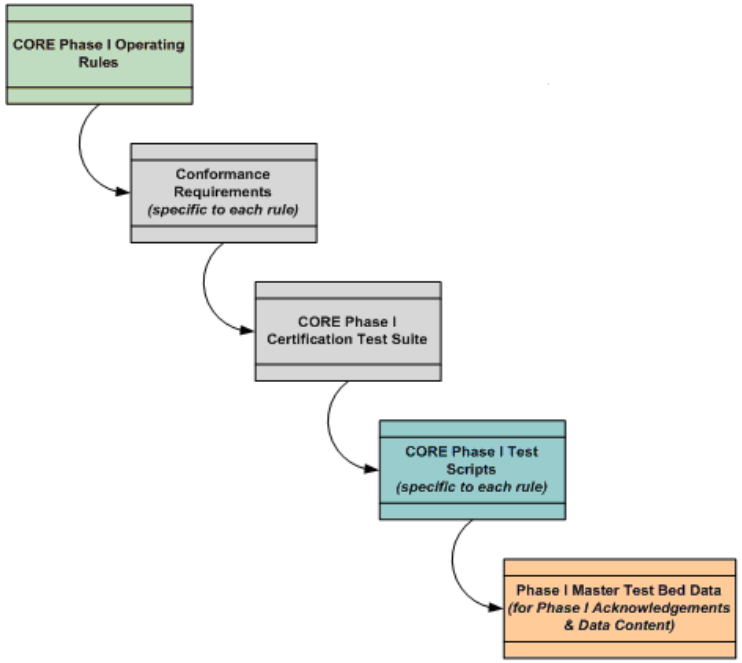
1.1 Purpose of This Document

This CORE Certification Test Suite document contains all of the requirements that must be met in order for an entity seeking CORE Phase I Certification to be awarded a CORE Certified Seal. As such, this test suite includes two Master Scenarios describing the end-to-end eligibility information exchange process in non-technical language (see §1.2). This Test Suite also specifies in detail the specific conformance requirements and detailed testing for each CORE rule (see §1.3, §1.4 and §3). This CORE Certification Test Suite includes all of the required Certification Testing for each CORE Phase I Rule, including specific detailed step-by-step test scripts by rule. (See §1.5 and §3 for each rule-specific testing requirements.)

Additional guidance to help stakeholders better understand the various types of stakeholders to which the CORE rules apply and how to determine when a specific rule detailed test script applies is also included (see §1.4).

Lastly, the Appendix contains the detailed Test Suite Supplement (see §4.1), which provides information and guidance about the CORE Phase I Master Test Bed Data, how the test data is made available, as well as loading and using the Master Test Bed Data. The Test Suite Supplement also includes specific instructions for certain test bed data elements that may be modified when loading and using the test data for certification testing.

The figure below depicts the high-level parts of the testing process.



1.2 Applicability of This Document

The CORE Phase I Certification Test Suite must be used by all stakeholders undergoing CORE Phase I Certification Testing. This is required in order to maintain standard and consistent test results and CORE Phase I rule compliance. There are no exceptions to this requirement.

1.3 The Master Scenarios

The CORE Phase I Certification Test Suite uses two Master Scenarios (§2) to describe both the real time and batch business processes for end-to-end insurance verification/eligibility inquiries using business language, not technical specifications to the extent appropriate.

Master Scenario #1: Single/Dual Clearinghouse Provider-to-Health Plan Model

Master Scenario #2: Provider Direct to Health Plan Model

The overall business process for insurance verification/eligibility inquiry does not change from a business viewpoint for each CORE Phase I rule. Rather, each CORE Phase I rule addresses a critical interoperability activity/task within the common business process.

Using only two Master Scenarios for all rules simplifies rule test scenario development since the key variables for each rule will be only the actual conformance language of the rule, each test scenario's test objectives, assumptions, and detailed step-by-step test scripts.

1.4 Structure of Test Scenarios for all Rules

Each test scenario for each rule contains the following sections:

- Key Rule Requirements (the CORE Phase I Rules document contains the actual rule language and is the final authority for all rule requirements)
- Certification conformance requirements by rule
- Test assumptions by rule
- Detailed step-by-step test scripts addressing each conformance requirement by rule for each stakeholder to which the test script applies
- Each stakeholder may indicate that a specific test script does not apply to it and is required to provide a rationale for indicating a specific test script is not applicable (See §1.5.1 for guidance in determining when a specific test script may not apply.)

1.5 Detailed Step-by-Step Test Scripts

1.5.1 Stakeholder Categories −Determining Test Script Applicability

The Detailed Step-by-Step Test Scripts for each rule specify which stakeholder type each test script applies to. The stakeholder categories are Provider, Health Plan, Clearinghouse, and Vendor.

Oftentimes Providers and Health Plans outsource various functions to Clearinghouses. In such cases, a specific Clearinghouse may be acting on behalf of either a Provider stakeholder or a Health Plan stakeholder. Thus, when establishing a testing profile with a CORE-authorized Certification Test Vendor a Clearinghouse may be asked to indicate if it is a Provider/Clearinghouse or a Health Plan/Clearinghouse. When a Provider/Clearinghouse role is selected, the Detailed Step-by-Step Test Scripts applicable to a Provider will apply to a Provider/Clearinghouse. Similarly, when a Health Plan/Clearinghouse role is selected, the Detailed Step-by-Step Test Scripts applicable to a Health Plan will apply to a Health Plan/Clearinghouse.

Vendor stakeholders must certify each specific product separately. (See Guiding Principles and Section 2 of the CORE 102 Eligibility and Benefits Certification Policy version 1.1.0.) Thus, when establishing a testing profile with a CORE-authorized Certification Testing Vendor a vendor stakeholder will be given the option to indicate if the product being certified is a Provider/Vendor product or a Health Plan/Vendor product. The Detailed Step-by-Step Test Scripts applicable to a Provider will apply to a Provider/Vendor product. Similarly, when a vendor stakeholder is certifying a Health Plan product, the Detailed Step-by-Step Test Scripts applicable to a Health Plan will apply to a Health Plan/Vendor product.

1.5.2 Guidance for Health Plans Seeking CORE Phase I Certification Who Work With a CORE Phase I Certified Clearinghouse[1]

Health plans seeking CORE Phase I certification that use a clearinghouse to send back eligibility responses to providers, and to receive eligibility inquiries from providers, may have some unique CORE-certification circumstances. Because there is a clearinghouse, or similar type of intermediary, between the health plan's eligibility system and the provider's eligibility system, the clearinghouse will act as a "proxy" for some of the CORE-certification requirements outlined in the CORE Phase I Test Suite. Therefore, dependent upon the scenario between the health plan and clearinghouse, the health plan may not have to undergo certification testing for some aspects of the rules, but rather choose the N/A option for each applicable test script. A rationale statement explaining the situation to the CORE-authorized testing vendor will be required to be uploaded for each test script for which the N/A option is chosen.

Reminder: There exist varying scenarios, outlined below for this type of situation. The requirements for meeting the CORE rule requirements for clearinghouses and health plans differ by situation, as such variability is dependent on how the health plan interacts with the clearinghouse and what services (i.e., functions and capabilities) the clearinghouse provides to the health plan. Therefore, please keep in mind that certification testing will differ by scenario.

1.5.2.1 Clearinghouse receives and returns non-standard data with the health plan

Clearinghouse is responsible for meeting the CORE requirements, except for data content rule, which the health plan system must meet.

1.5.2.2 Clearinghouse receives and returns 270/271 with health plans

Health plan is responsible for meeting the CORE requirements for all applicable rules. However, the clearinghouse may satisfy some requirements for response time and acknowledgements for some health plans, while other health plans will have complete systems capabilities for all CORE rules, and therefore will have to meet more rule requirements.

1.5.2.3 Clearinghouse provides eligibility query/response functions via an ASP (application services health plan)

Clearinghouse is responsible for meeting the CORE requirements for all CORE rules on behalf of the health plan.

The following is an overview of the CORE Phase I operating rules as they relate to this situation.

1.5.2.3.1 Rule 150 Batch Acknowledgements

For those health plans sending batch v5010 271 transactions through a clearinghouse, the clearinghouse and the health plan will mutually agree on the use of the ~~TA1 and 997~~ v5010 999. The clearinghouse may be responsible for meeting the specific CORE Rule 150 requirements for batch acknowledgements.[2]

1.5.2.3.2 Rule 151 Real Time Acknowledgements

For those health plans sending real time v5010 271 transactions through a clearinghouse, the clearinghouse and the health plan will mutually agree on the use of the ~~TA1 and 997~~ v5010 999. The clearinghouse may be responsible for meeting the specific CORE Rule 151 requirements for real time acknowledgements.[3]

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[1] There exist varying scenarios for this situation, outlined in §1.2.2.1 through §1.2.2.3. The requirements for meeting the CORE rule requirements for clearinghouses and health plans differ by situation, as such variability is dependent on how the health plan interacts with the clearinghouse and what services (i.e., functions and capabilities) the clearinghouse provides to the health plan. Therefore, please keep in mind that certification testing will differ by scenario.

[2] Please see reminder.

1.5.2.3.3 Rule 152 Companion Guide Rule

If the health plan has published a companion guide, the health plan will be responsible for meeting the CORE Rule 152 requirements for companion guides.

1.5.2.3.4 Rule 153 Connectivity Rule

For those health plans sending v5010 271 transactions through a clearinghouse, the clearinghouse and the health plan group will mutually agree upon the protocol to be used for communications between the health plan group and the clearinghouse. While it is possible that the agreed upon protocol may be HTTP/S, it also is permitted by the CORE rule that some other method for communication maybe used (as long as HTTP/S is offered as an option). The clearinghouse will be responsible for meeting the specific CORE Rule 153 requirements for communications. These requirements will be met through the communications between the clearinghouse and its payer trading partners.

1.5.2.3.5 Rule 154 Data Content Rule

Health plans wishing to be CORE Phase I certified must work with their HIS vendor and their clearinghouse to validate that they can meet all of the data content rules. The health plan's eligibility system must be able to send responses that meet the v5010 271 data content requirements.

1.5.2.3.6 Rule 155 Batch Response Time Rule

For those health plans sending batch v5010 271 transactions through a clearinghouse, the clearinghouse may be responsible for meeting the specific CORE Rule 155 requirements for batch response time.[4]

1.5.2.3.7 Rule 156 Real Time Response Time Rule

For those health plans sending real time v5010 271 transactions through a clearinghouse, the clearinghouse may be responsible for meeting the specific CORE Rule 156 requirements for real time response time.[5]

1.5.2.3.8 Rule 157 System Availability Rule

The System Availability Rule applies only to health plans (or information sources), so health plans are required to meet all certification requirements for this rule.

1.5.3 Guidance for Providers Seeking CORE Phase I Certification Who Work With a CORE Phase I Certified Clearinghouse[6]

Provider organizations seeking CORE Phase I certification that use a clearinghouse to send eligibility requests to payers, and to receive eligibility responses from payers, may have some unique CORE-certification issues. Because there is a clearinghouse, or similar type of intermediary, between the provider's eligibility system and the payer's eligibility system, the clearinghouse will act as a "proxy" for some of the CORE-certification requirements outlined in the CORE Phase I Test Suite. Therefore, dependent upon the scenario between the provider and clearinghouse, the provider may not have to undergo certification testing for some aspects of the rules, but rather

[3] Please see reminder.

[4] Please see reminder.

[5] Please see reminder.

[6] There exist varying scenarios for this situation, outlined §1.2.2.5 through §1.2.2.7. The requirements for meeting the CORE rule requirements for clearinghouses and health plans differ by situation, as such variability is dependent on how the health plan interacts with the clearinghouse and what services (i.e., functions and capabilities) the clearinghouse provides to the health plan. Therefore, please keep in mind that certification testing will differ by scenario.

choose the N/A option for each applicable test script. A rationale statement explaining the situation to the CORE-authorized testing vendor will be required to be uploaded for each test script for which the N/A option is chosen.

Reminder: *There exist varying scenarios, outlined below for this type of situation. The requirements for meeting the CORE rule requirements for clearinghouses and providers differ by situation, as such variability is dependent on how the provider interacts with the clearinghouse and what services (i.e., functions and capabilities) the clearinghouse provides to the provider. Therefore, please keep in mind that certification testing will differ by scenario.*

1.5.3.1 Clearinghouse receives and returns non-standard data with the provider

Clearinghouse is responsible for meeting the CORE requirements, except for data content rule, which the provider system must meet.

1.5.3.2 Clearinghouse receives and returns v5010 270/271 with providers

Provider is responsible for meeting the CORE requirements for all applicable rules. However, the clearinghouse may satisfy some requirements for response time and acknowledgements for some providers, while other providers will have complete systems capabilities for all CORE rules, and therefore will have to meet more rule requirements.

1.5.3.3 Clearinghouse provides eligibility query/response functions via an ASP (application services provider)

Clearinghouse is responsible for meeting the CORE requirements for all CORE rules on behalf of the provider.

The following is an overview of the CORE Phase I operating rules as they relate to this situation.

1.5.3.3.1 Rule 150 Batch Acknowledgements

For those provider organizations sending batch v5010 270 transactions through a clearinghouse, the clearinghouse and the provider will mutually agree on the use of the ~~TA1 and 997~~ v5010 999. The clearinghouse may be responsible for meeting the specific CORE Rule 150 requirements for batch acknowledgements.[7]

[7] Please see reminder.

1.5.3.3.2 Rule 151 Real Time Acknowledgements

For those provider organizations sending real time v5010 270 transactions through a clearinghouse, the clearinghouse and the provider will mutually agree on the use of the ~~TA1 and 997~~ v5010 999. The clearinghouse may be responsible for meeting the specific CORE Rule 151 requirements for real time acknowledgements.[8]

1.5.3.3.3 Rule 152 Companion Guide Rule

If the provider organization has published a companion guide, the provider organization will be responsible for meeting the CORE Rule 152 requirements for companion guides.

1.5.3.3.4 Rule 153 Connectivity Rule

For those provider organizations sending v5010 270 transactions through a clearinghouse, the clearinghouse and the provider group will mutually agree upon the protocol to be used for communications between the provider group and the clearinghouse. While it is possible that the agreed upon protocol may be HTTP/S, it also is permitted by the CORE rule that some other method for communication maybe used (as long as HTTP/S is offered as an option). Typically, the communication protocol used by a provider will be dictated by the vendor of the HIS or PMS that the provider group uses. The clearinghouse will be responsible for meeting the specific CORE Rule 153 requirements for communications. These requirements will be met through the communications between the clearinghouse and its payer trading partners.

1.5.3.3.5 Rule 154 Data Content Rule

Provider groups wishing to be CORE Phase I certified must work with their HIS/PMS vendor and their clearinghouse to validate that they can meet all of the data content rules. The provider's HIS/PMS must be able to send requests that meet the v5010 270 data content requirements and must be able to accept and display to the user all v5010 271 data elements identified in the CORE Rule 154 Data Content rule.

1.5.3.3.6 Rule 155 Batch Response Time Rule

For those provider organizations sending batch v5010 270 transactions through a clearinghouse, the clearinghouse may be responsible for meeting the specific CORE Rule 155 requirements for batch response time.[9]

1.5.3.3.7 Rule 156 Real Time Response Time Rule

For those provider organizations sending real time v5010 270 transactions through a clearinghouse, the clearinghouse may be responsible for meeting the specific CORE Rule 156 requirements for real time response time.[10]

1.5.3.3.8 Rule 157 System Availability Rule

The System Availability Rule applies only to health plans (and information sources), so providers are exempt from meeting certification requirements for this rule.

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[8] Please see reminder.

[9] Please see reminder.

[10] Please see reminder.

1.6 Test Suite Supplement

The CORE Phase I Test Suite Supplement (see Appendix) provides additional information and details about the use and format of the CORE Phase I Master Test Bed Data, as it applies to the CORE 154: 270/271 Data Content and CORE 150 Batch Acknowledgements and 151 Real Time Acknowledgements Rules. The supplement is to be used in conjunction with the CORE-Certification Test Suite version 1.1.0. It does not replace any of the CORE Phase I Policies and Rules but rather is intended to provide additional information and details regarding the use and format of the CORE Phase I Master Test Bed Data. Note: The CORE Phase I Master Test Bed Data only applies to the CORE 154: 270/271 Data Content and CORE 150 and 151 Acknowledgements Rules; the other CORE Phase I rules do not require the use of the test data.

1.6.1 Master Test Bed

The scope of the CORE Phase I Master Test Bed Data is limited to data needed for entities seeking to become CORE-certified to create and populate their internal files and/or databases. These files and data are then used for internal pre-certification testing and CORE Phase I certification testing for the CORE rules that require transaction-based testing, e.g. CORE Phase I Rules:

- 154: 270/271 Data Content
- 150 and 151 Acknowledgements Rules.

Thus, CORE-authorized certification testing vendors only use the CORE Phase I Master Test Bed Data to conduct CORE certification testing for the CORE 154: 270/271 Data Content and CORE 150 and 151 Acknowledgements Rules. The scope of the test bed data is not intended to include all data that an entity may require in order to load their internal systems. Therefore, entities may need to add other data to the master test data when loading internal systems.

Since the CORE Phase I rules do not address the specific use and data content of the ISA and GS control segments, the CORE Phase I Master Test Bed Data does not contain nor specify specific values that must be used in these control segments.

Thus, CORE-authorized certification testing vendors will be using only the CORE Phase I Master Test Bed Data to conduct CORE certification testing for the CORE 154: 270/271 Data Content and CORE 150 and 151 Acknowledgements Rules.

The CORE Phase I Master Test Bed Data accompanies this Test Suite.

- All entities seeking CORE Phase I certification will be required to test against this Master Test Bed Data.
- This data will be made available to all entities seeking CORE-certification for use of pre-certification internal self-testing.
- The Phase I Test Suite Supplement (see Appendix) should be used in accompaniment with the Phase I Master Test Bed Data.

1.6.1.1 Master Test Bed Data

The Master Test Bed Data is applicable only to the CORE 150 and 151 Acknowledgement Rules and the CORE 154: 270/271 Data Content Rule; however, all CORE Certification Testing related to these two rules will be conducted using the same CORE Phase I Master Test Bed Data, thus ensuring reliable and consistent test results for all CORE-authorized certification testing entities.

The CORE Phase I Master Test Bed Data is comprised of beneficiaries (subscribers/dependents) and their associated health plan coverage. The Test Suite Supplement provides guidance about the Master Test Bed Data. The CORE Phase I Master Test Bed Data is supplied only in an Excel spreadsheet format in a separate Excel

Workbook. Although CORE-certification testing will use this CORE Phase I Master Test Bed Data as presented in the Excel spreadsheet format, the types of transactions that will be tested against this data are specified in the CORE Phase I Test Suite under the Test Scripts for each of the rules.

The CORE Phase I Certification Test Suite requires that all organizations seeking CORE Phase I certification be tested using the same Master Test Bed Data. The CORE Phase I Master Test Bed Data is distributed in Excel spreadsheet format so that organizations may easily extract the key data elements and load them into their internal test databases. The CORE-Authorized Certification Testing Vendors will only use the CORE Phase I Master Test Bed Data to conduct CORE certification testing for the CORE 154: 270/271 Data Content and CORE 150 Batch Acknowledgements and 151 Real Time Acknowledgements Rules. Not all test beneficiaries (subscribers/dependents) and their associated health plans are utilized in Phase I testing. The Excel document containing the CORE Phase I Master Test Bed Data is available for download at the CAQH/CORE website (www.caqh.org/CORE_phase1.php).

2 MASTER TEST SCENARIOS

2.1 Single/Dual Clearinghouse Provider-to-Health Plan Business Model

2.1.1 Introduction

This Master CORE Business Process Scenario describes both the real time and batch business processes for end-to-end insurance verification/eligibility inquiries using business language, not technical specifications to the extent appropriate, in which there are either one or two clearinghouses providing services to the healthcare provider and health plan or information source. Since the overall business process for insurance verification/eligibility inquiry does not fundamentally change from a business viewpoint, each CORE rule addresses a critical interoperability activity/task within the common business process. Thus, the focus for this scenario is on the EDI aspects of the overall end-to-end business process and not on attempting to describe all of the activities and tasks typically performed by each of the stakeholders in the process.

2.1.2 Background

This scenario describes the healthcare insurance verification/eligibility end-to-end business process and the key activities and tasks conducted between a healthcare provider where each party uses the services of a healthcare clearinghouse. For purposes of CORE Certification Testing, stakeholders include providers, health plans, clearinghouses, switches, other intermediaries, and solution vendors.

Each stakeholder type is equipped with an automated system (the "system") appropriate to its needs, e.g., a provider would have a hospital (or health) information system, commonly referred to as an HIS, or an automated practice management system (the "system"), commonly referred to as a PMS.

The "system" is defined as all of the components necessary for the stakeholder to conduct its automated business processes, e.g., all necessary network nodes, all platform components delivered by the vendor, and all the vendor components (e.g. documentation) included with the system. The system may consist of one or many workstations, servers and mainframe systems, and may include capture patient registration information at the point of patient intake (or scheduling) at the workstation if the stakeholder is a provider.

2.1.3 Eligibility Business Process Description

2.1.3.1 Appointment Scheduling Process

An appointment scheduler at the provider's office is scheduling an appointment for either an office visit or admission (depending on the type of provider) for a patient in 2 weeks while on the phone with the patient. The scheduler inquires about the reason for the appointment, collects data from the patient following prompts on the workstation and enters all of the necessary information into the PMS/HIS.

When all of the necessary patient demographic and insurance information is entered, the scheduler is prompted to submit an insurance verification transaction by either a menu selection or by clicking an icon (as determined by the PMS/HIS vendor user interface design.)

The PMS/HIS automatically edits the eligibility transaction for completeness and valid data values where applicable and prompts the scheduler to correct any invalid or omitted data. When the transaction editing is completed, the PMS/HIS assigns a unique internal tracking number, records the identification and address of the workstation used by the scheduler, and creates the eligibility inquiry transaction.

Using internal tables/files, the PMS/HIS determines the Internet address for its clearinghouse, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the eligibility inquiry transaction, and establishes a communications session with the clearinghouse's system. The eligibility inquiry transaction created by the PMS/HIS for transfer to its clearinghouse/switch may be either in a proprietary format or a fully enveloped ASC X12 Interchange containing the 270 Eligibility inquiry transaction set.

2.1.3.2 Provider Clearinghouse Real Time Eligibility Inquiry Process

The clearinghouse's Internet portal accepts the provider's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the eligibility inquiry transaction, which is then extracted and passed to the appropriate systems in the clearinghouse for further processing. The clearinghouse's system edits the eligibility transaction for completeness and valid data values where applicable. If the eligibility transaction fails editing, the clearinghouse returns to the provider an appropriate error message or acknowledgement describing the reasons for failure and rejection, thereby allowing the provider to correct and re-submit the eligibility transaction. Such error message or acknowledgement may be either a proprietary or valid ASC X12 Acknowledgement, depending on the type and range of services the clearinghouse is providing.

Using internal tables/files and/or an external directory service, the clearinghouse system determines the Internet address for the clearinghouse serving the health plan specified in the provider's eligibility inquiry transaction, creates and envelopes the complete ASC X12 Interchange containing the 270 inquiry, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the ASC X12/270 Interchange, and establishes a communications session with the health plan's clearinghouse. Depending on the range and type of services being provided to the provider by the clearinghouse, the clearinghouse may or may not have responsibility for creating the correct ASC X12 Interchange containing the 270 Eligibility inquiry or for performing other data validation/transformation and/or editing functions prior to forwarding the eligibility inquiry to either the health plan or the health plan's clearinghouse. Upon successful transfer of the ASC X12/270 Interchange to the health plan's clearinghouse, the provider's clearinghouse maintains the communications session open and active until receipt of either a ASC X12/999 ~~X12/TA1, X12/997~~ or ASC X12/271 Interchange from the health plan's clearinghouse.[11]

If the ASC X12/270 Interchange fails the ~~technical~~ ASC X12 TR3 implementation guide ~~syntax~~ verification at the health plan's clearinghouse, the provider's clearinghouse receives the 999 Implementation Acknowledgement ~~TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate)~~ indicating the acceptance or rejection of the ~~Interchange or~~ Functional Group, extracts/reformats the ~~rejection~~ acknowledgement and takes appropriate action to resolve the any errors indicated or the rejection. This may be by returning it to the provider's PMS/HIS or correcting the errors within the clearinghouse.

[11] Alternatively, a single clearinghouse may be serving both the provider and the health plan to which the eligibility inquiry transaction is to be transmitted. In this case, the single clearinghouse would not only perform the reformatting of non-standard data and non-standard format received from the provider into the HIPAA-required standard, but would then perform the reformatting of the standard data and standard format into non-standard data and non-standard format required by the health plan. A similar set of functions would be performed when processing the eligibility response transaction received from the health plan. See Health Plan Clearinghouse Real Time Eligibility Inquiry Process section in this document for a complete description of this process.

When the ASC X12/271 eligibility response transaction is received from the health plan's clearinghouse, the clearinghouse's Internet portal records the message receipt date/time, assigns an internal tracking number to the message linked to the ASC X12/271 Interchange, returns a signal to the health plan's clearinghouse that the ASC X12/271 Interchange payload has been successfully stored into persistent storage, and passes the ASC X12/271 Interchange to the clearinghouse's EDI management system for further processing. The clearinghouse's EDI management system processes (validates) the ASC X12/271 Interchange which may contain either a 271 with AAA Validation Request rejection/error codes or a 271 with the requested benefit data. The EDI management system extracts the 271 response data, creates the required eligibility response transaction required by the provider's PMS/HIS (may be either a proprietary or valid ASC X12/271 Interchange), and transfers the eligibility response transaction to the provider's PMS/HIS.

2.1.3.3 Health Plan Clearinghouse Real Time Eligibility Inquiry Process

The health plan's clearinghouse Internet portal accepts the provider's clearinghouse's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the ASC X12/270 Interchange, returns a signal to the provider's clearinghouse that the ASC X12/270 Interchange payload has been successfully stored into persistent storage, and passes the ASC X12/270 Interchange to the clearinghouse's EDI management system for further processing. The clearinghouse's EDI management system, processes (validates) the ASC X12/270 Interchange.

If the ASC X12/270 Interchange passes ~~technical~~ ASC X12 TR3 implementation guide ~~syntax~~ verification, the EDI management system extracts the eligibility inquiry data from the 270 transaction set, creates the required internal eligibility inquiry transaction required by the health plan. Using internal tables/files and/or an external directory service, the clearinghouse system determines the Internet address for the health plan specified in the provider's eligibility inquiry transaction, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the eligibility inquiry transaction, and establishes a communications session with the health plan if such a communications link is not already open and active. Upon successful transfer of the eligibility inquiry transaction to the health plan, the clearinghouse maintains the communication session open and active pending receipt of the eligibility response transaction from the health plan.

If the ASC X12/270 Interchange fails ~~technical~~ ASC X12 TR3 implementation guide ~~syntax~~ verification, the EDI management system automatically generates the 999 Implementation Acknowledgement ~~TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate)~~ indicating the acceptance or rejection of the ~~Interchange or~~ Functional Group, returns the acceptance or rejection acknowledgement to the provider's clearinghouse, terminates the communications session (if necessary) and discontinues any further processing of the inquiry transaction.

When the eligibility response transaction is received from the health plan, the clearinghouse's EDI management system edits the eligibility response data for correctness and completeness, creates the ASC X12 Interchange containing the 271 eligibility response, passes the ASC X12/271 Interchange to the open communications session which returns the ASC X12/271 Interchange to the provider's clearinghouse. The ASC X12/271 Interchange may contain either a 271 with AAA Validation Request rejection/error codes or a 271 with the requested benefit data.

2.1.3.4 Health Plan Real Time Eligibility Inquiry Process

The health plan's Internet portal accepts the clearinghouse's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the eligibility inquiry transaction, which is then extracted and passed to the health plan's eligibility inquiry system for processing. The eligibility system accesses all of the necessary internal data stores (files, databases, etc.) to process the eligibility inquiry transaction to determine the benefits and status of coverage for the individual identified in the inquiry. The data is then assembled and routed to the health plan's clearinghouse. When the clearinghouse signals successful receipt of the eligibility response transaction to the health plan's system, the communications session may be terminated or maintained open and active as determined between the health plan and its clearinghouse.

2.1.3.5 Provider Real Time Eligibility Response Process

The provider's PMS/HIS receives the eligibility response transaction from its clearinghouse, records the message receipt date/time, assigns an internal tracking number to the message linked to the eligibility response transaction, and matches the tracking number, message receipt date/time to the corresponding eligibility inquiry transaction. The PMS/HIS then processes (validates) the eligibility response transaction, which is routed to the correct workstation for display to the scheduler.

If the eligibility response transaction indicates the inquiry was rejected, the PMS/HIS displays the reasons for such rejection, enabling the scheduler to resolve the rejection by obtaining corrected data as indicated from the patient during the initial appointment/admission scheduling phone call. The PMS/HIS then resubmits the corrected eligibility inquiry.

If the eligibility response transaction contains the requested benefit coverage, benefit status, and patient financial responsibility information, the PMS/HIS displays the benefit information, enabling the scheduler to confirm the benefit coverage and status with the patient and to inform the patient of any co-pay, co-insurance, or deductible amounts during the initial appointment/admission scheduling phone call.

The provider's scheduler then confirms the date and time of the appointment/admission with the patient, reminds the patient of any information required at the time of the appointment/admission and concludes the phone call with the patient.

2.1.3.6 Provider Pre-Appointment Batch Eligibility Process

On a daily basis the provider's PMS/HIS automatically scans all scheduled appointments/admissions for two days in advance of the current date, extracts all of the necessary data, creates one or more batches of eligibility inquiries for each health plan covering the patient appointments/admissions for that date, assigns unique internal tracking numbers and records the date/time for each batch.

Using internal tables/files and/or an external directory service, the PMS/HIS determines the Internet address for each health plan, envelopes the complete ASC X12 Interchange containing the batch of v5010 270 inquiries for each health plan, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the correct batch ASC X12/270 Interchange, establishes a communications session with each health plan's system and transfers the batch of eligibility inquiry transactions in either a proprietary non-standard format or ASC X12/270 Interchange to its clearinghouse for transmission to the health plan's clearinghouse prior to 9:00 pm ET, the daily cut-off time for batch submissions.

2.1.3.7 Provider Clearinghouse Batch Eligibility Inquiry Process

The clearinghouse's Internet portal accepts the provider's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the eligibility inquiry transaction, which is then extracted and passed to the appropriate systems in the clearinghouse for further processing. The clearinghouse's system edits the eligibility transaction for completeness and valid data values where applicable. If the eligibility transaction fails editing, the clearinghouse returns to the provider an appropriate error message or acknowledgement describing the reasons for failure and rejection, thereby allowing the provider to correct and re-submit the eligibility transaction. Such error message or acknowledgement may be either a proprietary or valid ASC X12 Acknowledgement, depending on the type and range of services the clearinghouse is providing.

Using internal tables/files and/or an external directory service, the clearinghouse system determines the Internet address for the clearinghouse serving the health plan specified in the provider's eligibility inquiry transaction, creates and envelopes the complete ASC X12 Interchange containing the v5010 270 inquiry, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the ASC X12/270 Interchange, and establishes a communications session with the health plan's clearinghouse. Depending on the range and type of services being provided to the provider by the clearinghouse, the clearinghouse may or may not have responsibility for creating the correct ASC X12 Interchange containing the 270 Eligibility inquiry or for performing other data validation/transformation and/or editing functions prior to forwarding the eligibility inquiry to either the health plan or the health plan's clearinghouse. Upon successful transfer of the ASC X12/270 Interchange

to the health plan's clearinghouse, the provider's clearinghouse either terminates (if necessary) or maintains the communications session open and active until receipt of either a ASC X12/999 ~~X12/TA1, X12/997~~ or ASC X12/271 Interchange from the health plan's clearinghouse.[12]

If the ASC X12/270 Interchange fails ~~technical~~ ASC X12 TR3 implementation guide ~~syntax~~ verification at the health plan's clearinghouse, the provider's clearinghouse receives the v5010 999 Implementation Acknowledgement ~~TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate)~~ indicating the acceptance or rejection of the ~~Interchange or~~ Functional Group, extracts/reformats the acceptance or rejection acknowledgement and takes appropriate action to resolve errors indicated or the rejection. This may be by returning it to the provider's PMS/HIS or correcting the errors within the clearinghouse.

When the ASC X12/271 eligibility response transaction is received from the health plan's clearinghouse, the clearinghouse's Internet portal records the message receipt date/time, assigns an internal tracking number to the message linked to the ASC X12/271 Interchange, returns a signal to the health plan's clearinghouse that the ASC X12/271 Interchange payload has been successfully stored into persistent storage, and passes the ASC X12/271 Interchange to the clearinghouse's EDI management system for further processing. The clearinghouse's EDI management system processes (validates) the ASC X12/271 Interchange which may contain either a 271 with AAA Validation Request rejection/error codes or a 271 with the requested benefit data. The EDI management system extracts the 271 response data, creates the required eligibility response transaction required by the provider's PMS/HIS (may be either a proprietary or valid ASC X12/271 Interchange), and transfers the eligibility response transaction to the provider's PMS/HIS.

2.1.3.8 Health Plan Clearinghouse Batch Eligibility Inquiry Process

The health plan's clearinghouse Internet portal accepts the provider's clearinghouse's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the ASC X12/270 Interchange, returns a signal to the provider's clearinghouse that the ASC X12/270 Interchange payload has been successfully stored into persistent storage, and passes the ASC X12/270 Interchange to the clearinghouse's EDI management system for further processing. The clearinghouse's EDI management system, processes (validates) the ASC X12/270 Interchange.

If the ASC X12/270 Interchange passes ~~fails technical~~ ASC X12 TR3 implementation guide ~~syntax~~ verification, the EDI management system automatically generates the 999 Implementation Acknowledgement ~~997 Functional Acknowledgement~~ indicating acceptance of the ASC X12/270 Interchange, returns the ASC X12/999 ~~X12/997~~ Interchange to the provider's clearinghouse, extracts the eligibility inquiry data from the v5010 270 transaction set, and creates the required internal eligibility inquiry transactions required by the health plan.

Using internal tables/files and/or an external directory service, the clearinghouse system determines the Internet address for the health plan specified in the provider's eligibility inquiry transaction, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the eligibility inquiry transaction, and establishes a communications session with the health plan if such a communications link is not already open and active. Upon successful transfer of the eligibility inquiry transactions to the health plan, the clearinghouse either terminates (if necessary) or maintains the communication session open and active pending receipt of the eligibility response transactions from the health plan.

If the ASC X12/270 Interchange fails ~~technical~~ ASC X12 TR3 implementation guide ~~syntax~~ verification, the EDI management system automatically generates the 999 Implementation Acknowledgement ~~TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate)~~ indicating the acceptance or rejection of

[12] Alternatively, a single clearinghouse may be serving both the provider and the health plan to which the eligibility inquiry transaction is to be transmitted. In this case, the single clearinghouse would not only perform the reformatting of non-standard data and non-standard format received from the provider into the HIPAA-required standard, but would then perform the reformatting of the standard data and standard format into non-standard data and non-standard format required by the health plan. A similar set of functions would be performed when processing the eligibility response transaction received from the health plan. See Health Plan Clearinghouse Real Time Eligibility Inquiry Process section in this document for a complete description of this process.

the ~~Interchange or~~ Functional Group, returns the acceptance or rejection acknowledgement to the provider's clearinghouse, terminates the communications session (if necessary) and discontinues any further processing of the inquiry transaction.

When the eligibility response transactions are received from the health plan, the clearinghouse's EDI management system edits the eligibility response data for correctness and completeness, creates the ASC X12 Interchange containing the v5010 271 eligibility responses, passes the ASC X12/271 Interchange to the communications module which returns the ASC X12/271 Interchange to the provider's clearinghouse. The ASC X12/271 Interchange may contain either a v5010 271 with AAA Validation Request rejection/error codes or a v5010 271 with the requested benefit data.

2.1.3.9 Health Plan Batch Eligibility Inquiry Process

The health plan's Internet portal accepts the provider's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the batch ASC X12/270 Interchange, which is then extracted and passed to the health plan's EDI management system for further processing. The health plan's Internet portal returns the correct HTTP message accepted code to the provider's PMS/HIS and terminates the communications session.

The health plan's EDI management system, processes (validates) the batch ASC X12/270 Interchange. If the batch ASC X12/270 Interchange fails ~~technical~~ ASC X12 TR3 implementation guide ~~syntax~~ verification, the EDI management system automatically generates the 999 Implementation Acknowledgement ~~TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate)~~ indicating the acceptance or rejection of the ~~Interchange or~~ Functional Group, stages the acceptance or rejection acknowledgement for subsequent retrieval by the provider's PMS/HIS, and discontinues any further processing of the batch ASC X12/270 Interchange.

If the batch ASC X12/270 Interchange passes ~~technical~~ ASC X12 TR3 implementation guide ~~syntax~~ verification, the EDI management system automatically generates the 999 Implementation Acknowledgement ~~997 Functional Acknowledgement~~ indicating the acceptance of the ASC X12/270 Functional Group, and stages the acceptance acknowledgement for subsequent retrieval by the provider's PMS/HIS.

The EDI management system extracts the eligibility inquiry data from the 270 transaction set, creates the required internal inquiry transaction(s) which are routed to the eligibility system for processing. The eligibility system accesses all of the necessary internal data stores (files, databases, etc.) to process the eligibility inquiries to determine the benefits and status of coverage for each of the individuals identified in the inquiries. The data is then assembled and routed to the health plan's EDI management system.

The EDI management system edits the eligibility response data for correctness and completeness, creates the batch(es) ASC X12 Interchange containing the 271 eligibility responses, stages the batch(es) ASC X12/271 Interchange for subsequent retrieval by the provider's PMS/HIS.

2.1.3.10 Provider's Pre-Appointment Batch Eligibility Response Process

Two hours after transferring the batch ASC X12/270 Interchange to the health plan's Internet portal, the provider's PMS/HIS establishes a communications session with each health plan's system, requests either a list of available files for retrieval or specific file(s). Specific file(s) may be either an ASC X12/999 ~~X12/TA1 Interchange, an X12/997 Interchange,~~ or an ASC X12/271 Interchange or any combination of these. The health plan's Internet portal responds appropriately to the provider's PMS/HIS request. The provider's PMS/HIS then retrieves the requested and/or available file(s), records the message receipt date/time, assigns internal tracking number(s) to the message and retrieved file(s) linked to the ASC X12 Interchange(s), and matches the tracking number, message receipt date/time to the corresponding ASC X12/270 Interchange. The PMS/HIS then processes (validates) the ASC X12 Interchange(s) retrieved.

If the batch ASC X12/271 Interchange fails ~~technical~~ ASC X12 TR3 implementation guide ~~syntax~~ verification, the PMS/HIS generates either an ASC X12/999 ~~X12/TA1 or X12/997~~ acceptance or rejection interchange, establishes a communication session with the appropriate health plan's Internet portal and transfers the ASC X12/999

~~X12/TA1 or X12/997~~ interchange to the health plan. The PMS/HIS also generates a notice to the provider's appropriate internal support staff for problem resolution following established internal procedures.

If the ASC X12/271 Interchange passes ~~technical~~ ASC X12 TR3 implementation guide ~~syntax~~ verification, the PMS/HIS extracts the eligibility response data from the v5010 271 transaction set, creates the required internal eligibility response transaction(s) which are routed to the correct workstation for analysis and processing by the designated support staff.

If the v5010 271 eligibility response transaction indicates the inquiry was rejected or that the benefit coverage or status has changed from the earlier inquiry, the PMS/HIS displays the new information, enabling the support staff to contact the patient prior to the appointment/admission to resolve the variances by obtaining corrected data. The PMS/HIS then resubmits the corrected eligibility inquiry.

If the v5010 271 eligibility response transaction contains the requested benefit coverage, benefit status, and patient financial responsibility information, the PMS/HIS displays the benefit information, enabling the support staff to re-confirm the appointment/admission with the patient in advance and remind the patient of any information to bring to the appointment/admission and of any payment responsibilities.

2.2 Provider Direct-to-Health Plan Business Model

2.2.1 Introduction

This Master CORE Business Process Scenario describes both the real time and batch business processes for end-to-end insurance verification/eligibility inquiries using business language, not technical specifications to the extent appropriate, in which the healthcare provider submits inquiries directly to the health plan or information source without using the services of a clearinghouse or other intermediary. Since the overall business process for insurance verification/eligibility inquiry does not fundamentally change from a business viewpoint, each CORE rule addresses a critical interoperability activity/task within the common business process. Thus, the focus for this scenario is on the EDI aspects of the overall end-to-end business process and not on attempting to describe all of the activities and tasks typically performed by each of the stakeholders in the process.

2.2.2 Background

This scenario describes the healthcare insurance verification/eligibility end-to-end business process and the key activities and tasks conducted between a healthcare provider connecting directly to a health plan. For purposes of CORE Certification Testing, stakeholders include providers, health plans, clearinghouses, switches, other intermediaries, and solution vendors.

Each stakeholder type is equipped with an automated system (the "system") appropriate to its needs, e.g., a provider would have a hospital (or health) information system, commonly referred to as an HIS, or an automated practice management system (the "system"), commonly referred to as a PMS.

The "system" is defined as all of the components necessary for the stakeholder to conduct its automated business processes, e.g., all necessary network nodes, all platform components delivered by the vendor, and all the vendor components (e.g. documentation) included with the system. The system may consist of one or many workstations, servers and mainframe systems, and may include capture patient registration information at the point of patient intake (or scheduling) at the workstation if the stakeholder is a provider.

2.2.3 Eligibility Business Process Description

2.2.3.1 Appointment Scheduling Process

An appointment scheduler at the provider's office is scheduling an appointment for either an office visit or admission (depending on the type of provider) for a patient in 2 weeks while on the phone with the patient. The scheduler inquires about the reason for the appointment, collects data from the patient following prompts on the workstation and enters all of the necessary information into the PMS/HIS.

When all of the necessary patient demographic and insurance information is entered, the scheduler is prompted to submit an insurance verification transaction by either a menu selection or by clicking an icon (as determined by the PMS/HIS vendor user interface design.)

The PMS/HIS automatically edits the eligibility transaction for completeness and valid data values where applicable and prompts the scheduler to correct any invalid or omitted data. When the transaction editing is completed, the PMS/HIS assigns a unique internal tracking number, records the identification and address of the workstation used by the scheduler, and creates the eligibility inquiry transaction.

Using internal tables/files and/or an external directory service, the PMS/HIS determines the Internet address for the health plan identified by the patient, creates and envelopes the complete ASC X12 Interchange containing the v5010 270 inquiry, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the ASC X12/270 Interchange, and establishes a communications session with the health plan's system.

2.2.3.2 Health Plan Real Time Eligibility Inquiry Process

The health plan's Internet portal accepts the provider's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the ASC X12/270 Interchange, which is then extracted and passed to the health plan's EDI management system for further processing. The health plan's EDI management system, processes (validates) the ASC X12/270 Interchange.

If the ASC X12/270 Interchange fails ~~technical~~ ASC X12 TR3 implementation guide ~~syntax~~ verification, the EDI management system automatically generates the v5010 999 Implementation Acknowledgement ~~TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate)~~ indicating the acceptance or rejection of the ~~Interchange or~~ Functional Group, returns the acceptance or rejection acknowledgement to the provider, terminates the communications session and discontinues any further processing of the inquiry transaction.

If the ASC X12/270 Interchange passes ASC X12 TR3 implementation guide ~~syntax~~ verification, the EDI management system extracts the eligibility inquiry data from the v5010 270 transaction set, creates the required internal inquiry transaction which is routed to the eligibility system for processing. The eligibility system accesses all of the necessary internal data stores (files, databases, etc.) to process the eligibility inquiry to determine the benefits and status of coverage for the individual identified in the inquiry. The data is then assembled and routed to the health plan's EDI management system.

The EDI management system edits the eligibility response data for correctness and completeness, creates the ASC X12 Interchange containing the v5010 271 eligibility response, passes the ASC X12/271 Interchange to the open communications session which returns the ASC X12/271 Interchange to the provider's PMS/HIS. The health plan's Internet portal then terminates the communications session upon successful transfer of the ASC X12/271 Interchange to the provider's system. The ASC X12/271 Interchange may contain either a v5010 271 with AAA Validation Request Validation Request rejection/error codes or a v5010 271 with the requested benefit data.

2.2.3.3 Provider's Real Time Eligibility Response Process

The provider's PMS/HIS receives the ASC X12/271 Interchange from the health plan, records the message receipt date/time, assigns an internal tracking number to the message linked to the ASC X12/271 Interchange, and matches the tracking number, message receipt date/time to the corresponding ASC X12/270 Interchange. The PMS/HIS then processes (validates) the ASC X12/271 Interchange.

If the ASC X12/271 Interchange fails ~~technical~~ ASC X12 TR3 implementation guide ~~syntax~~ verification, the PMS/HIS generates a notice to the provider's appropriate internal support staff for problem resolution following established internal procedures. No rejection acknowledgement is returned to the health plan.

If the ASC X12/271 Interchange passes ~~technical~~ ASC X12 TR3 implementation guide ~~syntax~~ verification, the PMS/HIS extracts the eligibility response data from the v5010 271 transaction set, creates the required internal eligibility response transaction which is routed to the correct workstation for display to the scheduler.

If the v5010 271 eligibility response transaction indicates the inquiry was rejected, the PMS/HIS displays the reasons for such rejection, enabling the scheduler to resolve the rejection by obtaining corrected data as indicated from the patient during the initial appointment/admission scheduling phone call. The PMS/HIS then resubmits the corrected eligibility inquiry.

If the v5010 271 eligibility response transaction contains the requested benefit coverage, benefit status, and patient financial responsibility information, the PMS/HIS displays the benefit information, enabling the scheduler to confirm the benefit coverage and status with the patient and to inform the patient of any co-pay, co-insurance, or deductible amounts during the initial appointment/admission scheduling phone call.

The provider's scheduler then confirms the date and time of the appointment/admission with the patient, reminds the patient of any information required at the time of the appointment/admission and concludes the phone call with the patient.

2.2.3.4 Provider's Pre-Appointment Batch Eligibility Process

On a daily basis the provider's PMS/HIS automatically scans all scheduled appointments/admissions for two days in advance of the current date, extracts all of the necessary data, creates one or more batches of eligibility inquiries for each health plan covering the patient appointments/admissions for that date, assigns unique internal tracking numbers and records the date/time for each batch.

Using internal tables/files and/or an external directory service, the PMS/HIS determines the Internet address for each health plan, envelopes the complete ASC X12 Interchange containing the batch of v5010 270 inquiries for each health plan, creates the HTTP/S message, assigns a payload identifier, records the date/time, links the message to the correct batch ASC X12/270 Interchange, establishes a communications session with each health plan's system and transfers the batch ASC X12/270 Interchange to the health plan.

2.2.3.5 Health Plan Batch Eligibility Inquiry Process

The health plan's Internet portal accepts the provider's system logon, records the message receipt date/time, assigns an internal tracking number to the message linked to the batch ASC X12/270 Interchange, which is then extracted and passed to the health plan's EDI management system for further processing. The health plan's Internet portal returns the correct HTTP message accepted code to the provider's PMS/HIS and terminates the communications session.

The health plan's EDI management system, processes (validates) the batch ASC X12/270 Interchange. If the batch ASC X12/270 Interchange fails ASC X12 TR3 implementation guide ~~syntax~~ verification, the EDI management system automatically generates the v5010 999 Implementation Acknowledgement ~~TA1 Interchange Acknowledgement or 997 Functional Acknowledgement (as appropriate)~~ indicating the acceptance or rejection of the ~~Interchange or~~ Functional Group, stages the acceptance or rejection acknowledgement for subsequent retrieval by the provider's PMS/HIS, and discontinues any further processing of the batch ASC X12/270 Interchange.

If the batch ASC X12/270 Interchange passes ASC X12 TR3 implementation guide ~~syntax~~ verification, the EDI management system automatically generates the 999 Implementation Acknowledgement ~~997 Functional Acknowledgement~~ indicating the acceptance of the ASC X12/270 Functional Group, and stages the acceptance acknowledgement for subsequent retrieval by the provider's PMS/HIS.

The EDI management system extracts the eligibility inquiry data from the v5010 270 transaction set, creates the required internal inquiry transaction(s) which are routed to the eligibility system for processing. The eligibility system accesses all of the necessary internal data stores (files, databases, etc.) to process the eligibility inquiries to determine the benefits and status of coverage for each of the individuals identified in the inquiries. The data is then assembled and routed to the health plan's EDI management system.

The EDI management system edits the eligibility response data for correctness and completeness, creates the batch(es) ASC X12 Interchange containing the v5010 271 eligibility responses, stages the batch(es) ASC X12/271 Interchange for subsequent retrieval by the provider's PMS/HIS.

2.2.3.6 Provider's Pre-Appointment Batch Eligibility Response Process

Two hours after transferring the batch ASC X12/270 Interchange to the health plan's Internet portal, the provider's PMS/HIS establishes a communications session with each health plan's system, requests either a list of available files for retrieval or specific file(s). Specific file(s) may be either an ASC X12/999 or ~~X12/TA1 Interchange, an X12/997 Interchange,~~ an ASC X12/271 Interchange or any combination of these. The health plan's Internet portal responds appropriately to the provider's PMS/HIS request. The provider's PMS/HIS then retrieves the requested and/or available file(s), records the message receipt date/time, assigns internal tracking number(s) to the message and retrieved file(s) linked to the ASC X12 Interchange(s), and matches the tracking number, message receipt date/time to the corresponding ASC X12/270 Interchange. The PMS/HIS then processes (validates) the ASC X12 Interchange(s) retrieved.

If the batch ASC X12/271 Interchange fails ASC X12 TR3 implementation guide ~~syntax~~ verification, the PMS/HIS generates ~~either~~ an ASC X12/999 ~~X12/TA1 or X12/997~~ rejection interchange, establishes a communication session with the appropriate health plan's Internet portal and transfers the ASC X12/999 ~~X12/TA1 or X12/997~~ interchange to the health plan. The PMS/HIS also generates a notice to the provider's appropriate internal support staff for problem resolution following established internal procedures.

If the ASC X12/271 Interchange passes ASC X12 TR3 implementation guide ~~syntax~~ verification, the PMS/HIS extracts the eligibility response data from the v5010 271 transaction set, creates the required internal eligibility response transaction(s) which are routed to the correct workstation for analysis and processing by the designated support staff.

If the v5010 271 eligibility response transaction indicates the inquiry was rejected or that the benefit coverage or status has changed from the earlier inquiry, the PMS/HIS displays the new information, enabling the support staff to contact the patient prior to the appointment/admission to resolve the variances by obtaining corrected data. The PMS/HIS then resubmits the corrected eligibility inquiry.

If the v5010 271 eligibility response transaction contains the requested benefit coverage, benefit status, and patient financial responsibility information, the PMS/HIS displays the benefit information, enabling the support staff to re-confirm the appointment/admission with the patient in advance and remind the patient of any information to bring to the appointment/admission and of any payment responsibilities.

3 TEST SCENARIOS BY RULE

The following sections cover certification testing requirements specific to each CORE Phase I Rule.

3.1 CORE 150 Batch Acknowledgements Rule Certification Testing

3.1.1 Key Rule Requirements

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

Requires that

~~1) A TA1 is returned ONLY to indicate an Interchange error resulting in the rejection of the entire Interchange; the ISA 14 I13 Acknowledgement Requested field is ignored(§1.1)~~

~~2) A TA1 must NOT be returned if there are no errors in the Interchange control segments(§1.1)~~

3) A 999 ~~997~~ is returned to indicate either acceptance of the batch or rejection of a Functional Group (including the enclosed Transaction Set) error resulting in the rejection of the entire Functional Group(§1.1)

4) A 999 ~~997~~ must ALWAYS be returned if there are no errors in the Functional Group and enclosed Transaction Set(§1.2)

5) A 271 eligibility response transaction must ALWAYS be returned for an Interchange, Functional Group and Transaction Set that complies with ASC X12 TR3 implementation guide ~~standard syntax~~ requirements(§1.2)

6) A 271 eligibility response transaction may contain either the appropriate AAA Validation Request segment(s) or the data segments containing the requested eligibility and benefit status details. (§1.2)

~~7) A TA1 must not be returned during the initial communications session in which the 270 batch is submitted(§2)~~

8) A 999 ~~997~~ must not be returned during the initial communications session in which the 270 batch is submitted(§2)

3.1.2 Conformance Testing Requirements

These scenarios test the following conformance requirements of the CORE Batch Acknowledgement 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.

~~1) A TA1 is returned ONLY to indicate an Interchange error resulting in the rejection of the entire Interchange; the ISA 14 I13 Acknowledgement Requested field is ignored~~

~~a) A TA1 must NOT be returned if there are no errors in the Interchange control segments~~

2) A 999 ~~997~~ is returned to indicate either acceptance of the batch or rejection of a Functional Group (including the enclosed Transaction Set) error resulting in the rejection of the entire Functional Group

   a) A 999 ~~997~~ must ALWAYS be returned if there are no errors in the Functional Group and enclosed Transaction Set

3.1.2 Conformance Testing Requirements

3) A 271 eligibility response transaction must ALWAYS be returned for an Interchange, Functional Group and Transaction Set that complies with ASC X12 TR3 implementation guide ~~standard syntax~~ requirements
   a) A 271 eligibility response transaction may contain either the appropriate AAA Validation Request segment(s) or the data segments containing the requested eligibility and benefit status details.

3.1.3 Test Scripts Assumptions

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

3.1.4 Detailed Step-By-Step Test Script

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[13]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[14]
1)	~~A TA1 is returned on an invalid X12 Interchange (Key Rule Requirement #1)~~	~~An X12 Interchange containing only a TA1 rejecting the entire interchange~~		~~☐ Pass~~	~~☐ Fail~~	~~☒~~	~~☒~~	~~☒~~	~~☒~~	~~☐~~
2)	~~A TA1 is not returned on a valid X12 Interchange (Key Rule Requirement #2)~~	~~No TA1 is returned~~		~~☐ Pass~~	~~☐ Fail~~	~~☒~~	~~☒~~	~~☒~~	~~☒~~	~~☐~~
3)	A 999 ~~997~~ is returned on an invalid Functional Group (Key Rule Requirement #3)	An ASC X12 Interchange containing only a 999 IA ~~997~~		☐ Pass	☐ Fail	☒	☒	☒	☒	☐
4)	A 999 ~~997~~ is returned on a ASC valid ASC X12 Interchange (Key Rule Requirement #4)	An ASC X12 Interchange containing only a 999 IA ~~997~~		☐ Pass	☐ Fail	☒	☒	☒	☒	☐
5)	A 271 Eligibility Response transaction set is always returned for a valid 270 Eligibility	An ASC X12 Interchange is returned containing only a 271 transaction set		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[13]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[14]
	Inquiry Transaction set (Key Rule Requirement #5)									

3.2 CORE 151 Real Time Acknowledgements Rule Certification Testing

3.2.1 Key Rule Requirements

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

Requires that

~~1) A TA1 is returned ONLY to indicate an Interchange error resulting in the rejection of the entire Interchange; the ISA 14 I13 Acknowledgement Requested field is ignored (§1)~~

~~2) A TA1 must NOT be returned if there are no errors in the Interchange control segments(§1)~~

3) A 999 ~~997~~ is returned ONLY to indicate a Functional Group (including the enclosed Transaction Set) error resulting in the rejection of the entire Functional Group(§1)

4) A 999 ~~997~~ must NOT be returned if there are no errors in the Functional Group and enclosed Transaction Set(§1)

5) A 271 eligibility response transaction must ALWAYS be returned for an Interchange, Functional Group and Transaction Set that complies with ASC X12 TR3 implementation guide ~~standard syntax~~ requirements(§1)

6) A 271 eligibility response transaction may contain either the appropriate AAA Validation Request segment(s) or the data segments containing the requested eligibility and benefit status details. (§1)

3.2.2 Conformance Testing Requirements

These scenarios test the following conformance requirements of the CORE Real Time Acknowledgement 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.

~~1) A TA1 is returned ONLY to indicate an Interchange error resulting in the rejection of the entire Interchange; the ISA 14 I13 Acknowledgement Requested field is ignored~~

~~2) A TA1 must NOT be returned if there are no errors in the Interchange control segments~~

3) A 999 ~~997~~ is returned ONLY to indicate a Functional Group (including the enclosed Transaction Set) error resulting in the rejection of the entire Functional Group

4) A 999 ~~997~~ must NOT be returned if there are no errors in the Functional Group and enclosed Transaction Set

5) A 271 eligibility response transaction must ALWAYS be returned for an Interchange, Functional Group and Transaction Set that complies with ASC X12 TR3 implementation guide ~~standard syntax~~ requirements

6) A 271 eligibility response transaction may contain either the appropriate AAA Validation Request segment(s) or the data segments containing the requested

eligibility and benefit status details.

3.2.3 Test Scripts Assumptions

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

3.2.4 Detailed Step-By-Step Test Script

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[15]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[16]
1)	~~A TA1 is returned on an invalid X12 Interchange (Key Rule Requirement #1)~~	~~An X12 Interchange containing only a TA1 rejecting the entire interchange~~		~~☐ Pass~~	~~☐ Fail~~	~~☐~~	~~☒~~	~~☒~~	~~☒~~	~~☐~~
2)	~~A TA1 is not returned on a valid X12 Interchange (Key Rule Requirement #2)~~	~~No TA1 is returned~~		~~☐ Pass~~	~~☐ Fail~~	~~☐~~	~~☒~~	~~☒~~	~~☒~~	~~☐~~
3)	A 999 ~~997~~ is returned on an invalid Functional Group (Key Rule Requirement #3)	An ASC X12 Interchange containing only a 999 IA ~~997 FA~~		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
4)	A 999 ~~997~~ is not returned on a valid ASC X12 Interchange (Key Rule Requirement #4)	No 999 ~~997~~ is returned		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[15]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[16]
5)	A 271 Eligibility Response transaction set is always returned for a valid 270 Eligibility Inquiry Transaction set (Key Rule Requirement #5)	An ASC X12 Interchange is returned containing only a 271 transaction set		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

3.3 CORE 152 Companion Guide Rule Certification Testing

3.3.1 Key Rule Requirements

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

All CORE-certified entities' Companion Guides covering the 270/271 eligibility inquiry and response transactions must follow the format/flow as defined in the CORE 270/271 Companion Guide Template for HIPAA Transactions.

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

3.3.2 Conformance Testing Requirements

These scenarios test the following conformance requirements of the CORE Companion Document 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.

Submission to an authorized CORE certification testing company the following

1) A copy of the table of contents of its official 270/271 companion document

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

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

3.3.3 Test Scripts Assumptions

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

3.3.4 Detailed Step-By-Step Test Script

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[17]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[18]
1)	Companion Document conforms to the flow and format of the CORE 270/271 Companion Document Template	Submission of the Table of Contents of the 270/271 companion document, including a example of the 270/271 content requirements		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2)	Companion Document conforms to the format for presenting each segment, data element and code flow and format of the CORE 270/271 Companion Document Template	Submission of a page of the 270/271 companion document depicting the presentation of segments, data elements and codes showing conformance to the required presentation format		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

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

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

3.4 CORE 153 Connectivity Rule Certification Testing

3.4.1 Key Rule Requirements

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

Real time requests

1) Must include a single inquiry or submission (e.g. one eligibility inquiry to one information source for one patient). (§2)

Batch requests

2) Are sent in the same way as real time requests. (§3)

Batch submissions

3) Response must be only the standard HTTP message indicating whether the request was accepted or rejected (see below for error reporting.) (§3)

4) Message receivers must not respond to a batch submission with an ASC X12 response such as a 999 ~~TA1 or 997~~ as described in the CORE 150: Eligibility and Benefits Batch Acknowledgement Rule version 1.1.0 in the HTTP response to the batch request, even if their systems' capabilities allow such a response. (See the CORE 155: Batch Response Time Rule version 1.1.0 for the response time requirements for 999 ~~TA1 or 997~~.) (§3)

Batch responses

5) Should be picked up after the message receiver has had a chance to process a batch submission (see the CORE 155: Batch Response Time Rule version 1.1.0 for details on timing). (§3.1)

Required Data Elements

6) Certain business data elements: authorization information, a payload identifier, and date and time stamps, must be included in the HTTP message body outside of the ASC X12 data. (§4.1)

7) Information Sources must publish their detailed specification for the message format in their publicly available Companion Guide. (§4.1)

8) In order to comply with the CORE 155 and 156: Response Time Rules version 1.1.0, message receivers will be required to track the times of any received inbound messages, and respond with the outbound message for that payload ID. (§4.1)

9) Message senders must include the date and time the message was sent in the HTTP Message Header tags. (§4.1)

Date and Time Requirements

10) Date must be sent and logged using 8 digits (YYYYMMDD) (§4.2)

11) Time must be sent and logged using a minimum of 6 digits (HHMMSS). (§4.2)

Security

12) The HTTP/S protocol, all information exchanged between the sender and receiver is encrypted by a session-level private key negotiated at connection time. (§5)

3.4.1 Key Rule Requirements

User ID and Password

13) CORE participants will employ User ID and Password as the default minimum criteria authentication mechanism. (§5.1)

14) Issuance, maintenance and control of password requirements may vary by participant and should be issued in accordance with the organizations' HIPAA Security Compliance policies. (§5.1)

15) The User ID and Password authentication must be encrypted by the HTTP/S protocol, but passed outside of the ASC X12 payload information as described in the HTTP Message format section. (§5.1)

16) The receiver may require the message sender to register the IP address for the host or subnet originating the transaction, and may refuse to process transactions whose source is not registered or does not correspond to the ID used. (§5.1)

17) Due to programming requirements of POSTing over HTTP/S, use of a digital certificate is required to establish communications. CORE-certified participants will make available information on how to obtain the receiver's root public certificate. (§5.1)

18) No additional security for file transmissions, such as the separate encryption of the ASC X12 payload data, is required in this Phase I CORE Rule for connectivity. By mutual consent, organizations can implement additional encryption, but HTTP/S provides sufficient security to protect healthcare data as it travels the Internet. (§5.1)

Response Time, Time Out Parameters and Re-transmission

19) If the HTTP Post Reply Message is not received within the 60 second response period, the provider's system should send a duplicate transaction no sooner than 90 seconds after the original attempt was sent. (§6)

20) If no response is received after the second attempt, the provider's system should submit no more than 5 duplicate transactions within the next 15 minutes. (§6)

21) If the additional attempts result in the same timeout termination, the provider's system should notify the provider to contact the health plan or information source directly to determine if system availability problems exist or if there are known Internet traffic constraints causing the delay. (§6)

Authorization Errors

22) If the username and/or password included in the request are not valid according to the message receiver, the message receiver must send back an HTTP 403 Forbidden error response with no data content. (§7.1)

Batch Submission Acknowledgement

23) At the message acknowledgement level, a message receiver must send back a response with a status code of HTTP 202 Accepted once the message has been received. This does not imply that the ASC X12 content has been validated or approved. (§7.2)

Real Time Response or Response to Batch Response Pickup

24) When a message receiver is responding to a real time request or a batch response pickup request, assuming that the message authorization passed, the receiver must respond with an HTTP 200 Ok status code and the ASC X12 data content as specified by the CORE 150 and 151 Batch and Real Time Acknowledgements Rules version 1.1.0. (§7.3)

3.4.1 Key Rule Requirements

Server Errors

25) It is possible that the HTTP server is not able to process a real time or batch request. In this case, the message receiver must respond with a standard HTTP 5xx series error such as HTTP 500 Internal Server Error or HTTP 503 Service Unavailable. (§7.4)

26) If a sender receives a response with this error code, they will need to resubmit the request at a later time, because this indicates that the message receiver will never process this message. (§7.4)

3.4.2 Conformance Testing Requirements

These scenarios test the following conformance requirements of the CORE Connectivity 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.

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

3.4.3 Test Scripts Assumptions

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

3.4.4 Detailed Step-By-Step Test Script

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[19]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[20]
1)	Valid Logon Attempt (Key Rule Requirement #24)	HTTP 200 OK		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2)	Invalid Logon Attempt (Key Rule Requirement #22)	HTTP 403 Forbidden response		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
3)	Verify that communications server/module creates, assigns, logs, links the required data elements to HTTP message payload (Key Rule Requirement #6 and #8)	Output a system generated audit log report showing all required data elements		☐ Pass	☐ Fail	☒	☒	☒	☒	☐

NOTE: If it is not possible to establish a connection with the CORE-authorized testing vendor, an organization may submit a written attestation of compliance to CORE Rule 153 ~~253~~ along with a copy of their CORE-compliant implementation.

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

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

3.5 CORE 154 270/271 Data Content Rule Certification Testing *(Service Type, Benefit Status & Patient Financial Responsibility)*

3.5.1 Key Rule Requirements

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

CORE Requirements for 270 Eligibility Inquiry

1) DELETED: ~~A date submitted in either the 2100C or 2100D loops is considered to apply globally to all of the service types specified in the EQ segment. (§1.2)~~
2) DELETED: ~~When the 270 is a generic request for eligibility and a date is submitted in either or both of the 2100C or 2100D loops, all CORE-certified participants are required to submit only code "307" Eligibility. (§1.2)~~

   a) DELETED: ~~The use of code "307" in either loop 2100C or 2100D means the submitter is requesting the health plan (or information source) to respond with the date on which the health plan coverage begins. (§1.2)~~

3) DELETED: ~~A date submitted in either the 21 10C or 2110D loop is considered to apply only to the benefit begin service date for the service type specified by each EQ01-1365 service type code. (§1.2)~~

   a) DELETED: ~~When a date is submitted in either or both of the 2110C or 2110D loops, all CORE-certified participants are required to submit only code "307" Eligibility. (§1.2)~~

4) DELETED: ~~When code "307" is used in either loop 2110C or 2110D it means the submitter is requesting the health plan (or information source) to respond in the corresponding 2110C or 2110D loops in the 271 with the date on which the benefit eligibility covering the individual begins only if the benefit begin date is different from the plan begin date specified in either the 2100C or 2100D loops. (§1.2)~~

CORE Requirements for v5010 271 Eligibility Inquiry Response

5) When ~~a health plan (or information source) receives a generic request for eligibility or if the health plan (or information source) does not support the specific service type as indicated by the code submitted, and~~ the individual is located in the system, the health plan must be return ~~the following:~~

   ~~a)~~ DELETED: ~~The status of the benefit in EB01-1390 using codes 1 through 8 (active through inactive status) or I (Non-covered) and using Code "30" in EB03-1365 as appropriate for the health plan covering the individual in either the 2110C or 2110D loop. (§2. 1)~~

   b) REVISED: The health plan name (if one exists within the health plan's or information source's system) in EB05-1204 Plan Coverage Description. Neither the health plan or information source is required to obtain such a health plan name from outside its own organization. (§2.2)

   c) The patient financial responsibility for co-insurance, co-payment and deductibles(§2.3)

   ~~d) To specify the co-insurance responsibility~~

6) REVISED: Use code "A" Co-Insurance in EB01-1390 Eligibility or Benefit Information data element and use EB08-954 Percent data element for each

3.5.1 Key Rule Requirements

reported type of service. ~~The percent amount expressed is the portion that is the patient's responsibility. Negative numbers are prohibited.~~ (§2.3.1)

7) DELETED: ~~When the patient's portion of responsibility for a benefit is nothing place zero (0) in data element EB08-954 and return this segment. (§2.3.1)~~

8) REVISED: ~~When co-insurance does not apply to a benefit, do not return this segment.~~ If the patient financial responsibility amounts differ for in and out of network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as appropriate.(§2.3.1)

9) REVISED: The health plan (or information source) may, at its discretion, elect not to return co-insurance information for the following services specified in EB03-1365: 1 – Medical Care; 30 – Health Plan Benefit Coverage; 35– Dental Care; 88 – Pharmacy; AL – Vision (Optometry) MH – Mental Health. This optional reporting does not preempt the health plan's (or information source's) requirement to report patient co-payment responsibility for the remaining ~~5~~ 7 CORE required service types (33 – Chiropractic, 48 – Hospital Inpatient, 50 – Hospital Outpatient, 86 – Emergency Services, 98 – Professional (Physician) Visit– Office), 47 – Hospital, UC – Urgent Care that must be reported in a generic request for eligibility (Service Type Code 30) or a service type not supported by the health plan. (§2.3.1)

To specify the co-payment responsibility

10) REVISED: Use code "B" Co-Payment in EB01-1390 Eligibility or Benefit Information data element and use EB07-782 Monetary Amount element for each reported type of service. ~~The dollar amount expressed is the portion that is the patient's responsibility. Negative numbers are prohibited.~~ (§2.3.2)

11) DELETED: ~~When the patient's portion of responsibility for a benefit is zero dollars, place zero (0) in data element EB07-782 and return this segment. (§2.3.2)~~

12) REVISED: ~~When a co-payment does not apply to a benefit, do not return this segment.~~ If the patient financial responsibility amounts differ for in and out of network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as appropriate.(§2.3.2)

13) REVISED: The health plan (or information source) may, at its discretion, elect not to return co-payment information for the following services specified in EB03-1365: 1 – Medical Care; 30 – Health Plan Benefit Coverage; 35– Dental Care; 88 – Pharmacy; AL – Vision (Optometry), MH – Mental Health. This optional reporting does not preempt the health plan's (or information source's) requirement to report patient co-payment responsibility for the remaining ~~5~~ 7 CORE required service types (33– Chiropractic, 48 – Hospital Inpatient, 50 – Hospital Outpatient, 86 – Emergency Services, 98 – Professional (Physician) Visit– Office), 47 – Hospital, UC – Urgent Care that must be reported in a generic request for eligibility (Service Type Code 30) or a service type not supported by the health plan. (§2.3.2)

To specify the deductible responsibility

14) REVISED: Use code "C" Deductible in EB01-1390 Eligibility or Benefit Information data element and use EB07-782 Monetary Amount to indicate the dollar amount of the deductible for the type of service specified in EB03-1365 service type code. ~~The dollar amount expressed is the portion that is the patient's responsibility. Negative numbers are prohibited.~~(§2.3.3)

15) DELETED: ~~When the patient's portion of responsibility for a benefit is zero dollars, place zero (0) in data element EB07-782 and return this segment. (§2.3.3)~~

16) REVISED: ~~When a deductible does not apply to a benefit, do not return this segment.~~ If the patient financial responsibility amounts differ for in and out of network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as appropriate.(§2.3.3)

17) If the deductible amount varies by the benefit coverage level specified in EB02-1207 Coverage Level Code, place the appropriate code in EB02 and use

3.5.1 Key Rule Requirements

additional occurrences of the EB Eligibility or Benefit Information segment as necessary for each benefit coverage level for each type of service, e.g., individual or family coverage. (§2.3.3)

18) REVISED: The health plan (or information source) may, at its discretion, elect not to return deductible information for the following services specified in EB03 -1365: 1 – Medical Care; 30 – Health Plan Benefit Coverage; 35– Dental Care; 88 – Pharmacy; AL – Vision (Optometry), MH – Mental Health. This optional reporting does not preempt the health plan's (or information source's) requirement to report patient deductible responsibility for the remaining ~~5~~ 7 CORE required service types (33 – Chiropractic, 48 – Hospital Inpatient, 50 – Hospital Outpatient, 86 – Emergency Services, 98 – Professional (Physician) Visit – Office), 47 – Hospital, UC – Urgent Care that must be reported in a generic request for eligibility (Service Type Code 30) or a service type not supported by the health plan. (§2.3.3)

Eligibility Dates

19) DELETED: ~~If the individual has active coverage (codes 1 through 5 in EB01-1390), the code "307" Eligibility date (defined to mean health plan begin in the context of this CORE rule) must be returned in the DTP segment in either the 21 00C or 21 00D loops. The health plan or information source may alternately return a range of dates if known using code RD8 in DTP02-1250 Date Time Period Format Qualifier data element.(§2.4)~~

20) DELETED: ~~If the benefit begin dates are different from the health plan begin dates specified in the 2100C or 2100D loops, then code "348" Benefit Begin date must The response will be as of the date the transaction is processed as specified in the 271 BHT04 Transaction Set Creation Date, unless a specific date (prior, current or future) was used from the DTP segment in either the 2100C or 2100D loops of the 270 eligibility inquiry. (§2.4)~~

21) The 270 eligibility inquiry may request a benefit coverage date 12 months in the past or up to the end of the current month. If the inquiry is outside of this date range and the health plan (or information source) does not support eligibility inquiries outside of this date range, the 271 response must include the AAA segment with code "62" Date of Service Not Within Allowable Inquiry Period in the AAA03-901 Reject Reason Code data element. (§2.4)

~~**Support Required for Generic Request or Service Code not Supported**~~

~~22) If the 270 submitted is a generic request for eligibility (service type code "30" in the "EQ" loops of the transaction), or a request for a service type not supported by the health plan (or information source), the following CORE service type code values must be returned in EB03-1365 service type code in either the 2110C or 2110D loops: (§2.5)~~

~~**CORE REQUIRED SERVICE TYPES**~~	
~~**CORE REQUIRED SERVICE TYPES (X12 270/271 Code Definition)**[21]~~	~~**CORE DESCRIPTION**~~

[21] ~~CORE descriptions (clarification/meaning) are meant to provide a general understanding of the specific services which are included in each service type, but may not be all inclusive.~~

3.5.1 Key Rule Requirements

~~1 – Medical Care~~	~~Medical care services to diagnose and/or treat medical condition, illness or injury. Medical services and supplies provided by physicians and other health care professionals.~~
~~30 – Health Benefit Plan Coverage~~	~~—~~
~~33 – Chiropractic~~	~~Professional services which may include office visits, manipulations, lab, x-rays, and supplies.~~
~~35 – Dental Care~~	~~Benefits for services, supplies or appliances for care of teeth.~~
~~48 – Hospital Inpatient~~	~~Hospital services and supplies for a patient who has been admitted to a hospital for the purpose of receiving medical care or other health services.~~
~~50 – Hospital Outpatient~~	~~Hospital services and supplies for a patient who has not been admitted to a hospital for the purpose of receiving medical care or other health services.~~
~~86 – Emergency Services~~	~~Medical services and supplies provided by physicians, Hospitals, and other healthcare professionals for the treatment of a sudden and unexpected medical condition or injury which requires immediate medical attention.~~
~~88 – Pharmacy~~	~~Drugs and supplies dispensed by a licensed Pharmacist, which may include mail order or internet dispensary.~~
~~98 – Professional (Physician) Visit – Office~~	~~Professional services of a Physician or other Health Care Professional during an office visit.~~
~~AL – Vision (Optometry)~~	~~Routine vision services furnished by an optometrist. May include coverage for eyeglasses, contact lenses, routine eye exams, and/or vision testing for the prescribing or fitting of eyeglasses or contact lenses.~~

~~23)~~ DELETED ~~If the individual has active coverage and any of the above codes are not a covered benefit, then code "I" Not Covered must be returned in the EB01. (§2.5)~~

24) DELETED ~~If the health plan's (or information source's) plan benefits do not fall into any of the service type codes listed above, except service type code "30", the health plan must return the Active Status information as specified in Subsection 2.1 of this rule and whatever additional appropriate service type code does define the benefit. (§2.5)~~

25) DELETED ~~If no specific service type code exists, the health plan may return the appropriate procedure code(s) in EB13 or a description MSG01. EB03 and EB13 cannot both be used in the same EB segment. (§2.5)~~

Support for CORE Required Service Types

26) REVISED The health plan (or information source) must support an explicit request for each of the CORE service types. The corresponding service type codes are: "1", "33", "35", "47", "48", "50", "86", "88", "98", or "AL", "MH", or "UC" submitted in the 270 EQ01 by providing the content identified in subsections 2.1 through 2.4 above for the submitted service type(s). (§2.6)

~~**Support for Other Service Type Codes**~~

27) DELETED ~~Additional covered service type codes may be returned at the health plan's (or information source's) discretion; however their absence does not imply that they are not covered. (§2.7)~~

3.5.2 Conformance Testing Requirements:

These scenarios test the following conformance requirements of the CORE 270/271 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.

1) DELETED: ~~Receipt by a health plan or information source of a valid generic request for eligibility 270 transaction created using the CORE Phase I Master Test Bed Data~~

2) REVISED: The creation of an eligibility response 271 transaction generated using the CORE Phase I Master Test Bed Data providing the following information about the individual identified in the 270 eligibility transaction

   a) REVISED: ~~health plan name covering the individual~~ the health plan is not required to obtain such a health plan name from outside its own organization

   ~~b) health plan begin date~~

   ~~c) benefit begin date~~

   ~~d) status of benefit coverage (service types) including indicating what benefits are covered/non-covered~~

   e) patient financial responsibility, including in-network and out-of-network

3.5.3 Test Scripts Assumptions

1) The provider's PMS/HIS system generates all of the required data necessary for its clearinghouse to generate the batch X12/270 eligibility inquiries.
2) The provider's clearinghouse's EDI management system generates a syntactically correct X12 interchange containing the 270 eligibility inquiry, therefore, no ~~TA1~~ or ~~997~~ 999 acknowledgement is to be returned by the health plan's system.
3) All HTTP/S communications sessions between all parties are successfully established with the respective Internet portals communications servers; therefore, no HTTP POST error messages are created by any of communications servers.
4) The health plan's eligibility system successfully locates and verifies the individuals identified in the batch 270 inquiry and outputs the required data required by its clearinghouse system to successfully generate a syntactically correct X12 interchange containing the 271 eligibility responses.
5) The health plan's EDI management system generates a syntactically correct X12 interchange containing the 271 eligibility response.
6) The CORE Phase I Master Test Bed Data will contain all of the values necessary to generate a response transaction covering each of the requirements specified in the Conformance section of this rule.
7) The CORE test suite will not include comprehensive testing requirements to test for all possible permutations of health plan benefit status or patient financial responsibility for all of the CORE required benefits addressed in the 271 response.

3.5.4 Detailed Step-By-Step Test Script

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[22]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[23]
~~1)~~	~~DELETED: Create a valid generic 270 eligibility inquiry (Rule Conformance Requirement #1)~~	~~Output a valid fully enveloped 270 eligibility inquiry transaction set~~		~~☐ Pass~~	~~☐ Fail~~	~~☒~~	~~☐~~	~~☒~~	~~☒~~	~~☐~~
2)	REVISED Create a valid 271 response transaction as defined in the CORE rule indicating the **name of the health plan** covering the individual specified in the 270 eligibility inquiry (Key Rule Requirement #5.b). The health plan is not required to obtain such a health plan name from outside its own	Output a valid fully enveloped 271 eligibility response transaction set with the correct health plan name in EB05-1204		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[22]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[23]
	organization.									
3)	Extract from a valid 271 response transaction as defined in the CORE rule the data indicating the **name of the health plan** covering the individual specified in the 270 eligibility inquiry (Key Rule Requirement #5.b) The health plan is not required to obtain such a health plan name from outside its own organization.	Provide a screen print of the output from Test #2 showing that the required information is displayed to the information requester		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
4)	REVISED: ~~-~~Create a valid 271 response transaction as defined in the CORE rule indicating the **benefit status** for all service type codes required by the CORE rule (Key Rule Requirement #5.c ~~& #5.d)~~	Output a valid fully enveloped 271 eligibility response transaction set with the correct benefit coverage status in EB01-1390 for each benefit type required by the CORE rule in EB03-1365		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
5)	REVISED: ~~-~~Extract from a valid 271 response transaction as defined in the CORE rule the data indicating the **benefit status** for all service type codes required by the CORE rule ~~-~~(Key Rule Requirement #5.c ~~& #5.d)~~	Provide a screen print of the output from Test #4 showing that the required information is displayed to the information requester		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[22]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[23]
6)	DELETED ~~Create a valid 271 response transaction as defined in the CORE rule indicating the **begin date** for **the health plan** covering the individual (Key Rule Requirement #19)~~	Output a valid fully enveloped 271 eligibility response transaction set with the correct health plan begin date in the DTP segment using the required code in DTP01-374 in either subscriber loop 2100C or dependent loop 2100D		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
7)	DELETED ~~Extract from a valid 271 response transaction as defined in the CORE rule the data indicating the **health plan begin date** covering the individual specified in the 270 eligibility inquiry (Key Rule Requirement #19)~~	Provide a screen print of the output from Test #6 showing that the required information is displayed to the information requester		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
8)	DELETED ~~Create a valid 271 response transaction as defined in the CORE rule indicating the begin date for the benefit that is different than the health plan begin date for certain benefits covering the individual (Key Rule Requirement #20)~~	Output a valid fully enveloped 271 eligibility response transaction set with the correct benefit begin dates in the DTP segment using the required code in DTP01-374 in either subscriber loop 2110C or dependent loop 2110D		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
9)	DELETED ~~Extract from a valid 271 response transaction as defined in the CORE rule the data indicating the begin date for the benefit that is different than~~	Provide a screen print of the output from Test #8 showing that the required information is displayed to the information		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[22]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[23]
	~~the health plan begin date for certain benefits covering the individual (Key Rule Requirement #20)~~	requester								
10)	Create a valid 271 response transaction as defined in the CORE rule indicating the patient financial responsibility for each of the benefits covering the individual (Key Rule Requirement #6 through #18)	Output a valid fully enveloped 271 eligibility response transaction set with the correct co-insurance, co-payment, and deductible patient financial responsibilities for both in/out of network in either EB08-954 or EB07-782 at either the subscriber loop 2110C or dependent loop 2100D levels		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
11)	Extract from a valid 271 response transaction as defined in the CORE rule the data indicating the patient financial responsibility for each of the benefits covering the individual (Key Rule Requirement #6 through #18)	Provide a screen print of the output from Test #10 showing that the required information is displayed to the information requester		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

3.6 CORE 155 Batch Response Time Rule Certification Testing

3.6.1 Key Rule Requirements

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

1) Maximum response time when processing in batch mode for the receipt of a 271 response to a 270 inquiry submitted by a provider or on a provider's behalf by a clearinghouse/switch by 9:00 pm Eastern time of a business day must be returned by 7:00 am Eastern time the following business day. A business day consists of the 24 hours commencing with 12:00 am (Midnight or 0000 hours) of each designated day through 11:59 pm (2359 hours) of that same designated day. The actual calendar day(s) constituting business days are defined by and at the discretion of each health plan or information source. (§1)
2) 999 ~~TA1 or 997~~ responses must be available to the submitter within one hour of receipt of the batch: to the provider in the case of a batch of 270 inquiries and to the health plan (or information source) in the case of a batch of 271 responses. (§2)
3) Conformance with this maximum response time rule shall be considered achieved if 90 percent of all required responses as specified in the CORE 150: Eligibility and Benefit Batch Acknowledgement Rule version 1.0.0 are returned within the specified maximum response time as measured within a calendar month. (§3)
4) Each CORE-certified entity must demonstrate its conformance with this maximum response time rule by demonstrating its ability to capture, log, audit, match and report the date (YYYYMMDD), time (HHMMSS) and control numbers from its own internal systems and the corresponding data received from its trading partners. (§3)

3.6.2 Conformance Testing Requirements

These scenarios test the following conformance requirements of the CORE Batch Response Time 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.

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

3.6.3 Test Scripts Assumptions

1) All transactions, data, communications session are valid, no error conditions are created or encountered.
2) The provider's PMS/HIS system generates all of the required data necessary for its clearinghouse to generate the batch ASC X12/270 eligibility inquiries.
3) The provider's clearinghouse's EDI management system generates a syntactically correct X12 interchange containing the 270 eligibility inquiry, therefore, no 999 ~~TA1 or 997~~ acknowledgement is to be returned by the health plan's system.
4) All HTTP/S communications sessions between all parties are successfully established with the respective Internet portals communications servers; therefore, no

3.6.3 Test Scripts Assumptions

HTTP POST error messages are created by any of communications servers.

5) The health plan's eligibility system successfully locates and verifies the individuals identified in the batch 270 inquiry and outputs the required data required by its clearinghouse system to successfully generate a syntactically correct ASC X12 interchange containing the 271 eligibility responses.

6) The health plan's EDI management system generates a syntactically correct ASC X12 interchange containing the 271 eligibility response.

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

3.6.4 Detailed Step-By-Step Test Script:

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[24]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[25]
1)	Verify that outer most communications module(s) transmits all required data elements in the eligibility inquiry message. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the ASC X12 transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent. (Key Rule Requirement #4)	Output a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[24]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[25]
2)	Verify that outer most communications module(s) captures, assigns, logs and links all required data elements from the ASC X12/271 Interchange to the submitted ASC X12/270 Interchange. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the ASC X12 transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent. (Key Rule Requirement #4)	Output a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐
3)	Verify that outer most communications module(s) transmits all required data elements in the eligibility response message. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the ASC X12 transaction to uniquely identify the transmission in addition to the times that the request was	Output a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[24]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[25]
	received and response was sent. (Key Rule Requirement #4)									
4)	Verify that outer most communications module(s) captures, assigns, logs and links all required data elements from the ASC X12/270 Interchange to the submitted ASC X12/271 Interchange. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the ASC X12 transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent. (Key Rule Requirement #4)	Output a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

3.7 CORE 156 Real Time Response Time Rule Certification Testing

3.7.1 Key Rule Requirements

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

1) Maximum response time when processing in real time mode[26] for the receipt of a 271 (or in the case of an error, a 999 ~~TA1 or 997~~) response from the time of submission of a 270 inquiry must be 20 seconds (or less). 999 ~~TA1 and 997~~ response errors must be returned within the same response timeframe. (§1)
2) Conformance with this maximum response time rule shall be considered achieved if 90 percent of all required responses are returned within the specified maximum response time as measured within a calendar month. (§1)
3) Each CORE-certified entity must demonstrate its conformance with this maximum response time rule by demonstrating its ability to capture, log, audit, match and report the date (YYYYMMDD), time (HHMMSS) and control numbers from its own internal systems and the corresponding data received from its trading partners. (§1)

3.7.2 Conformance Testing Requirements

These scenarios test the following conformance requirements of the CORE Real Time Response Time 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.

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

[26] Real-time mode is defined in the CORE Glossary of Terms.

3.7.3 Test Scripts Assumptions

1) All transactions, data, communications session are valid, no error conditions are created or encountered.
2) The provider's PMS/HIS system generates a syntactically correct X12 interchange containing the 270 eligibility inquiry, therefore, no 999 ~~TA1 or 997~~ acknowledgement is to be returned by the health plan's system.
3) The provider's PMS/HIS system's communications module successfully establishes the HTTP/S communication session with the health plan's Internet portal communications server; therefore, no HTTP POST error message is created by the health plan's communications server.
4) The health plan's eligibility system successfully locates and verifies the individual identified in the 270 inquiry and outputs the required data required by its EDI management system to successfully generate a syntactically correct ASC X12 interchange containing the 271 eligibility response.
5) The health plan's EDI management system generates a syntactically correct ASC X12 interchange containing the 271 eligibility response.
6) The CORE test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

3.7.4 Detailed Step-By-Step Test Script:

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[27]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[28]
1)	Verify that outer most communications module(s) transmits all required data elements in the eligibility inquiry message. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the ASC X12 transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent. (Key Rule Requirement #3)	Output a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[27]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[28]
2)	Verify that outer most communications module(s) captures, assigns, logs and links all required data elements from the ASC X12/271 Interchange to the submitted ASC X12/270 Interchange. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the ASC X12 transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent. (Key Rule Requirement #3)	Output a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☒	☐	☒	☒	☐

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[27]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[28]
3)	Verify that outer most communications module(s) transmits all required data elements in the eligibility response message. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the ASC X12 transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent. (Key Rule Requirement #3)	Output a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[27]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[28]
4)	Verify that outer most communications module(s) captures, assigns, logs and links all required data elements from the ASC X12/270 Interchange to the submitted ASC X12/271 Interchange. If transactions use an alternate communication method to HTTP/S, entities must store enough information from the ASC X12 transaction to uniquely identify the transmission in addition to the times that the request was received and response was sent. (Key Rule Requirement #3)	Output a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

3.8 CORE 157 System Availability Rule Certification Testing

3.8.1 Key Rule Requirements

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

System Availability Requirements

1) System availability must be no less than 86 percent per calendar week for both real-time and batch processing modes. This will allow for health plan, (or other information source) clearinghouse/switch or other intermediary system updates to take place within a maximum of 24 hours per calendar week for regularly scheduled downtime. (§1)

Reporting Requirements

2) Scheduled Downtime
   a) CORE-certified health plans (or information sources), clearinghouses/switches or other intermediaries must publish their regularly scheduled system downtime in an appropriate manner (e.g., on websites or in companion guides) such that the healthcare provider can determine the health plan's system availability so that staffing levels can be effectively managed. (§2.1)
3) Non-Routine Downtime
   a) For non-routine downtime (e.g., system upgrade), an information source must publish the schedule of non-routine downtime at least one week in advance. (§2.2)
4) Unscheduled Downtime
   a) For unscheduled/emergency downtime (e.g., system crash), an information source will be required to provide information within one hour of realizing downtime will be needed. (§2.3)

Other Requirements

5) No response is required during scheduled downtime(s.) (§2.4)
6) Each health plan, (or other information source) clearinghouse/switch or other intermediary will establish its own holiday schedule and publish it in accordance with the rule above. (§3)

3.8.2 Conformance Testing Requirements

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

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

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

3.8.3 Test Scripts Assumptions

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

3.8.4 Detailed Step-By-Step Test Script

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

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

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[29]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[30]
1)	Publication of regularly scheduled downtime, including holidays and method(s) for such publication. (Key Rule Requirement #2.a)	Submission of actual published copies of regularly scheduled downtime including holidays and method(s) of publishing		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2)	Publication of non-routine downtime notice and method(s) for such publication (Key Rule Requirement #3.a)	Submission of a sample notice of non-routine downtime including scheduled of down time and method(s) of publishing		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
3)	Publication of unscheduled/emergency downtime notice and method(s) for such publication (Key Rule Requirement #4.a)	Submission of a sample notice of unscheduled/emergency downtime including method(s) of publishing		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

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

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

4 APPENDIX

4.1 Test Suite Supplement

4.1.1 Using This Supplement

This Supplement is to be used in conjunction with the CORE Phase I Certification Test Suite. It does not replace any of the CORE Phase I Policies and Rules, but rather provides additional information and details regarding the use and format of the CORE Phase I Master Test Bed Data as it applies to the CORE 154 Eligibility and Benefits 270/271 Data Content and CORE 150 and 151 Acknowledgements Rules. Only CORE 154 Eligibility and Benefits 270/271 Data Content and CORE 150 and 151 Acknowledgements Rules require the use of the CORE Phase I Master Test Bed Data.

Topics in this Supplement are organized as follows:

§4.1.2 and subsections provides a high-level overview of the CORE Phase I Master Test Bed Data, where the data is found, and how that document is organized

§4.1.3 is a high-level overview of the use of the CORE Phase I Master Test Bed Data by the CORE authorized testing vendor(s)

§4.1.4 and subsections identifies specific allowable exceptions for users when loading the CORE Phase I Master Test Bed Data into their respective system; allowable exceptions relate to the modification or non-use of some of the test data elements

§4.1.5 specifies that only the CORE Phase I Master Test Bed Data can be used for certification testing along with identifying certain data that is not included in the master test bed data

§4.1.6 discusses at a high level the CORE Phase I Certification Test Suite certification testing requirements

§4.1.7 provides an example of the mapping of some of the CORE test bed data elements to the ASC X12 270 transaction set

4.1.2 CORE Phase I Certification Master Test Bed Data

4.1.2.1 About the Base Test Data and Format

The CORE Phase I Master Test Bed Data (specified in a separate Excel workbook) is comprised of 24 base test "cases" consisting of 16 subscriber only cases and 8 subscriber-with-dependent cases. Also included in the master test bed are data for 13 health plans. Each beneficiary (subscriber and dependent) is assigned to a specific health plan. The base test data are specified in a human-readable format in a separate Excel workbook, described in detail below. Although actual CORE Phase I certification testing will use this CORE Phase I Master Test Bed Data as presented in the base test data, the types of transactions that will be tested against this data are specified in the CORE Phase I Certification Test Suite Version 1.1.1 under the Detailed Test Scripts for the CORE 154 Eligibility and Benefits 270/271 Data Content and CORE 150 and 151 Acknowledgements Rules.

Users should extract all of the test bed data for health plans and beneficiaries from the Excel workbook. Beneficiaries who are dependents of a subscriber are identified as a dependent in the test bed data. Beneficiaries marked as a dependent should be extracted and may be loaded as subscriber to accommodate those health plans that require the assignment of a unique member ID to each beneficiary. In the context of this Appendix and the CORE Phase I Master Test Bed Data, CORE defines beneficiary to mean a person who is eligible to receive benefits under a health benefits plan whether or not the person is the subscriber or a dependent.

The test bed data has been provided in an Excel spreadsheet format only. The Excel workbook contains multiple tabs (spreadsheets) as follows:

- Tab 1: The title page of the workbook
- Tab 2: Beneficiary test data
- Tab 3-15: Health Plan test data

Test bed data is provided in both upper and lower case characters for ease of human readability. Users with systems that require all upper case characters will need to convert lower case characters accordingly when loading the data into their internal system.

Remember, the CORE Phase I Master Test Bed Data only encompasses the CORE 154 Eligibility and Benefits 270/271 Data Content and CORE 150 and 151 Acknowledgements Rules.

4.1.3 Loading the Test Data and How Vendors Use the Data

Users may load the test bed data into their internal systems via manual data entry or by exporting the data into any file format supported by Excel for further automatic processing.

The CORE authorized certification testing vendors will use only the master test bed data to test each entity according to their stakeholder type. Since CORE certification testing is not exhaustive, not all test beneficiaries (subscribers/dependents) and their associated health plans may be used in Phase I testing. Nevertheless, users should extract and load all of the master test bed data into their internal systems. The specific internal system into which the master test bed data is loaded is determined by each user, e.g., a development or production or test system, and may vary by user.

There are fields (cells) in both the Health Plan and Beneficiary data that can be modified in the CORE Phase I Master Test Bed Data. The specific fields are outlined below and highlighted in the actual CORE Phase I Master Test Bed Excel file. Many of the modifiable fields are data elements that are not addressed in or required by the Phase I rules, but are needed for testing. This said users are not permitted to modify:

- Dates
- Any patient demographic

Should an entity determine it needs to modify any of CORE Phase I Master Test Bed Data in order to load it into their internal systems, such modifications and how the data was adjusted should be reported to CAQH so lessons learned can be applied to later Phases of CORE.

4.1.4 Allowable Exceptions When Loading Specific Test Data

Exceptions identified below for ease of reference.

4.1.4.1 Health Plan Data Options

4.1.4.1.1 Group #

The Group number is not validated by either of the CORE-authorized certification testing vendors in any of the certification test scripts. Therefore the Group number can be modified, or not used, by any health plan or information source based on its eligibility system requirements for Group number when undergoing certification testing.

4.1.4.1.2 Health Plan #

The Health Plan number is not validated by either of the CORE-authorized certification testing vendors in any of the certification test scripts. Therefore the Health Plan number can be modified, or not used, by any health plan or information source based on its eligibility system requirements for Plan number when undergoing certification testing.

4.1.4.1.3 Health Plan Name

The Health Plan Name is required by the CORE rule and its presence in the 271 response transaction is validated by the CORE-authorized certification testing vendors. However, the actual name value of the Health Plan Name is not validated by the CORE-authorized certification testing vendor(s) in any of the certification test scripts. Therefore, while the Health Plan Name must be loaded into an entity's testing system, the name value can be modified by any health plan or information source based on its eligibility system requirements for Health Plan Name when undergoing certification testing. When a user modifies any Health Plan Name for any of the health plan test data tabs it must also modify the Health Plan Name on the corresponding beneficiary test data tab in order to retain the appropriate association of the beneficiary to the correct health plan.

4.1.4.1.4 Health Plan Coverage Level

The CORE-authorized certification testing vendor(s) can accommodate a health plan or information source modifying the Coverage Level (EB02) from Employee to Individual as needed in order to load the benefit into its eligibility system. Therefore the Coverage Level can be modified by any health plan or information source based on its eligibility system requirements for coverage level when undergoing certification testing.

4.1.4.1.5 Health Plan Patient Liability

The CORE-authorized certification testing vendor(s) can accommodate a health plan or information source modifying the data value for Patient Liability data (In-Network and Out-of-Network Annual Deductible, Co-Payment and Co-Insurance) as needed in order to load the benefit into its eligibility system. When the cell contains a data value, the actual data value may be modified to an appropriate data value for loading into the eligibility system, but a value MUST be loaded. Therefore the Patient Liability amounts can be modified by any health plan or information source based on its eligibility system requirements for such data when undergoing certification testing.

4.1.4.1.6 ASC X12 Information Source Name

The name "PlanA Certification Payer" is used only in the NM103 segment in the 2100A Information Source loop. The name of the Information Source is not validated by the CORE-authorized certification testing vendor(s) in any of the certification test scripts. Therefore this value can be modified by any health plan or information source based on its eligibility system requirements when undergoing certification testing.

4.1.4.2 Beneficiary Data Options

4.1.4.2.1 Member ID

The CORE-authorized certification testing vendor(s) can accommodate health plan and information source needs (e.g., length, format, datatype) regarding Member ID (MID) in their testing products. Thus, a health plan or information source may modify the MID in the CORE Phase I Master Test Bed Data in order to load the test data into its eligibility system.

4.1.4.2.2 Dependent Beneficiary

The CORE-authorized certification testing vendors can accommodate health plan or information source needs regarding loading dependents in the CORE Phase I Master Test Bed Data with a unique Member ID (MID) into the health plan or information source eligibility systems as follows:

A health plan or information source may load the subscriber in its eligibility system using the MID as specified in the CORE Phase I Master Test Bed Data for the subscriber and then separately load the dependent from the CORE Phase I Master Test Bed Data into it eligibility system as a subscriber using the MID as specified in the CORE Phase I Master Test Bed Data for the dependent

Or alternatively

A health plan or information source may modify the dependent's MID in the CORE Phase I Master Test Bed Data to correspond to the subscriber's MID as specified in the Master Test Bed Data and then load the dependent appropriately in its eligibility system.

4.1.4.2.3 Employee ID

The Employee ID is not validated by the CORE-authorized certification testing vendor(s) in any of the certification test scripts. Therefore the Employee ID can be modified, or not used, by a health plan or information source based on its eligibility system requirements for Employee ID when undergoing certification testing.

4.1.4.2.4 Provider Name

The Provider Name is not validated by the CORE-authorized certification testing vendor(s) in any of the certification test scripts. Therefore the Provider Name can be modified, or not used, by a health plan or information source based on its eligibility system requirements for Provider Name when undergoing certification testing.

4.1.4.2.5 NPI (National Provider ID)

The NPI is not validated by the CORE-authorized certification testing vendor(s) in any of the certification test scripts. Therefore the NPI can be modified, or not used, by a health plan or information source based on its eligibility system requirements when undergoing certification testing.

4.1.4.2.6 Gender

The Gender of a beneficiary is not validated by the CORE-authorized certification testing vendor(s) in any of the certification test scripts. Therefore Gender can be modified, or not used, by a health plan or information source based on its eligibility system requirements for Gender when undergoing certification testing.

4.1.4.2.7 ASC X12 Information Receiver Name

The Information Receiver Name is used only in the NM103 segment in the 2100B Information Receiver loop. The name of the Information Receiver is not validated by the CORE-authorized certification testing vendor(s) in any of the certification test scripts. Therefore this value can be modified by any health plan or information source based on its eligibility system requirements when undergoing certification testing.

4.1.4.2.8 Identifiers and Other Data on the ASC X12 Control Segments

The CORE Phase I Rules do not address the specific use and data content of the ISA, GS and ST Control Segments. However, some test scripts for the CORE 154 Eligibility and Benefits 270/271 Data Content and CORE 150 and 151 Acknowledgements Rules require that the entity undergoing certification testing must be able to conduct a valid ASC X12 Interchange containing either a 270 inquiry or 271 response transaction set.

The Master Test Bed Data does not specify any specific values that must be used in these control segments. Users are referred to the ASC X12 005010X279 Eligibility Benefit Inquiry and Response Implementation Guideline Technical Report Type 3 (v5010 270/271) ~~X12N HIPAA-adopted 270/271 Implementation Guide~~ Appendix for the proper use and values.

4.1.5 Using the Test Bed Data

All CORE-authorized certification testing vendors will use only data from the CORE Phase I Master Test Bed Data, combined with the CORE Test Suite Scenarios and Detailed Test Scripts, when conducting CORE certification testing for the CORE 154 Eligibility and Benefits 270/271 Data Content and CORE 150 and 151 Acknowledgements Rules.

Although the CORE Phase I Master Test Bed Data is comprised of 32 beneficiaries (subscribers/dependents) and 13 associated health plans, the actual CORE Phase I Certification Testing does not include all beneficiaries (subscribers/dependents) and associated health plans. Each CORE-authorized certification testing vendor will determine which of the beneficiaries (subscribers/dependents) and associated health plans will be used during actual certification testing. This means that CORE-authorized certification testing vendors will only create 270s and 271s and accept corresponding 270s and 271s that match the actual or modified beneficiary and health plan information in the CORE Phase I Master Test Bed Data.

The CORE Phase I Master Test Bed Data does not contain ISA/GS sender and receiver IDs. The actual 270 and 271 transaction sets sent during certification testing should have appropriate ISA/GS sender and receiver IDs as agreed to between the CORE-authorized Certification Testing Vendor and the user, as well as appropriate control numbers at the ISA/GS/ST/BHT03 levels as required by the ASC X12 Standards and the HIPAA-adopted v5010 270/271 Implementation Guides. Batch test transaction cases may contain multiple eligibility requests and responses in each message. Therefore, organizations planning to undergo CORE-certification testing with a CORE-authorized certification testing vendor should extract the CORE Phase I Master Test Bed Data needed to appropriately load their internal databases for internal testing and CORE-certification testing purposes.

The CORE Phase I Master Test Bed Data is not intended to provide all of the data elements that the user may need to completely populate its internal test file or test database in order to test for CORE Phase I compliance against the Detailed Test Scripts. Depending upon their specific database structure requirements, users may be required to add other test data, or modify the CORE Phase I Master Test Bed Data as outlined in §4.1.3

4.1.6 Test Data and CORE Certification

The CORE Phase I Certification Test Suite defines specific certification testing requirements and detailed Test Scripts for each of the CORE Phase I rules. These detailed Test Scripts are not intended to exhaustively and comprehensively test all requirements of the CORE Phase I rules. Rather, the Test Scripts focus on a key subset of each rule's requirements. Consequently, the scope of the CORE Phase I Master Test Bed Data is limited to data needed for the entity seeking to become CORE-certified to create and populate its internal files and/or databases for internal pre-certification testing and CORE certification testing for the CORE 154 Eligibility and Benefits 270/271 Data Content and CORE 150 and 151 Acknowledgements Rules.

Use of any non-CORE base test bed data for CORE certification testing outside of the guidelines set forth in §4.1 may result in unsuccessful testing results, which will not be accepted by CAQH.

4.1.7 CORE Certification Master Test Bed Data References

4.1.7.1 270/271 ASC X12 Reference Sheet

This table provides an example of the data mapping from the CORE Phase I Master Test Bed Data to its respective ASC X12 data element.

HEALTH PLAN				ASC X12 Mapping
Field	**Min Len**	**Max Len**	**Data Attributes**	**Loop/Segment**
NPI	10	10	Alpha Numeric	2100B/NM109 with 2100B / NM108 = "XX"
Subscriber ID	2	30	Alpha Numeric	2100C/NM109 with NM108 = "MI"
Subscriber First Name	1	25	Alpha Numeric	2100C/NM104
Subscriber Last Name	1	35	Alpha Numeric	2100C/NM103
Subscriber DOB	1	35	CCYYMMDD	2100C/DMG02 with DMG01 = “D8”
Service Type Code	1	2	Alpha Numeric	2110C or 2110D/EB03
Dependent First Name	1	25	Alpha Numeric	2100D/NM104
Dependent Last Name	1	35	Alpha Numeric	2100D/NM103
Dependent DOB	1	35	CCYYMMDD	2100D/DMG02 with DMG01 = "D8"
Health Plan Name	1	50	Alpha Numeric	2110C or 2110D/EB05
Health Plan Number	1	17	Alpha Numeric	2100C/REF02 with REF01 = “18”
Group Number	1	17	Alpha Numeric	2100C/REF02 with REF01 = “6P”

In addition to the CORE Phase I Master Test Bed Data, the following reference sources will be of assistance when conducting CORE-certification testing:

CORE 104: Testing Policy

CORE 150: Batch Acknowledgements Rule

CORE 151: Real Time Acknowledgements Rule

CORE 154: Eligibility and Benefits 270/271 Data Content Rule

HIPAA adopted ASC X12 005010X279 Eligibility Benefit Inquiry and Response Implementation Guideline Technical Report Type 3 ~~X12N 270/271 Implementation Guides~~

ASC X12 Standards Version 005010 ~~004010~~