CAQH CORE Claim Status (276/277) Infrastructure Rule

Version CS.2.0

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Revision History for CAQH CORE Claim Status (276/277) Infrastructure Rule

Version	Revision	Description	Date
2.0.0	Major	Phase II CAQH CORE 250: Claim Status balloted and approved via CAQH CORE Voting Process.	2010
2.1.0	Minor	Adjustments to the Phase II CAQH CORE 250: Claim Status Rule to support ACS X12 HIPAA-adopted v5010.	March 2011
CS.1.0	Minor	• Non-substantive adjustments to support re-organization of operating rules into rule sets organized by business transaction (e.g., eligibility, claims, etc.) rather than phase (e.g., Phase I, II, etc.) as approved by the CAQH CORE Board in 2019. • Operating rule naming, versioning and numbering methodologies updated to align with business transaction-based rule sets.	May 2020
CS.2.0	Major	• Substantive updates to system availability requirements to align with current business needs. • Additional non-substantive adjustments for clarity.	April 2022

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1. Background Summary

The CAQH CORE Eligibility & Benefits Operating Rules focus on improving electronic eligibility and benefits verification, as eligibility is the first transaction in the claims process. Thus, if eligibility and benefits are correct, all the transactions that follow will be more effective and efficient. Building on this, CAQH CORE determined that the operating rules should be extended to include rules around the claim status transaction that allow providers to check the status of a claim electronically, without manual intervention, or confirm claims receipt. Benefits to electronic claim status inquiry and response will provide for:

- Less staff time spent on phone calls and websites
- Increased ability to conduct targeted follow-up
- More accurate and efficient processing and payment of claims

This CAQH CORE Claim Status (276/277) Infrastructure Rule for the HIPAA-adopted X12 005010X212 Health Care Claim Status Request and Response (276/277) Technical Report Type 3 (TR3) implementation guide and associated errata (hereafter v5010 276, v5010 277 or v5010 276/v5010 277) will facilitate the industry's momentum to increase access to the claim status transaction, and will encourage CORE-certified entities to use the infrastructure they have for the HIPAA-adopted X12 005010X279A1 Eligibility Benefit Inquiry and Response (270/271) Technical Report Type 3 implementation guide and associated errata (hereafter v5010 270/271), and apply this infrastructure to claims status.

2. Issue To Be Addressed And Business Requirement Justification

In order to electronically process a claim status inquiry, providers need to have a robust v5010 277 claim status response. This robust response includes the health plans providing the status of the claim, such as pre- adjudication acceptance or rejection, an incorrect or incomplete claim is pended, or that the claim is suspended and additional information is being requested. HIPAA provides a foundation for the electronic exchange of claim status information, but does not go far enough to ensure that today's paper-based system can be replaced by an electronic, interoperable system. HIPAA's mandated data scope does not require the financial information needed by providers, and HIPAA neither addresses the standardization of data definitions nor contains business requirements by which the HIPAA-outlined data can flow efficiently and on a timely basis.

Using the available but not-required (situational) elements of the v5010 276/v5010 277, the CAQH CORE Claim Status (276/277) Infrastructure Rule defines the specific business information requirements that health plans must satisfy and which vendors, clearinghouses and providers should use if they want to be CORE-certified. As with all CAQH CORE rules, these requirements are intended as a base or minimum set of requirements and it is expected many CORE- certified entities will add to these requirements as they work towards the goal of administrative interoperability. The CAQH CORE Claim Status (276/227) Infrastructure Rule requires that health plans respond to an inquiry in real time (within 20 seconds), make appropriate use of the standard acknowledgements to eliminate the "black hole," support the CAQH CORE "safe harbor" connectivity requirement, and ensure that the system components required to process claim status inquiries are available 86 percent of the time.

By requiring the delivery and use of this claim status information via the v5010 276/v5010 277, the CAQH CORE Claim Status (276/227) Infrastructure Rule helps provide the information that is necessary to electronically process a claim status inquiry and thus reduce the current cost of today's paper-based transaction process.

3. Scope

3.1. What the Rule Applies To

The CAQH CORE Claim Status (276/277) Infrastructure Rule complements and extends the CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule to the conduct of the v5010 276/v5010 277. This rule specifies that a CORE-certified entity must conduct these transactions in real time, respond within 20 seconds, make their systems available 86 percent of the time, use the X12 standard acknowledgments and support the CAQH CORE Connectivity safe harbor requirements.

3.2. When the Rule Applies

This rule applies when a CORE-certified entity uses, conducts, or processes the v5010 276/v5010 277 claims status transactions.

3.3. What the Rule Does Not Require

This rule does not address any v5010 276/v5010 277 transaction content requirements of the v5010 276/v5010 277 implementation guide. This rule does not require any entity to:

- Conduct, use, or process the v5010 276/v5010 277 claim status transactions if it currently does not do so.
- Integrate its current claim status processing system components into its current eligibility processing system if they are not currently integrated.

3.4. Outside the Scope of This Rule

This rule does not address the data content of the v5010 276 nor the data content of the health plan's response using the v5010 277.

3.5. How the Rule Relates to Other CAQH CORE Operating Rules

This rule applies the CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule requirements (e.g., Response Time, System Availability, Acknowledgements, and Companion Guide), which were created to increase access to the v5010 270/271 transactions, and applies these requirements, where appropriate, to the v5010 276/v5010 277 claim status transactions.

As with other CAQH CORE Operating Rules, general CAQH CORE policies also apply to CAQH CORE Claim Status Operating Rules. The CAQH CORE policies include:

- CORE Certification Testing for each stakeholder wishing to be awarded a CORE-certified Seal
- Entities seeking CORE Certification may use a contracted party to meet operating rules, e.g. some providers meet CORE Connectivity requirements via their vendor products
- A health plan system exemption policy for system migration
- Entities only need to test for and meet batch rule requirements if they currently offer batch for claim status transactions. A CAQH CORE guiding principle is to move to real time; thus, CAQH CORE rules do not require entities to build batch capabilities.

3.6. Assumptions

The following assumptions apply to this rule:

- All the CAQH CORE Guiding Principles apply to this rule and all other operating rules.
- This rule is not a comprehensive companion document addressing any content requirements of either the v5010 276 Claim Status Request or v5010 277 Claim Status Response transaction sets.

- Compliance with all operating rules is a minimum requirement; a CORE-certified entity is free to offer more than what is required in the rule.
- Providers, vendors, clearinghouses and health plans (or other information sources) all need to meet appropriate aspects of the rule and all will be tested via CORE Certification Testing.

4. Rule

4.1. Claim Status Connectivity Requirements

These requirements address proposed usage patterns for both batch and real time transactions, the exchange of security identifiers, and communication-level errors and acknowledgements. It does not attempt to define the specific content of the message exchanges beyond declaring that the HIPAA-adopted X12 formats must be used between covered entities and security information must be sent outside of the X12 payloads.

These requirements are designed to provide a "safe harbor" that application vendors, providers, and health plans (or other information sources) can be assured will be supported by any CORE-certified trading partner. All CORE-certified organizations must demonstrate the ability to implement connectivity as described in the most recent published and CAQH CORE adopted version of the CAQH CORE Connectivity Rule (hereafter referred to as CAQH CORE Connectivity Rule to support v5010 of the X12 administrative transactions, whether or not adopted by HIPAA. These requirements are not intended to require trading partners to remove existing connections that do not match the rule, nor is it intended to require that all CAQH CORE trading partners must use this method for all new connections. CAQH CORE expects that in some technical circumstances, trading partners may agree to use different communication mechanism(s) and/or security requirements than that described by these requirements.

These requirements describe some of the specifics for implementing HTTP/S connectivity for healthcare administrative transaction exchange.

4.2. Claim Status Real Time Acknowledgement Requirements

These requirements assume a successful communication connection has been established and that all parties in the transaction routing path are CORE-certified.

These requirements address only acknowledgements for receivers of the v5010 276 for Real Time. It does not address acknowledgements that receivers of the v5010 277 must consider.

4.2.1. *Use of the v5010 999 and v5010 277 Acknowledgements for Real Time*

4.2.1.1. *Reporting on Real Time v5010 276 Submission That Is Rejected*

Functional Group or Transaction Set Rejection

If the v5010 276 passes X12 Interchange editing, but an error resulting in a rejection is found during the validation of the Functional Group(s) or Transaction Set(s) within a Functional Group, the receiver of the v5010 276 (clearinghouse, intermediary, health plan or information source) must always return an

X12 005010X231A1 Implementation Acknowledgement for Health Care Insurance (999) (hereafter v5010 999) for the Functional Group of the v5010 276 inquiry to indicate a rejection (negative acknowledgement). If the Functional Group is not rejected, a v5010 999 must not be returned.

4.2.1.2. *Reporting on a Real Time v5010 276 that is Accepted*

If the v5010 276 complies with the X12 v5010 276 TR3 implementation guide requirements, then the v5010 277 Claim Status Response will be returned to the submitter.

Therefore, the submitter of a v5010 276 in real time will receive only one acknowledgement/response from the receiver (clearinghouse, intermediary, health plan or information source): a v5010 999 (rejection); or a v5010 277.

4.2.2. *Conformance*

Conformance with this section's requirements are considered achieved when all of the required detailed step-by-step test scripts specified in the Claim Status CAQH CORE Certification Test Suite are successfully passed.

For Claim Status, the certification testing approach is similar to other operating rule sets. In other operating rules, entities are not tested for their compliance with all sections of a rule, rather just certain sections as testing is not exhaustive and is paired with the CAQH CORE Enforcement Policy. CORE Certification requires entities to be compliant with all aspects of the rule when working with all trading partners, unless the CORE-certified entity has an exemption. Refer to the Claim Status CAQH CORE Certification Test Suite for details.

Per the Claim Status CAQH CORE Certification Test Suite, conformance with this rule is considered achieved by receivers of the v5010 276 (clearinghouse, intermediary, health plan or information source) if all of the following criteria are achieved:

1. A v5010 999 is returned only to indicate a Functional Group (including the enclosed Transaction Set) error resulting in the rejection of the entire Functional Group.
    a. A v5010 999 must not be returned if there are errors not resulting in the rejection of the Functional Group and enclosed Transaction Set.
2. A v5010 277 must always be returned for an Interchange, Functional Group and Transaction Set that complies with X12 v5010 276 requirements.
    a. A v5010 277 may contain either the appropriate STC Claim or Line Level Status Information segment(s) in the case of a business level error or the data segments containing the requested claim status details.

4.3. Claim Status Batch Acknowledgement Requirements

These requirements for use of acknowledgements for batch mode places parallel responsibilities on both submitters of the v5010 276 (providers) and submitters of the v5010 277 (health plans or information sources) for sending and accepting the v5010 999. The goal of this approach is to adhere to the principles of EDI in assuring that transactions sent are accurately received and to facilitate health plan correction of errors in their outbound responses.

The rule assumes a successful communication connection has been established and that all parties in the transaction routing path are CORE-certified.

4.3.1. *Use of the v5010 999 Acknowledgement for Batch v5010 276 and v5010 277*

The receiver of the batch (the provider, clearinghouse, intermediary, health plan or information source) must always return a v5010 999 for each Functional Group of a v5010 276 batch or a v5010 277 batch to indicate that the Functional Group was either accepted, accepted with errors, or rejected.

4.3.2. *Requirements for Return of a v5010 999*

The v5010 999 must not be returned during the initial communications session in which the v5010 276 batch is submitted. *See §4.5 Claim Status Batch Response Time Requirements for the timing and availability of this acknowledgement.*

4.3.3. *Conformance*

Conformance with this section's requirements is considered achieved when all of the required detailed step-by-step test scripts specified in the Claim Status CAQH CORE Certification Test Suite are successfully passed.

For Claim Status, the certification testing approach is similar to other CAQH CORE operating rule sets where entities are not tested for their compliance with all sections of a rule, rather just certain sections as testing is not exhaustive and is paired with the CAQH CORE Enforcement Policy. CORE Certification requires entities to be compliant with all aspects of the rule when working with all trading partners, unless the CORE-certified entity has an exemption. Refer to Claim Status CAQH CORE Certification Test Suite for details.

Per the Claim Status CAQH CORE Certification Test Suite, conformance with this rule is considered achieved by receivers of the batch (provider, clearinghouse, intermediary, health plan or information source) if all of the following criteria are achieved:

1. A v5010 999 is returned to indicate acceptance, rejection or errors in a Functional Group (including the enclosed Transaction Set).
    a) A v5010 999 must always be returned even if there are no errors in the Functional Group and enclosed Transaction Set.
2. A v5010 277 response transaction must always be returned for an Interchange, Functional Group and Transaction Set that complies with X12 TR3 implementation guide requirements.

4.4. Claim Status Real Time Response Time Requirements

Maximum response time when processing in real time mode for the receipt of a v5010 277 (or in the case of a rejection, a v5010 999) from the time of submission of a v5010 276 must be 20 seconds (or less). V5010 999 response rejections must be returned within the same response timeframe.[1] *See §4.6 Claim Status System Availability Requirements for notification process of holidays.*

4.4.1. *Conformance Measurement*

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.

Each CORE-certified entity must demonstrate its conformance with this maximum response time rule by demonstrating its ability to capture, log, audit, match and report the date (YYYYMMDD), time (HHMMSS) and control numbers from its own internal systems and the corresponding data received from its trading partners.

4.4.2. *Conformance*

Conformance with this section's requirements is considered achieved when all of the required detailed step-by-step test scripts specified in the Claim Status CAQH CORE Certification Test Suite are successfully passed.

For Claim Status, the certification testing approach is similar to other operating rule sets where entities are not tested for their compliance with all sections of a rule, rather just certain sections as testing is not exhaustive and is paired with the CAQH CORE Enforcement Policy. CORE Certification requires entities to be compliant with all aspects of the rule when working with all trading partners, unless the CORE-

[1] See §4.2 Claim Status Real Time Acknowledgement Requirements, which requires return of either a v5010 999 or a v5010 277 response.

certified entity has an exemption. Refer to the Claim Status CAQH CORE Certification Test Suite for details.

The Claim Status CAQH CORE Certification Test Suite for this rule includes the following:

1. The actual delivery of statistics by a CORE-certified entity will be required only in response to a verified compliance complaint. Otherwise, a CORE-certified entity's compliance with the response time requirements will be based on good faith.
2. All CORE-certified entities are required to conform to this and other CORE rules regardless of the connectivity mode and methods used between CORE-certified trading partners.
3. This rule assumes that all parties in the transaction routing path are CORE-certified and compliant.
4. The recommended maximum response time between each participant in the transaction is 4 seconds or less per hop as long as the 20-second total roundtrip requirement is met.

4.5. Claim Status Batch Response Time Requirements

When a v5010 276 batch submitted in batch processing mode is subsequently converted to real time processing by any intermediary clearinghouse or switch for further processing by the health plan (or information source) before being returned to the submitter as a batch v5010 277, the Claim Status Batch Response Time Requirements shall apply. *(See §4.4 Claim Status Real Time Response Time Requirements)*

Maximum response time when processing in batch mode for the receipt of a v5010 277 batch to a v5010 276 batch 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. (*See §4.6 Claim Status System Availability Requirements for notification process of holidays.)*

4.5.1. *Batch Response Time v5010 999 Acknowledgement Requirements*

A v5010 999 must be available to the submitter within one hour of receipt of the batch: to the provider in the case of a batch v5010 276 and to the health plan (or information source) in the case of a batch v5010 277.[2]

4.5.2. *Conformance Measurement*

Conformance with this maximum response time requirement 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.

Each CORE-certified entity must demonstrate its conformance with this maximum response time requirement 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.

[2] See §4.3 Claim Status Batch Acknowledgements Requirements, which requires return of a v5010 999 in all cases indicating rejection/acceptance of the batch.

4.5.3. *Conformance*

Conformance with this section's requirements is considered achieved when all of the required detailed step-by-step test scripts specified in the Claim Status CAQH CORE Certification Test Suite are successfully passed.

For Claim Status, the certification testing approach is similar to other operating rules sets where entities are not tested for their compliance with all sections of a rule, rather just certain sections as testing is not exhaustive and is paired with the CAQH CORE Enforcement Policy. CORE Certification requires entities to be compliant with all aspects of the rule when working with all trading partners, unless the CORE-certified entity has an exemption. Refer to the Claim Status CAQH CORE Certification Test Suite for details.

The Claim Status CAQH CORE Certification Test Suite for this rule includes the following:

- The actual delivery of statistics by a CORE-certified entity will be required only in response to a verified compliance complaint. Otherwise, a CORE-certified entity's compliance with the response time requirements will be based on good faith. Please see the CAQH CORE Enforcement Policy for details on filing complaints and who is permitted to file complaints.
- All CORE-certified entities are required to conform to this rule regardless of the connectivity mode and methods used between CORE-certified trading partners.
- This rule assumes that all parties in the transaction routing path are CORE-certified and compliant.

4.6. Claim Status System Availability

Many healthcare providers have a need to determine the status of a claim that has been submitted for adjudication outside of the typical business day and business hours. Additionally, many institutional providers are now allocating staff resources to performing administrative and financial back-office activities on weekends and evenings. As a result, providers have a business need to be able to conduct claim status transactions at any time.

On the other hand, health plans have a business need to take their claims processing and other systems offline periodically in order to perform the required system maintenance. This typically results in some systems not being available for timely v5010 276 and v5010 277 certain nights and weekends. The rule was created to address these conflicting needs.

4.6.1. System Availability Requirements

4.6.1.1. Weekly System Availability Requirement

System availability must be no less than 90 percent per calendar week for both Real Time and Batch Processing Modes. System is defined as all necessary components required to process an X12N v5010 837 Claim transaction, an X12C v5010 999 transaction, and an X12N v5010 277CA transaction. Calendar week is defined as 12:01 a.m. Sunday to 12:00 a.m. the following Sunday. This will allow for a HIPAA-covered health plan or its agent to schedule system updates to take place within a maximum of 17 hours per calendar week for regularly scheduled downtime.

4.6.1.2. Quarterly System Availability Requirement

A HIPAA-covered health plan or its agent may choose to use an additional 24 hours of scheduled system downtime per calendar quarter. System is defined as all necessary components required to process a 5010X217 278 Request and Response and a 5010X231 999 transaction. This will allow a HIPAA-covered health plan or its agent to schedule additional downtime for substantive system migration. This additional

allowance in a system downtime is in excess of the allowable weekly system downtime specified in Section 4.6.1.1.[3]

4.6.2. *Reporting Requirements*

4.6.2.1. *Scheduled Downtime*

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.

4.6.2.2. *Non-Routine Downtime*

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.

4.6.2.3. *Unscheduled Downtime*

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.

4.6.2.4. *No Response Required*

No response is required during scheduled downtime(s).

4.6.2.5. *Holiday Schedule*

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.

4.6.3. *Conformance*

Conformance with this rule is considered achieved when all of the required detailed step-by-step test scripts specified in the Claim Status CAQH CORE Certification Test Suite are successfully passed.

For Claim Status, the certification testing approach is similar to other operating rule sets where entities are not tested for their compliance with all sections of a rule, rather just certain sections as testing is not exhaustive and is paired with the CAQH CORE Enforcement Policy. CORE Certification requires entities to be compliant with all aspects of the rule when working with all trading partners, unless the CORE-certified entity has an exemption. Refer to the Claim Status CAQH CORE Certification Test Suite for details.

Per the Claim Status CAQH CORE Certification Test Suite, each CORE-certified entity must demonstrate its conformance with this system availability rule by publishing the following documentation:

- Actual published copies of regularly scheduled downtime schedule, including holidays, and method(s) of publishing.
- Sample of non-routine downtime notice and method(s) of publishing.
- Sample of unscheduled/emergency downtime notice and method(s) of publishing.

[3] See CAQH CORE Claim Status FAQs on System Availability for additional guidance on implementation and conformance with quarterly system availability requirement for federally mandated versions of operating rules.

4.7. Claim Status Companion Guide

Health plans or information sources have the option of creating a "companion guide" that describes the specifics of how they will implement the HIPAA transactions. The companion guide is in addition to and supplements the X12 v5010 TR3 implementation guide.

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

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

Although CAQH CORE Participants believe that a standard template/common structure is desirable, they recognize that different health plans may have different requirements. The CAQH CORE Master Companion Guide Template gives health plans the flexibility to tailor the document to meet their particular needs.

Note: The CAQH CORE Master Companion Guide Template has been adapted from the CAQH/WEDI Best Practices Companion Guide Template originally published January 1, 2003.

4.7.1. *Claim Status Companion Guide Requirements*

All CORE-certified entities' Companion Guides covering the v5010 276/v5010 277 transactions must follow the format/flow as defined in the CAQH CORE Master Companion Guide Template.

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

4.7.2. *Conformance*

Conformance with this section's requirements is considered achieved when all of the required detailed step-by-step test scripts specified in the Claim Status CAQH CORE Certification Test Suite are successfully passed.

For Claim Status, the certification testing approach is similar to other operating rule sets. In other operating rules, entities are not tested for their compliance with all sections of a rule, rather just certain sections as testing is not exhaustive and is paired with the CAQH CORE Enforcement Policy. CORE Certification requires entities to be compliant with all aspects of the rule when working with all trading partners, unless the CORE-certified entity has an exemption. Refer to the Claim Status CAQH CORE Certification Test Suite for details.

Per the Claim Status CAQH CORE Certification Test Suite, conformance with this rule is considered achieved by health plans (or information sources) if all of the following criteria are achieved:

1) Publication to its trading partner community of its detailed companion guide specifying all requirements for submitting and processing the v5010 276 and the v5010 277 transaction in accordance with this rule.
2) Submission to an authorized CORE certification testing company the following:
   a) A copy of the table of contents of its official v5010 276/v5010 277 companion guide.

b) A copy of a page of its official v5010 276/v5010 277 companion guide depicting its conformance with the format for specifying the v5010 276/v5010 277 data content requirements.
c) 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 v5010 276/v5010 277 content requirements of the companion guide is located.