



**CAQH CORE Eligibility & Benefits (270/271)
Infrastructure Rule**

Version EB.2.0

April 2022

**CAQH Committee on Operating Rules for Information Exchange (CORE)
Eligibility & Benefits (270/271) Infrastructure Rule vEB.2.0**

Revision History for CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule

Version	Revision	Description	Date
2.0.0	Major	Phase I CAQH CORE 270/271: Eligibility & Benefits Data Content Rule balloted and approved balloted and approved via CAQH CORE Voting Process.	2010
2.1.0	Minor	Adjustments to the Phase I CAQH CORE 270/271: Eligibility & Benefits Rule to support X12 HIPAA-adopted v5010.	March 2011
EB.1.0	Minor	<ul style="list-style-type: none"> • Non-substantive adjustments to support re-organization of operating rules into rule sets organized by business transaction (e.g., Eligibility & Benefits, Claim Status, 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
EB.2.0	Major	<ul style="list-style-type: none"> • Substantive updates to system availability requirements to align with current business needs. • Update Connectivity reference to align with the most recent published and CAQH CORE adopted version of the CAQH CORE Connectivity Rule. • Additional non-substantive adjustments for clarity. 	April 2022

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Introduction

Six Phase I CAQH CORE Operating Rules were combined in 2020 to create the CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule (see Revision History) as part of the CAQH CORE Eligibility & Benefits Rule Set. A single rule to support all infrastructure operating rule requirements is consistent with all other CAQH CORE rule sets and simplifies ongoing maintenance. The operating rule requirements were not impacted by this update. The rule is divided into seven sections by requirement type:

1. Connectivity
2. Real Time Acknowledgements
3. Batch Acknowledgements
4. Real Time Response Times
5. Batch Response Times
6. System Availability
7. Companion Guide

1 Eligibility & Benefits Connectivity Requirements

1.1. Rule Requirements

The CAQH CORE Connectivity Rule addresses proposed usage patterns for both Batch and Real Time transactions, the exchange of security identifiers, and communications-level errors and acknowledgements. It does not attempt to define the specific content of the message exchanges beyond declaring that the formats must be used between entities and that security information must be sent outside of the message envelope payload.

This connectivity requirement is designed to provide a “safe harbor” that application vendors, providers, and health plans (or their agents¹) 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). 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 this requirement.

1.2. Conformance Requirements

Conformance with this connectivity requirement is considered achieved by HIPPA-covered entities or their agents if all of the criteria described in the CAQH CORE Connectivity Rule are achieved.

2 Eligibility & Benefits Real Time Acknowledgement Requirements

2.1. Background Summary

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

This requirement addresses only acknowledgements for receivers of the X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter X12 v5010 270) for Real Time. It does not address acknowledgements that receivers of the X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter X12 v5010 271) must consider.

¹ One who agrees and is authorized to act on behalf of another, a principal, to legally bind an individual in particular business transactions with third parties pursuant to an agency relationship. Source: West's Encyclopedia of American Law, edition 2. Copyright 2008 The Gale Group, Inc. All rights reserved.

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2.2. Rule Requirements

2.2.1. Use of the 999 and X12 v5010 271 Acknowledgements for Real Time

2.2.1.1. Reporting on a Real Time X12 v5010 270 Submission that is Rejected

Functional Group or Transaction Set Rejection

If the X12 v5010 270 passes X12 Interchange editing, but an error resulting in a rejection is found during the validation of the Functional Group or Transaction Set within a Functional Group, the receiver of the X12 v5010 270 (clearinghouse, intermediary, health plan or its agent) must always return an X12 005010X231A1 Implementation Acknowledgement for Health Care Insurance (999) (hereafter X12 v5010 999) for the Functional Group of the X12 v5010 270 to indicate a rejection (negative acknowledgement). If the Functional Group is not rejected, an X12 v5010 999 must not be returned.

2.2.1.2. Reporting on a Real Time X12 v5010 270 Submission that is Accepted

If the X12 v5010 270 complies with the X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (herein X12 v5010 270/271, X12 v5010 270, X12 v5010 271) Technical Report Type 3 (TR3) implementation guide requirements, then the X12 v5010 271 will be returned to the submitter.

The AAA segments in the X12 v5010 271 will be used to report business level error situations.

2.2.1.3. Summary

Therefore the submitter of an X12 v5010 270 in Real Time will receive only one acknowledgement/response from the receiver (clearinghouse, intermediary, health plan or its agent): an X12 v5010 999 (rejection); or an X12 v5010 271.

2.3. Conformance Requirements

Conformance with this Real Time acknowledgement rule is considered achieved by receivers of the X12 v5010 270 request (clearinghouse, intermediary, health plan or its agent) if all of the following criteria are achieved:

1. An X12 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) An X12 v5010 999 must not be returned if there are errors not resulting in the rejection of the Functional Group and enclosed Transaction Set
2. An X12 v5010 271 must always be returned for an Interchange, Functional Group and Transaction Set that complies with X12 v5010 270 requirements
 - a) An X12 v5010 271 may contain either the appropriate AAA Validation Request segment(s) in the case of a business level error or the data segments containing the requested eligibility and benefit status details

3 Eligibility & Benefits Batch Acknowledgement Requirements

3.1. Background Summary

This rule for use of acknowledgements for Batch Mode places parallel responsibilities on both submitters of the X12 v5010 270 request (providers) and responders to the X12 v5010 271 responses (health plans or their agents) for sending and accepting the X12 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.

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3.2. Rule Requirements

3.2.1. Use of the X12 v5010 999 and X12 v5010 271 Acknowledgements for Batch

3.2.1.1. Reporting on a Batch X12 v5010 270 or X12 v5010 271 Submission

Functional Group or Transaction Set Acknowledgement

If the X12 v5010 270 Batch inquiries or X12 v5010 271 Batch responses pass X12 Interchange editing, the receiver of the Batch (the provider, clearinghouse, intermediary, health plan or its agent) must always return an X12 v5010 999 for each Functional Group of X12 v5010 270 inquiries or X12 v5010 271 responses to indicate that the Functional Group was either accepted, accepted with errors, or rejected and to specify for each included X12 v5010 270 inquiry or X12 v5010 271 response Transaction Set that Transaction Set was either accepted, accepted with errors, or rejected.

Therefore, in Batch Mode, the receiver (provider, clearinghouse, intermediary, health plan or its agent) will always return An X12 v5010 999 acknowledgement indicating either rejection or acceptance of the Batch.

If the X12 v5010 270 Batch is accepted for processing, a Batch of X12 v5010 271 responses is subsequently returned to the submitter by the health plan (or its agent). The AAA segments in the X12 v5010 271 responses are used to report business level error situations.

3.2.2. Requirements for Return of an X12 v5010 999

The X12 v5010 999 Implementation Acknowledgement must not be returned during the initial communications session in which the X12 v5010 270 Batch is submitted. Reference the CAQH CORE Connectivity Rule and [Section 5](#) of this rule for the timing and availability of these two acknowledgements.

3.3. Conformance Requirements

Conformance with this Batch acknowledgement rule is considered achieved by receivers of the Batch (provider, clearinghouse, intermediary, health plan or its agent) if all of the following criteria are achieved:

1. An X12 v5010 999 is returned to indicate acceptance, rejection or errors in a Functional Group (including the enclosed Transaction Set)
 - a) An X12 v5010 999 must always be returned even if there are no errors in the Functional Group and enclosed Transaction Set
2. An X12 v5010 271 response transaction must always be returned for an Interchange, Functional Group and Transaction Set that complies with X12 TR3 implementation guide requirements
 - a) An X12 v5010 271 response transaction may contain either the appropriate AAA Validation Request segment(s) in the case of a business level error or the data segments containing the requested and benefit status details

4 Eligibility & Benefits Real Time Response Time Requirements

4.1. Rule Requirements

4.1.1. X12 v5010 270 Real Time Mode Response Time Requirements

Maximum response time when processing in Real Time mode for the receipt of an X12 v5010 271 or in the case of an error, an X12 v5010 999 from the time of submission of an X12 v5010 270 must be 20 seconds (or less). X12 v5010 999 errors must be returned within the same response timeframe.² See [Section 6](#) for notification process of holidays.

² See [Section 2](#), which requires return of either a 999 or 271 response.

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4.2. Conformance Requirements

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.

The Eligibility & Benefits 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

5 Eligibility & Benefits Batch Response Time Requirements

5.1. Background Summary

When X12 v5010 270 eligibility inquiries submitted in Batch Processing Mode are subsequently converted to Real Time Processing by any intermediary clearinghouse or switch for further processing by the health plan (or its agent) before being returned to the submitter as a Batch of X12 v5010 271 responses, the Eligibility & Benefits Batch Response Time Requirements shall apply.

5.2. Rule Requirements

5.2.1. X12 v5010 270 Batch Mode Response Time Requirements

Maximum response time when processing in Batch Mode for the receipt of an X12 v5010 271 to an X12 v5010 270 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 00:00 hours) of each designated day through 11:59 pm (23:59 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 its agent. See [Section 6](#) for notification process of holidays.

5.2.2. X12 v5010 999 Batch Mode Response Time Requirements

An X12 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 of X12 v5010 270; and to the health plan (or its agent) in the case of a Batch of X12 v5010 271.³

5.3. Conformance Requirements

Conformance with this Batch response time rule shall be considered achieved if 90 percent of all required responses as specified in [Section 3](#) are returned within the specified maximum response time as measured within a calendar month.

³ See [Section 3](#), which requires return of an X12 v5010 999 to be sent in all cases indicating rejection/acceptance of the Batch.

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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.

The Eligibility & Benefits 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 rule 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

6 Eligibility & Benefits System Availability Requirements

6.1. Background Summary

Many healthcare providers have a need to determine an individual's health plan coverage at the time and point of patient registration and intake, which may occur on a 24x7x365 basis or outside of the typical business day and business hours. Additionally, many institutional providers are now allocating staff resources to performing patient pre-registration activities on weekends and evenings. As a result, providers have a business need to be able to conduct health plan eligibility transactions at any time. On the other hand, health plans have a business need to take their eligibility and other systems offline periodically in order to perform the required system maintenance. This typically results in some systems not being available for timely eligibility inquiries and responses certain nights and weekends. The rule was created to address these conflicting needs.

6.2. Rule Requirements

6.2.1. System Availability Requirements

6.2.1.1. 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 X12 v5010 270/271 Eligibility Benefit Request and Response transaction and an X12 v5010 999 transaction. Calendar week is defined as 12:01 a.m. Sunday to 12:00 a.m. the following Sunday. This will allow for a HIPAA-covered health plan or its agent to schedule system updates to take place within a maximum of 17 hours per calendar week for regularly scheduled downtime.

6.2.1.2. 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 X12 v5010 270/271 Eligibility Benefit Request and Response and an X12 v5010 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 6.2.1.1.⁴

6.2.2. Reporting Requirements

6.2.2.1. Scheduled Downtime

HIPAA-covered health plans (or their agents), clearinghouses/switches or other intermediaries must publish their regularly scheduled system downtime in an appropriate manner (e.g., on websites or in

⁴ See [CAQH CORE Eligibility & Benefit FAQs on System Availability](#) for additional guidance on implementation and conformance with quarterly system availability requirement for federally mandated versions of operating rules.

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companion guides) such that the healthcare provider can determine the health plan's system availability and staffing levels can be effectively managed.

6.2.2.2. Non-Routine Downtime

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

6.2.2.3. Unscheduled Downtime

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

6.2.2.4. No Response Required

No response is required during scheduled downtime(s).

6.2.3. Holiday Schedule

Each HIPAA-covered health plan, (or its agent), clearinghouse/switch, or other intermediary will establish its own holiday schedule and publish it in accordance with the rule above.

6.3. Conformance Requirements

Each CORE-certified entity must demonstrate its conformance with this system availability rule by publishing the following documentation:

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

7 Eligibility & Benefits Companion Guide Requirements

7.1. Background Summary

Health plans or their agents 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 TR3 Implementation Guide.

Historically, health plans or their agents have independently created companion guides that vary in format and structure. Such variance can be confusing to trading partners/providers who must review numerous companion guides along with the X12 Implementation Guides. To address this issue, CAQH CORE developed the CAQH CORE Master Companion Guide Template for health plans or their agent. Using this template, health plans or their agents 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.

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7.2. Rule Requirements

All CORE-certified entities' companion guides covering the X12 v5010 270/271 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.

7.3. Conformance Requirements

Conformance with this companion guide rule is considered achieved by health plans (or their agents) 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 X12 v5010 270 and returning the X12 v5010 271 transaction in accordance with this rule
2. Submission to a CAQH CORE-authorized the following:
 - a) A copy of the table of contents of its official X12 270/271 companion guide
 - b) A copy of a page of its official X12 270/271 companion guide depicting its conformance with the format for specifying the X12 270/271 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 X12 270/271 data content requirements of the companion guide is located

8 Conformance Requirements

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