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3 Scope

3.1 What the Rule Applies To

This CAQH CORE Attachments (275/278) Prior Authorization Data Content Rule applies to the exchange of patient-specific medical information or supplemental documentation sent to support prior authorizations sent via the X12 005010X217 278 Health Care Services Review – Request for Review and Response Technical Report Type 3 and associated errata (hereafter referenced as X12 v5010X217 278).

To support the efficient exchange of additional information or documentation to support a prior authorization, the rule also applies to the conduct of the following X12 transactions:

- X12 v6020X290 999 Implementation Acknowledgement for Health Care Insurance Technical Report Type 3 (hereafter referred to as X12 v6020X290 999).
- X12 v6020X257 824 Application Advice Technical Report Type 3 (hereafter referred to as X12 v6020X257 824).

In addition, the rule applies across the following electronic attachment submission methods:

X12 Attachment Submission Method:

- X12 006020X316 275 Additional Information to Support a Health Care Services Review Technical Report Type 3 (hereafter referred to as X12 v6020X316 275).

Electronic Non-X12 Additional Documentation Payload Format and Submission Methods:

- Other payload types (e.g., HL7 C-CDA, .pdf, .doc, etc.) exchanged via CORE Connectivity Rule vC4.0.0.

3.2 When the Rule Applies

This CAQH CORE Attachments (275/278) Prior Authorization Data Content Rule applies when:

- A provider and its agent electronically send patient-specific medical information or supplemental documentation (solicited or unsolicited) to a health plan to support a X12 v5010X217 278 prior authorization Request.

And

- A health plan and its agent electronically process patient-specific medical information or supplemental documentation and respond to a provider to support a X12 v5010X217 278 prior authorization Response.

3.3 What the Rule Does Not Require

While the rule requirements address the optional use of non-X12 additional documentation submission format methods, the rule does not require any entity or its agent to:

- Exchange documentation using an electronic, non-X12 additional documentation submission format method (e.g., HL7 C-CDA, .pdf, .doc, etc.) exchanged via CORE Connectivity Rule vC4.0.0.
- This rule does not require use of a specific reassociation methodology.

3.4 ***Maintenance of This Rule***

Any updates to change rule requirements will be made in alignment with CAQH CORE processes for updating versions of the operating rules, as determined by industry need, or CAQH CORE Participants.

3.5 *Assumptions*

A goal of this rule is to adhere to the principles of electronic data interchange (EDI) in assuring that clinical information sent is accurately received and to facilitate correction of errors for electronically submitted additional documentation requests.

The following assumptions apply to this rule:

- A successful communication connection has been established.
- This rule is a component of the larger set of CAQH CORE Operating Rules; as such, all the CAQH CORE Guiding Principles apply to this rule and all other rules.
- This rule is not a comprehensive companion document addressing any content requirements of the X12 5010X217 278, X12 6020X316 275, X12 6020X290 999, X12 6020X257 824 or HL7 C-CDA.
- Compliance with all CAQH CORE Operating Rules is a minimum requirement; any HIPAA-covered entity is free to offer more than what is required in the rule.

4 Data Content Rule Requirements for Attachments using the X12 275 Transaction

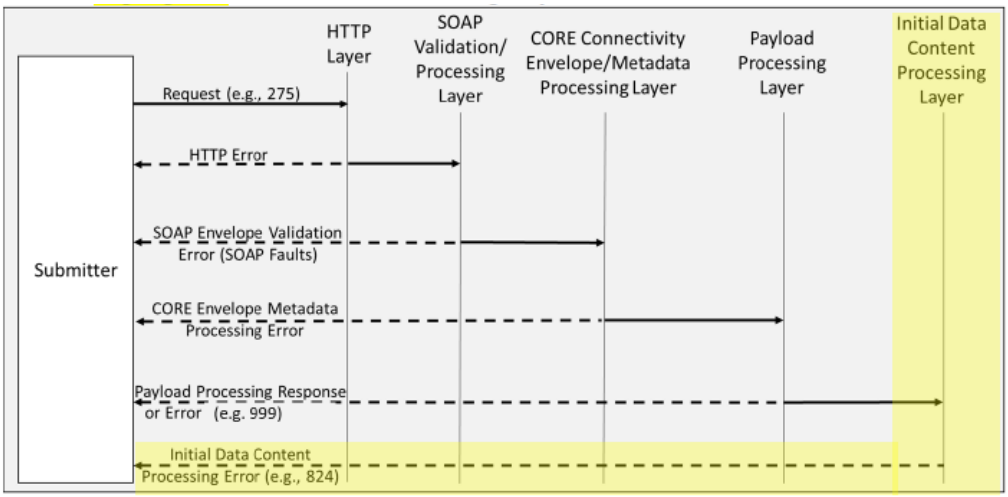
The rule requirements in this section apply only when an entity and their agent use an X12 attachment method listed in Section 3.1 When the Rule Applies.

4.1 Data Error Handling Requirements for Attachments using the X12 275 Transaction

This section of the rule details data error handling requirements pertaining to attachments sent via the X12 v6020X316 275 transaction.

The CAQH CORE Connectivity Rule vC4.0.0 specifies that when an X12 v6020X316 275 is submitted using either SOAP or REST, it goes through several initial layers of error handling, identified in Figure 4.1.1 CAQH CORE Connectivity. If no errors are encountered at any HTTP Layer through Payload Processing Layer, the submission is passed to the next processing layer. If there is an error at any HTTP layer preceding the Payload Processing Layer the payload does not get passed to the next HTTP layer. The receiver (server) must return a X12 v6020X290 999 whether or not there is an error processing the payload at the Payload Processing Layer.

Figure 4.1 CAQH CORE Connectivity



NOTE: In Figure 4.1 above, the dotted line arrows indicate error messages being returned to the Submitter (client) if there is a processing error at the corresponding logical processing layer. The straight-line arrows indicate the request and response messages.

Once the Initial Data Content Processing Layer processes the content of the payload, the receiver (server) must return an X12 v6020X290 999 to notify providers and their agents (submitter/client) of the acceptance, acceptance with error, or rejection of the X12 v6020X316 275 transaction *(See CAQH CORE Attachments (275/278) Prior Authorization Infrastructure Rule Requirement §4.4.)*. Though a response is not required at the Initial Data Content Processing Layer, if the receiver (server) responds, they must return a X12 v6020X257 824 to notify providers and their agents (submitter/client) the acceptance, acceptance with error, or rejection of the X12 v6020X316 275 transaction or the content of the Binary Data Segment (BDS) segment in the X12 v6020X316 275 transaction.

Note: HIPAA-covered entities and their agents must also send a X12 v5010X217 278 Response in accordance with the CAQH CORE Prior Authorization & Referrals (278) Infrastructure Rule vPA2.0 and CAQH CORE Prior Authorization & Referrals (278) Data Content Rule vPA1.0 to notify providers and their agents that the original X12 v5010X217 278 Request, and associated X12 v6020X316 275 was approved, denied, or pended for additional information.

4.2 Reassociation Requirements

To speed up the adjudication of an X12 v5010X217 278 Request, a provider and its agent may submit the necessary additional documentation or attachment along with the initial submission of the X12 v5010X217 278 transaction, typically referred to as an unsolicited attachment, to support the Request.

There are two submission methods a provider can use to deliver an unsolicited attachment:

1. Using the X12 v6020X316 275 transaction to provide additional documentation.
2. Using a non-X12 method (e.g., CORE Connectivity[1], FHIR, DIRECT messaging, web portals, etc.) to provide additional documentation.

The following requirements address X12 submission methods for the reassociation of solicited and unsolicited attachments sent to support a X12 v5010X217 278 Request.

4.2.1 Reassociation of an Unsolicited X12 275 to an X12 278 Request

A HIPAA-covered provider and its agent must use PWK02 Code EL in Loop 2000E/Loop 2000F in the X12 v5010X217 278 Request to notify a HIPAA-covered health plan and its agent that additional documentation is being transmitted electronically using the Binary Data Segment (BDS) in X12 v6020X316 275[2].

4.2.1.1 Common Reference Data Used to Reassociate a X12 275 and an X12 278 Request

When a provider sends a X12 v6020X316 275 to support an X12 v5010X217 278 Prior Authorization Request, CAQH CORE recommends the use of the following common reference data to be included on the X12 v6020X316 275 for patient identification and reassociation purposes.

This list of recommendations is not intended to be either exhaustive or prohibitive. The terms included in the list below are defined in Appendix §6.1: X12 TR3 Data Element and Common Reference Data Mapping.

- ACN
- Authorization ID
- Case reference/ID #
- DOB
- DOS
- Internal Medical Facility #
- Member ID
- Member Name
- Prior Authorization Tracking #
- Reference #

[1] CORE Connectivity vC4.0.0 specifies requirements for the exchange of messages using SOAP and REST. Additionally, CORE Connectivity is payload agnostic, meaning the SOAP and REST Services are not aware of the content they are serving.

[2] While this requirement does not prohibit providers and their agents from using alternative methods to submit the unsolicited additional documentation (e.g., CORE Connectivity, FHIR, DIRECT messaging, web portals, etc.), it specifies the use of PWK02 Code EL if the additional documentation is sent via a X12 v6020X316 275 transaction.

4.2.2 Reassociation of a Solicited X12 275 to an X12 278 Request

A HIPAA-covered health plan and its agent must use PWK02 Code EL in Loop 2000E/Loop 2000F in a pended X12 5010X217 278 Response to request the electronic submission of additional documentation supporting medical necessity in the X12 v6020X316 275.

5 Data Content Rule Requirements for Attachments using the Non-X12 Method

The rule requirements in this section apply only when an entity and their agent use a non-X12 attachment method such as those listed in *Section 3.1 When the Rule Applies*.

5.1 Data Error Handling Requirements *for Attachments using the Non-X12 Method*

The CAQH CORE Connectivity Rule vC4.0.0 specifies that once additional documentation via an X12 v6020X316 275 or non-X12 method is submitted using either SOAP or REST, it goes through several initial layers of error handling. This section of the rule details data error handling requirements pertaining to attachments sent via non-X12 methods.

Additional documentation sent via a non-X12 method cannot receive data error handling messages via the X12 v6020X257 824 transaction. Therefore, a health plan and its agent must send the applicable X12 v6020X290 999 and X12 v5010X217 278 Responses in accordance with the CAQH CORE Prior Authorization & Referrals (278) Infrastructure Rule vPA2.0 and CAQH CORE Prior Authorization & Referrals (278) Data Content Rule vPA1.0 to notify a provider and its agent that the original X12 v5010X217 278 Request, and any associated additional documentation sent to support the 278 Request, was approved, denied, or pended for additional information.

5.2 Reassociation Requirements

To speed up the adjudication of an X12 v5010X217 278 Request, a provider and its agent may submit the necessary additional documentation or attachment along with the initial submission of the X12 v5010X217 278 transaction, typically referred to as an unsolicited attachment to support the Request. There are two submission methods a provider can use to deliver an unsolicited attachment:

1. Using the X12 v6020X316 275 transaction to provide additional documentation.
2. Using a non-X12 method (e.g., CORE Connectivity[3], FHIR, DIRECT messaging, web portals, etc.) to provide additional documentation.

The following requirements address non-X12 submission methods for the reassociation of solicited and unsolicited attachments sent to support an X12 v5010X217 278 Request.

[3] CORE Connectivity vC4.0.0 specifies requirements for the exchange of messages using SOAP and REST. Additionally, CORE Connectivity is payload agnostic, meaning the SOAP and REST Services are not aware of the content they are serving.

5.2.1 Use of CORE Connectivity vC4.0.0 Headers to Reassociate Additional Documentation using the Non-X12 Method

Reassociation of additional documentation sent via a non-X12 format for the original X12 v5010X217 278 Prior Authorization Request varies greatly depending on the submission mode of the additional documentation method. CORE Connectivity vC4.0.0 includes requirements for the exchange of messages using SOAP and REST that is payload agnostic, meaning the SOAP and REST services are not aware of the content they are serving. HIPAA-covered providers and their agents using CAQH CORE Connectivity vC4.0.0 to transmit a non-X12 payload must follow the appropriate header requirements to notify health plans and their agents that additional documentation is being transmitted electronically.

In the unsolicited non-X12 scenario using CORE Connectivity vC4.0.0 as the submission method, a provider and its agent can indicate using SOAP or REST headers that an attachment was sent and specify the attachment body type (e.g., .pdf or HL7 C-CDA, etc.).

When sending a non-X12 unsolicited attachment using CORE SOAP Connectivity Rule vC4.0.0 Requirements §4.4.3 *<SDO>_<PayloadType>_<Version>_<Sub-version>* the provider and its agent may identify the <PayloadType> from the following list:

- HL7 C-CDA
- .pdf
- .doc
- .docx
- .txt
- .jpg

When sending a non-X12 unsolicited attachment using CORE REST Connectivity Rule vC4.0.0 Requirements §5.3.2 Specifications for REST API URI Path Endpoints for Payload Types the provider and its agent may identify the identify the REST API URI Path Endpoint from the following list:

- HL7 C-CDA
- .pdf
- .doc
- .docx
- .txt
- .jpg

As the industry continues to evolve, this rule may be updated to include requirements for additional non-X12 submission methods and attachment types.

5.2.1.1 CORE-required Minimum Attachment Data Elements of Unsolicited Additional Documentation using the Non-X12 Method

For health plans to effectively match attachment payloads (e.g., HL7 C-CDA, .pdf, .doc, etc.) to the correct administrative transaction the need for a uniform identifier data set is required to facilitate reassociation.

The *CORE-required Minimum Attachment Data Elements* as defined in Table 1 identifies the necessary data elements necessary for successful reassociation of the non-X12 attachment payload and the X12 v5010X217 278. A provider and its agent must include the CORE-required Minimum Attachment Data Elements as part of the attachment payload when sending additional information to facilitate reassociation to a prior authorization transaction. These data elements can be included in some fashion (e.g., a separate document along with the payload or included in the payload document itself) as part of the attachment payload.

This rule does not prohibit a provider and its agent and a health plan and its agent from mutually agreeing to exchange more data in addition to the required minimum data needed for reassociation.

Table 1. CORE-Required Minimum Attachment Data Elements for Reassociation using Non-X12 Attachment Methods

#	Element	CAQH CORE Element Definition
1	**Member ID**	Identifier assigned to the patient by the health plan. Health plans may assign • a unique identifier to all individuals covered by the contract or • a high-level identifier to the contract subscriber which is used to identify the dependent by adding a suffix There is no adopted standard to identify patients. A common practice is for each provider and plan to use different identifiers for the same individual.
2	**Auth #**	An *authorization ID* is a character string that is associated with a process that is checked to determine the authority to perform a specified operation. Authorization ID concept/wording is not used in the X12 v5010X217 278 TR3
3	**DOB**	Date of Birth
4	**Provider ID (general either NPI/TIN)**	The **NPI** (**National Provider Identifier**) is a 10-digit numerical identifier used to identify an individual provider or a health care entity. The federal taxpayer identification number (**TIN**) that identifies the physician/practice/supplier to whom payment is made for the line-item service. This number may be an employer identification number (EIN) or social security number (SSN).
5	**Patient ID**	The glossary of the accreditation manual defines a **patient identifier** as "Information directly associated with an individual that

#	Element	CAQH CORE Element Definition
		reliably identifies the individual as the person for whom the service or treatment is intended.
6	**DOS**	The **date of service** is the specific date at which a patient has been given medical treatment. It is recorded for billing purposes and as an item in a patient's medical record.
7	**NPI**	The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identifier for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
8	**Prior Authorization "Tracking" #**	Sometimes insurance companies provide a set number of services that they will cover, or they provide a certain time period during which they will cover services for a client. They use **prior authorization numbers** that need to be included in the claims submitted for those services.
9	**Patient Last Name**	Patient name includes a set of words by which a person is known, i.e. First, Middle, and Last or Family Name. A legal name identifies a person for administrative and other official purposes, like insurance payments. It is generally the name that appears on a person's birth certificate but may change over time, as individuals adopt nicknames. Last name/surname: Generational titles such as Jr, Sr, III are considered part of the last name, and should be included in this field.
10	**Procedure**	A **medical procedure** is a course of action intended to achieve a result in the delivery of healthcare. A *medical procedure* with the intention of determining, measuring, or diagnosing a patient condition or parameter is also called a *medical* test.
11	**Subscriber/Dependent First & Last Name**	The X12 ASC standard describes subscriber and dependent as follows: • The subscriber is a person who can be uniquely identified to an information source by a unique Member Identification Number (which may include a unique suffix to the primary policy holder's identification number). The subscriber may or may not be the patient. • The dependent is a person who cannot be uniquely identified to an information source by a unique Member Identification Number but can be identified by an information source when associated with a subscriber. First and last names are generally the name that appears on a person's birth certificate but may change over time, as individuals adopt nicknames.

#	Element	CAQH CORE Element Definition

6 Appendix

6.1 X12 TR3 Data Element and Reference Identification Mapping

#	Reference Metadata	Description	X12 v5010217 278 Request	X12 v5010X217 278 Response	X12 v6020X316 275
1	**Member ID**	Name of patient; patient could be either the health plan subscriber or a dependent of the subscriber	Loop 2010C Subscriber/2010D Dependent NM1 Segment is Required Segment and conveys name and identification number of subscriber who may also be the patient. • NM103 Last Name • NM104 First Name	Loop 2010C Subscriber/2010D Dependent NM1 Segment is Required Segment and conveys name and identification number of subscriber who may also be the patient. • NM103 Last Name • NM104 First Name	Loop 1000A Information Source Name *(Required to identify creator and sender of 275)* Loop 1000B Information Receiver Name *(Required to identify receiver of 275)* Loop 1000C Patient Name *(Required to identify the patient as identified in the corresponding 278)*
2	**Auth #**	Identifier assigned to the patient by the health plan. Health plans may assign • a unique identifier to all individuals covered by the contract or • a high-level identifier to the contract subscriber which is used to identify the dependent by adding a suffix There is no adopted standard to identify patients. A common practice is for each provider and plan to use different identifiers for the same individual.	Loop 2010C Subscriber/2010D Dependent NM1 Segment is Required Segment and conveys name and identification number of subscriber who may also be the patient. NM108/NM109 Member Identification Number in Loop 2010C; NM108/NM109 Member Identification Number not used in Loop 2010D • One subscriber Loop 2010C if the subscriber is the patient • One subscriber Loop 2010C if the dependent is the patient and has a unique member ID • One subscriber Loop 2010C and one dependent Loop 2010D if the dependent is the patient and the dependent does not have a unique identifier different from the subscriber member ID	Loop 2010C Subscriber/2010D Dependent NM108/NM109 Member Identification Number in Loop 2010C; NM108/NM109 Member Identification Number not used in Loop 2010D • One subscriber Loop 2010C if the subscriber is the patient • One subscriber Loop 2010C if the dependent is the patient and has a unique member ID • One subscriber Loop 2010C and one dependent Loop 2010D if the dependent is the patient and the dependent does not have a unique identifier different from the subscriber member ID	Loop 1000C Patient Name *(Required to identify the patient as identified in the corresponding 278)*
3	**DOB**	Patient date of birth	Loop 2010C DMG01/DMG02 Birth Date – use is Situational	Loop 2010C DMG01/DMG02 Birth Date	

#	Reference Metadata	Description	X12 v5010217 278 Request	X12 v5010X217 278 Response	X12 v6020X316 275
			• Required when birth date is needed to identify the patient If not required, do not send	• Required when used by the health plan to determine medical necessity. If not required, do not send.	
4	**Provider ID (general either NPI/TIN)**	An identifier assigned by the provider to the prior authorization request it is submitting to the health plan An identifier assigned by the health plan to the prior authorization response it is returning to the provider	Loop 2000E TRN Segment Patient Event Tracking Number/Loop 2000F Service Level Tracking Number – use is Situational in both loops • Segment can repeat 2 times If a second clearinghouse needs to assign their own TRN segment, they must replace the TRN from the first clearinghouse and retain it to be returned in the 278 response	Loop 2000E TRN Segment Patient Event Tracking Number/Loop 2000F Service Level Tracking Number • Segment can repeat 3 times • Health plan must return TRNs received in request • Health plan must return TRN when it assigns a trace number to this patient event in the response for tracking purposes	Loop 1000C Patient Name – REF Segment Patient Event Trace Number – Use in both solicited and unsolicited 275 *(Required when Patient Event Tracking Number appears in TRN segment of associated 278)*
5	**Patient ID**	An alphanumeric value used to associate documentation exchanged electronically between trading partners to a specific transaction	Loop 2000E Patient Event/2000F Service Level Segment PWK05 66 Identification Code Qualifier AC Attachment Control Number Segment PWK06 67 Identification Code – Designated Implementation Name = Attachment Control Number • Data Element PWK06 Code AC Attachment Control Number *(Means of associating electronic claim with documentation forwarded by other means)* 67 - Identification Code is an alphanumeric data element in X12 base standard • Required in Patient Event Loop when provider has additional documentation associated with this health care services review • Required in Service Level Loop when provider has additional documentation associated with this health care services review that applies to the service(s) requested in this loop	Loop 2000E Patient Event/2000F Service Level Segment PWK05 66 Identification Code Qualifier AC Attachment Control Number Segment PWK06 67 Identification Code – Designated Implementation Name = Attachment Control Number • Data Element PWK06 Code AC Attachment Control Number *(Means of associating electronic claim with documentation forwarded by other means)* 67 - Identification Code is an alphanumeric data element in X12 base standard • Required in Patient Event Loop when the health plan requests additional patient information • Required in Service Level Loop when the health plan needs to request additional information that applies to the service(s) requested in this Service loop	LOOP 2000A TRN Segment Attachment Control Number - required use segment • Unsolicited 275 requires provider PWK06 ACN from 278 PWC06 request. • Solicited 275 requires health plan PWL06 ACN from 278 PWK06 response.
6	**DOS**	The date of service is the specific time at which a patient has been given medical treatment. It is recorded for billing purposes and as an item in a patient's medical record. It also matters for insurance	Loop 2000E Patient Event DTP Event Date • Required when the proposed or actual date or range of dates of this patient event are known. Loop 2000F Service DTP Service Date	Loop 2000E Patient Event DTP Event Date/Loop 2000F Service DTP Service Date • Required when the health plan authorizes service for a specific date or date range If not required, do not send	N/A

#	Reference Metadata	Description	X12 v5010217 278 Request	X12 v5010X217 278 Response	X12 v6020X316 275
		purposes, since health insurers base their reimbursement or payment on the date of service, along with other billing factors. Also known as Event Date – meaning the proposed or actual date or range of dates services will be provided to a patient.	• Required when proposed or actual date or range of dates of service is different from the Patient Event Date		
7	**NPI**	N/A	Loop 2000E — UM Segment Health Care Services Review Information Patient Event Level • UM01 1525 Request Category Code • UM02 1322 Certification Type Code • UM03 1365 Service Type Code	Loop 2000E — UM Segment Health Care Services Review Information Patient Event Level • UM01 1525 Request Category Code • UM02 1322 Certification Type Code • UM03 1365 Service Type Code	Loop 2000A Service Trace Number *(Required when additional information pertains to specific services, etc. originally referenced in 278 and 278 contains a Service Trace Number in associated Services loop)*
8	**PA "Tracking" #**	N/A	Loop 2000E — UM Segment Health Care Services Review Information Patient Event Level UM04 C023 Health Care Service Location Information	Loop 2000E — UM Segment Health Care Services Review Information Patient Event Level UM04 C023 Health Care Service Location Information	N/A
9	**Patient Last Name**	Authorization ID concept/wording is not used in the v5010 278 TR3	N/A	N/A	N/A
10	**Procedure**	Reference # concept needs better description. Could be the following data elements • BGN02-127 Reference Identification (Transaction Set Identifier Code) in 824 transaction. *(Use a value assigned by the submitter of the 824)* OTI Segment Original Transaction Identification • OTI03-127 Reference Identification in 824 transaction – Required Use *(824 may be used to report acceptance, rejection of entire transaction, an item within a transaction, or a subordinate portion of a transaction).*	N/A	N/A	N/A
11	**Subscriber/**	Patient date of birth	Loop 2010C DMG01/DMG02 Birth Date – use is Situational	Loop 2010C DMG01/DMG02 Birth Date	

#	Reference Metadata	Description	X12 v5010217 278 Request	X12 v5010X217 278 Response	X12 v6020X316 275
	Dependent First & Last Name		• Required when birth date is needed to identify the patient If not required, do not send	• Required when used by the health plan to determine medical necessity. If not required, do not send.	

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