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1 **1. CAQH CORE Attachments Operating Rules: Background**

2 ***1.1 CAQH CORE Overview***

3 CAQH CORE is an industry-wide facilitator committed to the creation, and adoption of healthcare
4 operating rules that support standards, accelerate interoperability, and align administrative and clinical
5 activities among providers, health plans, and patients. Guided by more than 100 participating
6 organizations – including providers, health plans representing 75 percent of insured Americans,
7 government entities, vendors, associations and standards development organizations – CAQH CORE
8 Operating Rules drive a trusted, simple and sustainable healthcare information exchange that evolves
9 and aligns with market needs.[1] CAQH CORE Operating Rules are developed using a consensus-based
10 approach among industry stakeholders, and are designed to facilitate interoperability, improve
11 utilization of administrative transactions, enhance efficiency and lower the cost of information exchange
12 in healthcare. To date, this cross-industry commitment has resulted in operating rules that address
13 many pain points of healthcare business transactions including eligibility and benefits verification, claims
14 and claims status, claim payment and remittance, health plan premium payment enrollment and
15 disenrollment, prior authorization, and aspects of value-based healthcare such as patient attribution.

16 ***1.2 Industry Interest in Attachments Operating Rules***

17 Attachments refer to the exchange of patient-specific medical information or supplemental
18 documentation to support an administrative healthcare transaction and are the bridge between clinical
19 and administrative data. They provide health plans vital information for adjudication of a subset of
20 claims, prior authorizations, referrals, post-adjudication appeals, audits and more. However, the
21 attachments workflow is primarily manual and a source of significant administrative burden. According
22 to the 2020 CAQH Index, only 22 percent of attachments are processed using a fully electronic method.[2]
23 The Index also estimated that adoption of electronic attachment transactions could reduce healthcare
24 industry per-transaction costs for exchange of attachments by over $377 million annually, $4.09 per
25 transaction.[3]

26 Industry has waited for federal action on an attachments standard for many years. In 1996, HIPPA
27 mandated the adoption of an electronic standard for attachments, along with many other
28 administrative transactions. In most cases, the HIPAA-mandated standards have been federally adopted,
29 and companion operating rules have been developed to support these transactions. The extended wait
30 for a federal attachment standard has driven a sense of uncertainty, deterred vendor development of a
31 standardized approach, and resulted in a range of standards and specifications to support the exchange
32 of attachments.

[1] In 2012, CAQH CORE was designated by the Secretary of the Department of Health and Human Services (HHS) as the author for federally mandated operating rules under Section 1104 of the Patient Protection and Affordable Care Act (ACA).
[2] 2020 CAQH Index, CAQH.
[3] Ibid.

Since 2012, CAQH CORE has maintained a focus on attachments, collaborating with industry to provide education and gather insights on industry opportunities via operating rule development input, national webinars, and surveys. In 2019, CAQH CORE published the CAQH CORE Report on Attachments: Bridge to a Fully Automated Future to Share Medical Documentation, which examines the challenges associated with the exchange of medical information and supplemental documentation used for administrative transactions. The report identifies five areas to improve processes and accelerate the adoption of electronic attachments. These opportunity areas include workflows, data variability, exchange mechanisms, connectivity, security and infrastructure, and resources.

Building on the report findings, CAQH CORE launched a multi-stakeholder Attachments Advisory Group consisting of industry leaders representing health plans, providers, vendors government entities and advisors. The group evaluated pain points caused by the exchange of additional documentation across use cases, prioritizing a list of opportunity areas for operating rule development to reduce administrative burden for the Prior Authorization and Claims Attachments Use Cases.

2. Issues to be Addressed and Business Requirement Justification

2.1 Problem Space

Attachments uniquely combine data from two disparate systems – clinical and administrative. Due to limited administrative and clinical system integration, and the lack of a federally mandated electronic transaction standard for attachments by the Department of Health and Human Services (HHS), health plans, providers and vendors have been hesitant to develop standardized approaches to automate the exchange of attachments. This has led to varied and incomplete electronic solutions and work arounds.

The 2018 CAQH CORE Attachments Environmental Scan revealed that the majority of attachments today are submitted manually, as paper forms and records sent through the mail or by fax, presenting an incredible administrative burden to both health plans and providers. A regional health plan participating in the CAQH CORE Attachments Environmental Scan indicated that it takes 792 labor hours, the equivalent of nearly 20 people working full-time, to process the attachments it receives by mail, fax and web portal in the course of one week.

In late 2019, CAQH CORE conducted an industry-wide survey to further inform the development of operating rules to support a more standardized workflow. Surveys were received from over 340 organizations across three stakeholder types: providers, health plans and vendors/clearinghouses. The results, which showed wide variability in how attachments are exchanged, highlighted the prevalence of mail and fax with nearly 60% of organizations using mail and fax to exchange prior authorization and claims attachments.[4]

Health plans and providers participating in CAQH CORE attachments research identified multiple pain points throughout the attachments workflow. For example, providers are often unaware of the clinical documentation required by the health plan to complete a prior authorization or claim submission and frequently send unsolicited attachments with too much, too little or incorrect information to health plans based on past experience with the provision of a specific service. Health plans must sort through

[4] CAQH CORE Attachments Survey Issue Brief.

70 the clinical information sent by the provider and establish what is required to complete the prior
71 authorization or claim submission, and what is incorrect or missing from the submission. Once all the
72 necessary clinical documentation is received from the provider, which may require multiple
73 communications back and forth between provider and health plan, the health plan must spend
74 additional time linking the original submission with the relevant attachments. Throughout this process,
75 providers are often not aware whether an attachment was received by the health plan, resulting in
76 further unnecessary duplicate attachments sent to the health plan and manual follow up by providers
77 who want to confirm if the additional documentation was received successfully.

78 Clearly defined exchange standards, accurate data and supporting infrastructure requirements are
79 needed to ensure attachments flow seamlessly through the healthcare system. During the development
80 of the CAQH CORE Attachments Operating Rules, the following priorities rose to the top:

81 • Enhance attachments workflow process via electronic methods for identifying attachment-specific
82 data to support adjudication of a claim or prior authorization.
83 • Establish standard codes for providers to communicate when additional documentation is being
84 sent to a health plan.
85 • Streamline attachment documentation requests and reassociation of attachments.
86 • Establish requirements for acknowledgements, data errors and response times by health plans when
87 attachments are sent electronically.
88 • Develop data file format requirements for quality, readability and size efficiency.

89 ***2.2 Business Requirement Justification and Focus of the CAQH CORE Attachment (275/837) Health***
90 ***Care Claims Infrastructure Rule***

91 For each transaction addressed by the CAQH CORE Operating Rules, the CAQH CORE Participants
92 developed foundational infrastructure rules addressing response time, appropriate Batch and Real Time
93 acknowledgements, system availability, common companion guide formats and a connectivity safe
94 harbor. By promoting consistent connectivity and infrastructure expectations between health plans and
95 providers, manual processes are reduced, and electronic transaction usage increased.

96 This CAQH CORE Attachment (275/837) Health Care Claims Infrastructure Rule addresses the X12
97 006020X314 275 Additional Information to Support a Claim Submission (hereafter referred to as the X12
98 v6020X314 275).

99 This rule continues to facilitate industry momentum to increase access to electronic administrative
100 transactions, and encourages all HIPAA-covered entities, business associates, intermediaries and
101 vendors to build on or extend the infrastructure they have established for other business transactions,
102 including the X12 005010X222 Health Care Claim (837) Professional, X12 005010X223 Health Care Claim
103 (837) Institutional, and X12 005010X224 Health Care Claim (837) Dental transactions and their
104 associated errata (collectively hereafter referenced as X12 v5010 837).

105 This CAQH CORE Attachments (275/837) Health Care Claims Infrastructure Rule is designed to bring
106 consistency and reduce time to adjudication of a claim submission that requires additional
107 documentation. These infrastructure rule requirements include:

108 - Batch and Real Time exchange of the X12 v6020X314 275 transaction
109 - Minimum system availability uptime
110 - Consistent use of the v6020X290 999 Acknowledgement for Batch and Real Time exchanges
111 - Minimum supported file size
112 - Use of the public internet for connectivity
113 - Use of best practice template for format and flow of Companion Guides for entities that issue
114 them
115 - Standard electronic policy access for required information
116 - Support for multiple electronic attachments to support a single claim submission

117 During the development of this rule, CAQH CORE participants used discussion, research and straw poll
118 results to determine which infrastructure requirements should be applied to the exchange of the X12
119 v6020X314 275 transaction. The table below lists the infrastructure requirements incorporated into this
120 rule in §4.

Infrastructure Requirements for the X12 v6020X316 275 Transaction	
CAQH CORE Infrastructure Requirement Description	**Apply to CAQH CORE Attachment (275/278) Prior Authorization Infrastructure Rule for the X12 v6020X314 275**
Processing Mode	Y
Connectivity	Y
System Availability	Y
Real Time Processing Mode Response Time	Y
Batch Processing Mode Response Time	Y
Real Time Acknowledgements (errors only)	Y
Batch Acknowledgement (errors and acceptance)	Y
File Size	Y
Companion Guide	Y
Electronic Policy Access of Required Information	Y

121 As with all CAQH CORE Operating Rules, the CAQH CORE Attachments (275/837) Infrastructure Rule
122 requirements are intended as a base or minimum set of requirements, and it is expected that many
123 entities will go beyond these requirements as they work toward the goal of administrative
124 interoperability.

125 By applying these CAQH CORE infrastructure requirements to the conduct of the X12 v6020X314 275
126 transaction for exchanging additional documentation in support of X12 v5010 837 claim submissions,
127 this CAQH CORE Attachments (275/837) Health Care Claim Infrastructure Rule helps provide the
128 information that is necessary to electronically send attachments uniformly and consistently, reducing
129 administrative burden, and payment and patient care delays.

3 Scope

3.1 What the Rule Applies To

This CAQH CORE Attachments (275/837) Health Care Claim Infrastructure Rule applies to the conduct of the following X12 transactions sent in Batch ~~and~~ or Real Time Processing Modes:

- X12 005010X222 Health Care Claim (837) Professional, X12 005010X223 Health Care Claim (837) Institutional, and X12 005010X224 Health Care Claim (837) Dental transactions and their associated errata (collectively hereafter referenced as X12 v5010 837).
- X12 006020X314 275 Additional Information to Support a Health Care Claim or Encounter Technical Report Type 3 (hereafter referenced as X12 v6020X314 275).[5,6]
- X12 006020X290 999 Implementation Acknowledgement for Health Care Insurance Technical Report Type 3 (hereafter referenced as X12 v6020X290 999).
- X12 006020X257 824 Application Advice Technical Report Type 3 (hereafter referenced as X12 v6020X257 824).
- X12 v6020X313 277 Health Care Claim Request for Additional information Technical Report Type 3 (hereafter referred to as X12 v6020X313 277).

This rule optionally applies to other payload types (e.g., HL7 C-CDA, .pdf, etc.) exchanged using ~~via~~ CORE Connectivity Rule ~~and to non-X12 payload exchange scenarios (e.g., CORE Connectivity, FHIR, etc.).~~

3.2 When the Rule Applies

This CAQH CORE Attachments (275/837) Health Care Claim Infrastructure Rule applies when:

- A provider and its agent electronically send patient-specific information or supplemental documentation (solicited or unsolicited) to a health plan and its agent to support a X12 v5010 837 Health Care Claim.

And

- A health plan and its agent electronically process patient-specific information or supplemental documentation and respond to a provider and its agent to support a X12 v5010 837 Health Care Claim.

3.3 What the Rule Does Not Require

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

- Exchange documentation using an electronic, non-X12 additional documentation submission method (e.g., HL7 C-CDA, .pdf, .doc, etc.) ~~exchanged~~ via CORE Connectivity.

---

[5] Given the X12 attachment standards have not been mandated under HIPAA, health plans, providers, vendors, and their agents are not federally required to support the X12 6020X314 275 transaction.
[6] Stakeholders and their agents may choose to implement higher versions of the X12 v6020X314 275 transaction but must also continue to support X12 v6020X314 275 in accordance with this rule.

3.4 Outside the Scope of This Rule

This rule does not address any data content requirements of the X12 v6020X314 275 transaction. This CAQH CORE Attachments (275/837) Health Care Claims Infrastructure Rule is applicable to improving access for additional information to support a Health Care Claim submission and not addressing data content requirements for transactions identified in §3.1.

Additional ~~T~~transactions ~~which are not included in the scope of~~ outside the scope of this rule ~~include~~, but that are addressed in existing CAQH CORE Operating Rules include:

- X12 v5010X212 276/277 Health Care Claim Status Request/Response Transactions *(see CAQH CORE Claim Status (276/277) Infrastructure Rule vCS.1.0)*
- X12 v5010X214 277 Claim Acknowledgement see CAQH CORE Health Care Claims Operating Rules *(see CAQH CORE Health Care Claim (837) Infrastructure Rule vHC.1.0)*
- X12 v5010X221 835 Health Care Claim/Payment Remittance Advice Transaction (*see CAQH CORE Payment & Remittance (835) Infrastructure Rule vPR.1.0)*

3.5 Maintenance of This Rule

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

3.6 Assumptions

A goal of this rule is to adhere to the principles of electronic data interchange (EDI) in assuring that transactions sent are 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 v6020X314 275 Additional Information to Support Health Care Claim transactions, X12 v5010 837, X12 v6020X290 999, X12 v6020X257 824, or X12 v6020X313 277.
- 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.

191 # 4 Infrastructure Rule Requirements for Attachments using the X12 275 Transaction

192 ## *4.1 Processing Mode Requirements for X12 275 Attachments*

193 A HIPAA-covered health plan and its agent must implement the server requirements for Batch
194 Processing Mode for the X12 v6020X314 275 Attachment transaction as specified in the CAQH CORE
195 Connectivity Rule. Optionally, a HIPAA-covered health plan and its agent may elect to also implement
196 the server requirements for Real Time Processing Mode as specified in the CAQH CORE Connectivity
197 Rule.

198 The CAQH CORE Connectivity Rule Real Time Processing Mode requirements are applicable when Real
199 Time Processing Mode is offered for this transaction. The CAQH CORE Connectivity Rule Batch
200 Processing Mode requirements are applicable when Batch Processing is offered for this transaction.

201 A HIPAA-covered health plan and its agent conducting the X12 v6020X314 275 Attachment transaction is
202 required to conform to the processing mode requirements specified in this section regardless of any
203 other connectivity modes and methods used between trading partners.

204 ## *4.2 Connectivity Requirements for X12 275 Attachments*[7]

205 A HIPAA-covered entity and its agent must be able to support the most current published and CAQH
206 CORE adopted version of the CAQH CORE Connectivity Rule (hereafter referred to as CAQH CORE
207 Connectivity Rule).

208 This requirement addresses usage patterns for Real Time and Batch Processing Modes, the exchange of
209 security identifiers, and communications-level errors and acknowledgements. It does not attempt to
210 define the specific content of the message payload exchanges beyond declaring the formats that must
211 be used between entities and that security information must be sent outside of the message envelope
212 payload.

213 All HIPAA-covered entities must demonstrate the ability to implement connectivity as described in the
214 CAQH CORE Connectivity Rule. The CAQH CORE Connectivity Rule is designed to provide a “Safe Harbor”
215 that application vendors, HIPAA-covered providers and their agents and HIPAA-covered health plans and
216 their agents (or other information sources) can be assured will be supported by any trading partner.
217 Supported means that the entity is capable and ready at the time of the request by a trading partner to
218 exchange data using the CAQH CORE Connectivity Rule as described in this section. These requirements
219 are not intended to require trading partners to remove existing connections that do not match the rule,
220 nor are they intended to require that all trading partners must use this method for all new connections.
221 CAQH CORE expects that in some technical circumstances, trading partners may agree to use different
222 communication mechanism(s) and/or security requirements than those described by these
223 requirements.

[7] The HL7 CDA R2 Attachment Implementation Guide: Exchange of C-CDA Based Documents, Release 1 describes standards-based approaches to sending a CDA Document for Attachments using electronic transactions in Appendix F, including CORE Connectivity + X12 275.

224 The requirement to support the CAQH CORE Connectivity Rule does not apply to retail pharmacy. For
225 retail pharmacy the entity should reference the NCPDP Connectivity Operating Rule v1.0 that can be
226 obtained from www.ncpdp.org. NCPDP and CAQH CORE support a shared goal of continued alignment
227 for connectivity across retail pharmacy and medical.

228 ### *4.3 System Availability and Reporting Requirements for X12 275 Attachments*

229 Many healthcare providers have a need to send additional information to support health
230 care claims outside of the typical business day and business hours. Additionally, many
231 institutional providers are now allocating staff resources to performing administrative and
232 financial back-office activities on weekends and evenings. As a result, providers have a
233 business need to be able to submit additional information to support a health care claim
234 transaction at any time.

235 On the other hand, HIPAA-covered health plans have a business need to periodically take
236 their additional information processing and other systems offline to perform required system
237 maintenance. This typically results in some systems not being available for timely processing
238 of X12 v6020X314 275 and X12 v6020X290 999 on certain nights and weekends. This rule
239 requirement addresses these conflicting needs.

240 #### *4.3.1 System Availability Requirements*

241 System availability must be no less than 86 percent per calendar week for both Real Time
242 and Batch Processing Modes. Calendar week is defined as 12:01 a.m. Sunday to 12:00 a.m.
243 the following Sunday. This will allow for a HIPAA-covered health plan and its agent to
244 schedule system updates to take place within a maximum of 24 hours per calendar week
245 for regularly scheduled downtime.

246 #### *4.3.2 Reporting Requirements*

247 ##### *4.3.2.1 Scheduled Downtime*

248 A HIPAA-covered health plan and its agent must publish its regularly scheduled system
249 downtime in an appropriate manner (e.g., on websites or in Companion Guides) such that
250 the HIPAA-covered health plan's trading partners can determine the health plan's system
251 availability so that staffing levels can be effectively managed.

252 ##### *4.3.2.2 Non-Routine Downtime*

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

255 ##### *4.3.2.3 Unscheduled Downtime*

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

259 ##### *4.3.2.4 No Response Required*

260 No response is required during scheduled, non-routine, or unscheduled downtime(s).

261 #### *4.3.2.5 Holiday Schedule*

262 Each HIPAA-covered health plan and its agent will establish its own holiday schedule
263 and publish it in accordance with the rule requirements above.

264 ### *4.4 Payload Acknowledgements and Response Time Requirements for X12 275 Attachments*

265 Providers are often not aware whether an attachment sent to support a health care claim submission
266 was received. As a result, providers often re-send the attachment or revert to manual processes (e.g.,
267 fax, phone, etc.) to determine the status of the health care claim and corresponding attachment. The
268 following rule requirements address the method and response time for a health plan and its agent to
269 return an acknowledgement of receipt to providers and their agents when sending a X12 v6020X314 275
270 or non-X12 attachment (e.g., HL7 C-CDA, .pdf, etc.).

271 ### *4.4.1 Payload Acknowledgements for X12 275 Attachments*

272 #### *4.4.1.1 Use of the X12 999 Implementation Acknowledgement*

273 The requirements in this section apply to a HIPAA-covered health plan and its agent when it receives an
274 X12 v6020X314 275 in Real Time or Batch to support an X12 v5010 837 Health Care Claim.[8]

275 When any Functional Group of a X12 v6020X314 275 Attachment Transaction Set is accepted,
276 accepted with errors, or rejected the HIPAA-covered health plan and its agent must return a
277 X12 v6020X290 999 transaction. The X12 v6020X290 999 transaction must report each error
278 detected to the most specific level of detail supported by the X12 v6020X290 999 transaction.

279 #### *4.4.1.2 Response Time Requirements for Availability of Acknowledgements*

280 Each HIPAA-covered entity and its agent must support this maximum response time requirement to
281 ensure that at least 90 percent of all required responses are returned within the specified maximum
282 response time as measured within a calendar month.

283 Each HIPAA-covered entity and its agent must capture, log, audit, match, and report the date
284 (YYYYMMDD), time (HHMMSS) and control numbers from its own internal systems and the
285 corresponding data received from its trading partners.

286 Each HIPAA-covered entity and its agent must support these response time requirements in this section
287 and other CAQH CORE Operating Rules regardless of the connectivity mode and methods used between
288 trading partners.

289 #### *4.4.1.3 Batch Mode Response Time Requirements*

290 Maximum elapsed time for the availability of an X12 v6020X290 999 transaction to any X12 v6020X314
291 275 Attachment transaction that is submitted by a provider, or on a provider's behalf by a
292 clearinghouse/switch in Batch Processing Mode, by 9:00 pm Eastern Time of a business day must be no
293 later than 7:00 am Eastern Time the second business day following submission.

---

[8] Health plans and their agents should refer to the CAQH CORE Health Care Claim (837) Infrastructure Rule for specific requirements pertaining to response times to notify providers and their agents that the original X12 v5010 837 Health Care Claim was processed.

294 A business day consists of the 24 hours commencing with 12:00 am (Midnight or 0000 hours) of each
295 designated day through 11:59 pm (2359 hours) of that same designated day. The actual calendar day(s)
296 constituting business days are defined by and at the discretion of each HIPAA-covered health plan and
297 its agent.

298 ##### *4.4.1.4 Real Time Response Time Requirement*

299 *Maximum* response time for the receipt of an X12 v6020X290 999 Response from the time of
300 submission of an X12 v6020X314 275 must be 20 seconds when processing in Real Time Processing
301 Mode. The recommended maximum response time between each participant in the transaction routing
302 path is 4 seconds or less per hop as long as the 20-second total roundtrip *maximum* requirement is met.

303 ##### *4.4.1.5 Basic Requirements for Receivers of Acknowledgments*

304 The receiver (defined in the context of this CAQH CORE Operating Rule as the HIPAA-covered provider
305 and its agent) of an X12 v6020X290 999 transaction is required to:

306 • Process any X12 v6020X290 999 transaction within one business day of its receipt

307 And

308 • Recognize all error conditions that can be specified using all standard acknowledgements named
309 in this rule

310 And

311 • Pass all such error conditions to the end user as appropriate

312 Or

313 • Display to the end user text that uniquely describes the specific error condition(s),
314 ensuring that the actual wording of the text displayed accurately represents the error
315 code and the corresponding error description specified in the related X12 v6020X290
316 999 specification without changing the meaning and intent of the error condition
317 description.

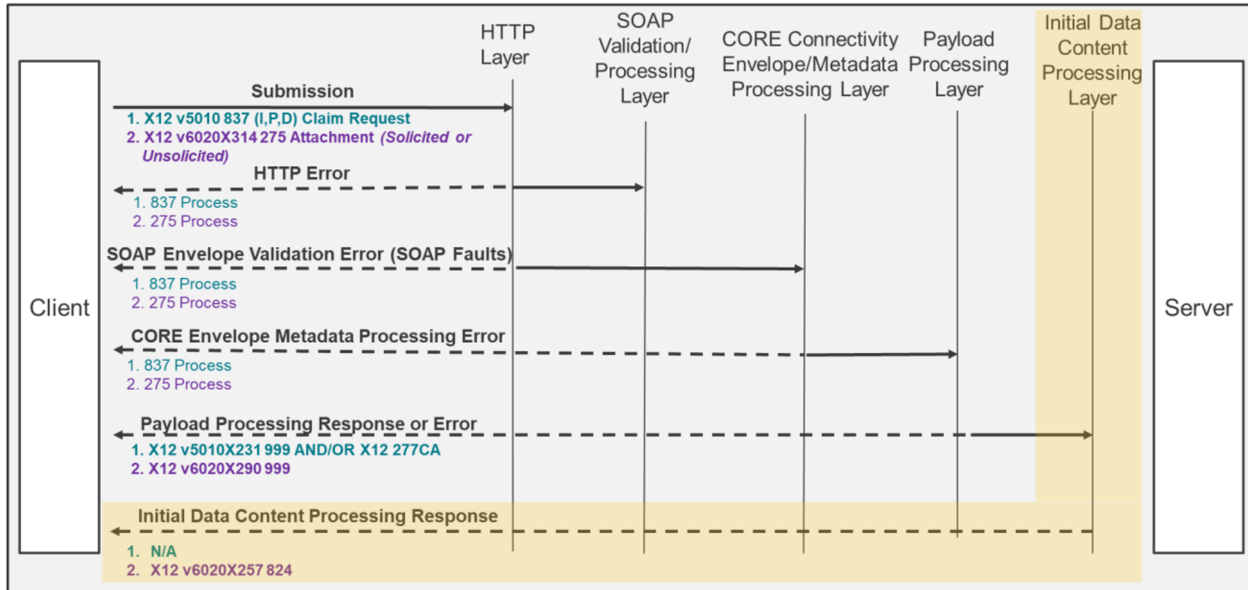
318 The actual wording of the text displayed is at the discretion of the HIPAA-covered provider and its
319 agent.

320 #### *4.5 Data Error Handling Requirements for Attachments using the X12 275 Transaction*

321 This section of the rule details data error handling requirements pertaining to attachments sent via the
322 X12 v6020X314 275 transaction.

323 CAQH CORE Connectivity specifies that when an X12 v6020X314 275 is submitted using either SOAP or
324 REST, it goes through several initial layers of error handling, identified in Figure 4.5 CAQH CORE
325 Connectivity. If no errors are encountered at any HTTP Layer through Payload Processing Layer, the
326 submission is passed to the next processing layer. If there is an error at any HTTP layer preceding the
327 Payload Processing Layer the payload does not get passed to the next HTTP layer. The receiver (server)
328 must return a X12 v6020X290 999 whether or not there is an error processing the payload at the
329 Payload Processing Layer.

Figure 4.5 CAQH CORE Connectivity – Data Error Handling



NOTE: *Claim Status (276/277) is not depicted in this diagram*

NOTE: In Figure 4.5 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 Payload Processing Response or Error Layer is completed, 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 v6020X314 275 transaction *(See ~~CAQH CORE Attachments (275/837) Health Care Claims Infrastructure Rule Requirement~~ §4.4.)*. Though a response is not required at the Initial Data Content Processing Layer, if the receiver (server) responds, it must also return a X12 v6020X257 824 to notify providers and their agents (submitter/client) of the acceptance, acceptance with error, or rejection of the X12 v6020X314 275 transaction and the content of the Binary Data Segment (BDS) segment in the X12 v6020X314 275 transaction in addition to the X12 v6020X290 999.[9]

4.5.1 Use of the X12 999 Implementation Acknowledgement for Functional Group Acknowledgement of the X12 824 Transaction

A receiver of an X12 v6020X257 824 transaction must return an X12 v6020X290 999 for each Functional Group of X12 v6020X257 824 transactions to indicate that the that it was either accepted, accepted with errors or rejected.

[9] Usage of the X12 v6020X257 824 is independent from other X12 responses to the X12 v5010 837 and X12 v6020X290 999.

4.6 File Size Requirements for X12 275 Attachments

Each HIPAA-covered entity and its agent must support the receipt and processing of the *minimum* file size requirements to ensure attachments can be processed across varying systems.

4.6.1 Front-End Server File Size Requirement for Attachments using an X12 275 Transaction

A HIPAA-covered entity and its agent must be able to accept a *Minimum* 64MB of Base64 encoded data by their front-end servers when the encoded data received is exchanged via the X12 v6020X314 275 transaction.

4.6.2 Internal Document Management System File Size Requirement for Attachments using an X12 275 Transaction

A HIPAA-covered entity and its agent must be able to accept a *Minimum* 64MB file size document by their internal document management systems used for holding and processing attachments.

4.6.3 Use of Multiple LX Loops on an X12 275 Transaction when Sending Multiple Attachments for a Single Claim

Multiple attachments are often needed to support a single claim for which the overall size could exceed 64MB[10]. As the X12 v6020X314 275 transaction supports a single BDS Segment in each LX Loop, the submitter (client) may decide to use more than one LX loop to submit multiple attachments. The receiver (server) must support the capability to receive multiple LX loops per X12 v6020X314 275 when the submitter (client) chooses to send multiple LX loops for one claim submission.

4.7 Companion Guide for X12 275 Attachments

A HIPAA-covered health plan and its agent have the option of creating a "Companion Guide" that describes the specifics of how it will implement the X12 transactions. The Companion Guide is in addition to and supplements the X12 TR3 Implementation Guide.

~~Currently~~ Historically, HIPAA-covered health plans and 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 TR3 Implementation Guides. To address this issue, CAQH CORE developed the CAQH CORE Master Companion Guide Template for health plans and information sources. Using this template, health plans and 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 health care industry experts, this template organizes information into several simple sections – General Information (§1-9) and Transaction-Specific Information (§10) – accompanied by an appendix. Note that the Companion Guide template is presented in the form of an example from the viewpoint of a fictitious Acme Health Plan.

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[10] The standard BDS segment can support substantially more than 64MB. The submitter (client) is not required to limit the Base64 encoded data to this minimum and may elect to insert substantially more than 64MB in the BDS segment, but receivers (servers) are only required to support a base of 64MB per X12 v6020X314 275, in accordance with §4.6.1 and §4.6.2 of this rule.

383 ~~Although CAQH CORE believes that a standard template/common structure is desirable, it recognizes~~
384 ~~that different HIPAA-covered health plans may have different requirements. The CAQH CORE Master~~
385 ~~Companion Guide template gives health plans the flexibility to tailor the document to meet their~~
386 ~~particular needs.~~

387 The requirements specified in this section do not ~~currently~~ apply to retail pharmacy.

388 ### *4.7.1 Companion Guide Requirements for X12 275 Attachments*

389 If a HIPAA-covered entity and its agent publishes a Companion Guide covering the X12 v6020X314 275,
390 the Companion Guide must follow the format/flow as defined in the CAQH CORE Master Companion
391 Guide Template for X12 ~~T~~transactions ~~(CAQH CORE Master Companion Guide Template~~ available HERE~~)~~.

392 **NOTE**: This rule does not require any HIPAA-covered entity to modify any existing Companion Guides
393 that cover HIPAA-mandated/non-HIPAA-mandated transactions.

394 ### *4.8 Electronic Policy Access of Required Information*

395 A health plan and its agent must offer an electronic method to be determined by health plan and its
396 agent for identifying the attachment-specific data needed to support a claim adjudication request by
397 any trading partner (e.g., a healthcare provider). To support patient care, such information must be
398 accurate and current and must clearly communicate to providers what supporting documentation is
399 needed. This rule DOES NOT establish which policy requirements a health plan and its agent must use
400 for claims adjudication (e.g., requiring what information/data or 'attachment' would be needed for
401 adjudication).

402 However, CAQH CORE recommends specifying the following list ~~of recommendations~~. The list is not
403 intended to be either exhaustive or prohibitive as the specific details of a trading partner relationship
404 are outside the scope of the CAQH CORE Rules.

- Billing Policies
- Claim Process & Procedures
- Coverage Guidelines/Policies
- Documentation Requirements
- Medical Policies
- Payment Policies
- Provider Appeal & Grievance Policy
- Provider Manual
- Services that Require UM Review
- UM Timeliness Standards

405 ## 5 Infrastructure Rule Requirements for Additional Documentation Without ~~u~~Using the ~~Non-~~X12 275
406 ~~Method~~

407 The rule requirements in this section apply only when an entity and their agent use CORE Connectivity
408 without an X12 payload format to exchange an electronic attachment, such as those listed in §3.1.

409 ### *5.1 Connectivity Requirements for Additional Documentation using CORE Connectivity*

410 If a HIPAA-covered entity and its agent elect to use CORE Connectivity as their non-X12 method of
411 additional documentation submission, the most current published and CAQH CORE adopted version of
412 the CAQH CORE Connectivity Rule (hereafter referred to as CAQH CORE Connectivity Rule) must be
413 supported.

414 This requirement addresses SOAP and REST usage patterns for Real Time and Batch Processing Modes,
415 the exchange of security identifiers, and communications-level errors and acknowledgements. It does
416 not attempt to define the specific content of the message payload exchanges beyond declaring the
417 formats that must be used between entities and that security information must be sent outside of the
418 message envelope payload.

419 All HIPAA-covered entities and their agents must demonstrate the ability to implement connectivity as
420 described in the CAQH CORE Connectivity Rule. The CAQH CORE Connectivity Rule is designed to provide
421 a "Safe Harbor" that application vendors, HIPAA-covered providers and their agents and HIPAA-covered
422 health plans and their agents (or other information sources) can be assured will be supported by any
423 trading partner. Supported means that the entity is capable and ready at the time of the request by a
424 trading partner to exchange data using the CAQH CORE Connectivity Rule as described in this section.
425 These requirements are not intended to require trading partners to remove existing connections that do
426 not match the rule, nor are they intended to require that all trading partners must use this method for
427 all new connections. CAQH CORE expects that in some technical circumstances, trading partners may
428 agree to use different communication mechanism(s) and/or security requirements than those described
429 by these requirements.

430 The requirement to support the CAQH CORE Connectivity Rule does not apply to retail pharmacy. For
431 retail pharmacy the entity should reference the NCPDP Connectivity Operating Rule v1.0 that can be
432 obtained from www.ncpdp.org. NCPDP and CAQH CORE support a shared goal of continued alignment
433 for connectivity across retail pharmacy and medical.

434 ### *5.2 System Availability and Reporting Requirements for Additional Documentation using the*
435 ### *Non-X12 Method*

436 Many HIPAA-covered providers and their agents have a need to send additional information
437 to support health care claims outside of the typical business day and business hours.
438 Additionally, many institutional providers are now allocating staff resources to performing
439 administrative and financial back-office activities on weekends and evenings. As a result,
440 providers have a business need to be able to submit additional information to support a
441 health care claims transaction at any time.

442 On the other hand, HIPAA-covered health plans have a business need to periodically take
443 their additional information processing and other systems offline to perform required system
444 maintenance. This typically results in some systems not being available for timely processing
445 of additional information or documentation on certain nights and weekends. This rule
446 requirement addresses these conflicting needs.

447 ### *5.2.1 System Availability Requirements*

448 System availability must be no less than 86 percent per calendar week for both Real Time
449 and Batch Processing Modes. Calendar week is defined as 12:01 a.m. Sunday to 12:00 a.m.
450 the following Sunday. This will allow for a HIPAA-covered health plan and its agent to
451 schedule system updates to take place within a maximum of 24 hours per calendar week
452 for regularly scheduled downtime.

453 ### *5.2.2 Reporting Requirements*

454 #### *5.2.2.1 Scheduled Downtime*

455 A HIPAA-covered health plan and its agent must publish its regularly scheduled system
456 downtime in an appropriate manner (e.g., on websites) such that the HIPAA-covered health
457 plan's trading partners can determine the health plan's system availability so that staffing
458 levels can be effectively managed.

459 #### *5.2.2.2 Non-Routine Downtime*

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

462 #### *5.2.2.3 Unscheduled Downtime*

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

466 #### *5.2.2.4 No Response Required*

467 No response is required during scheduled, non-routine, or unscheduled downtime(s).

468 #### *5.2.2.5 Holiday Schedule*

469 Each HIPAA-covered health plan and its agent will establish its own holiday schedule
470 and publish it in accordance with the rule requirements above.

471 ## *5.3 File Size Requirements for Additional Documentation using the Non-X12 Method*

472 Each HIPAA-covered entity and its agent must support the receipt and processing of the *minimum* file
473 size requirements to ensure attachments can be processed across varying systems.

474 ### *5.3.1 Front-End Server File Size Requirement for Additional Documentation using the Non-X12*
475 ### *Method*

476 A HIPAA-covered entity and its agent must be able to accept a *Minimum* 64MB of Base64 encoded data
477 by their front-end servers when the encoded data received is exchanged via a non-X12 method.

478 ### *5.3.2 Internal Document Management Systems File Size Requirement for Additional*
479 ### *Documentation using the Non-X12 Method*

480 A HIPAA-covered entity and its agent must be able to accept a *Minimum* 64MB file size document by
481 their internal document management systems used for holding and processing attachments.

482 ### *5.4 Electronic Policy Access of Required Information*

483 A health plan and its agent must offer an electronic method to be determined by health plan and its
484 agent for identifying the attachment-specific data needed to support a claim adjudication request by
485 any trading partner (e.g., a healthcare provider). This rule DOES NOT establish which policy
486 requirements a health plan and its agent must use for claims adjudication (e.g., requiring what
487 information/data or 'attachment' would be needed for adjudication.

488 However, CAQH CORE recommends specifying the following list ~~of recommendations~~. The list is not
489 intended to be either exhaustive or prohibitive as the specific details of a trading partner relationship
490 are outside the scope of the CAQH CORE Rules.

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