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1 CAQH CORE Attachments Rule: Background

1.1 CAQH CORE Overview

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

1.2 Industry Interest in Attachments Operating Rules

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

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

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

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

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

2.2 Business Requirement Justification and Focus of the CAQH CORE Attachment (275/278) Prior Authorization Infrastructure Rule

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

This CAQH CORE Attachment (275/278) Prior Authorization Infrastructure Rule addresses the X12 006020X316 275 Additional Information to Support a Health Care Services Review Technical Report Type 3 (hereafter referred to as the X12 v6020X316 275).

This rule continues to facilitate industry momentum to increase access to electronic administrative transactions, and will encourage all HIPAA-covered entities, business associates, intermediaries and vendors to build on or extend the infrastructure they have established for other business transactions, including 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).

The CAQH CORE Attachments (275/278) Prior Authorization Infrastructure Rule is designed to bring consistency and reduce time to final determination of a prior authorization that requires additional documentation. These infrastructure rule requirements include:

- Batch and Real Time exchange of the X12 v6020X316 275 transaction
- Minimum system availability uptime
- Consistent use of the X12 v6020X290 999 Acknowledgement for Batch and Real Time exchanges
- Minimum supported file size
- Use of the public internet for connectivity
- Use of best practice template for format and flow of Companion Guides for entities that issue them

During the development of this rule, CAQH CORE participants used discussion, research and straw poll results to determine which infrastructure requirements should be applied to the exchange of the X12 v6020X316 275 transaction. The table below lists the infrastructure requirements incorporated into this 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 v6020X316 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	N

As with all CAQH CORE Operating Rules, the CAQH CORE Attachments (275/278) Prior Authorization Infrastructure Rule requirements are intended as a base or minimum set of requirements, and it is expected that many entities will go beyond these requirements as they work toward the goal of administrative interoperability.

By applying these CAQH CORE infrastructure requirements to the conduct of the X12 v6020X316 275 transaction for exchanging additional documentation in support of v5010X217 278 prior authorization Requests, this CAQH CORE Attachments (275/278) Prior Authorization Infrastructure Rule helps provide the information that is necessary to electronically send attachments uniformly and consistently, reducing administrative burden and patient care delays.

3 Scope

3.1 What the Rule Applies To

This CAQH CORE Attachments (275/278) Prior Authorization Infrastructure Rule applies to the conduct of the following X12 transactions sent in Batch ~~and~~ or Real Time Processing Modes:

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

This rule optionally applies to other payload types (e.g., HL7 C-CDA, .pdf, etc.) exchanged using 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 (275/278) Prior Authorization 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 v5010X217 278 Prior Authorization Request.

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 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 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 X316 275 transaction but must also continue to support X12 v6020X316 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 v6020X316 275 transaction. This CAQH CORE Attachments (275/278) Prior Authorization Infrastructure Rule is applicable to improving access for additional information to support a Health Care Services Review and Request and not addressing data content requirements for transactions identified in §3.1.

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 v6020X316 275 Additional Information to Support a Health Care Services Review transactions, X12 v5010X217 278, X12 v6020X290 999 or X12 v6020X257 824.
- 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 Infrastructure Rule Requirements for Attachments using the X12 275 Transaction

4.1 Processing Mode Requirements for X12 275 Attachments

A HIPAA-covered health plan and its agent must implement the server requirements for either Batch Processing Mode **OR** Real Time Processing Mode for the X12 v6020X316 275 Attachment transaction as specified in the most recent CORE Connectivity Rule. Optionally, a HIPAA-covered health plan and its agent may elect to implement both Real Time and Batch Processing Modes.

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

A HIPAA-covered health plan and its agent conducting the X12 v6020X316 275 Attachment transaction is required to conform to the processing mode requirements specified in this section regardless of any other connectivity modes and methods used between trading partners.

4.2 Connectivity Requirements for X12 275 Attachments[7]

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

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

All HIPAA-covered entities must demonstrate the ability to implement connectivity as described in the most recent CORE Connectivity Rule. The CAQH CORE Connectivity Rule is designed to provide a "Safe Harbor" that application vendors, HIPAA-covered providers and their agents and HIPAA-covered health plans and their agents (or other information sources) can be assured will be supported by any trading partner. Supported means that the entity is capable and ready at the time of the request by a trading partner to exchange data using the CAQH CORE Connectivity Rule as described in this section. These requirements are not intended to require trading partners to remove existing connections that do not match the rule, nor are they intended to require that all 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 those described by these requirements.

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

4.3 System Availability and Reporting Requirements for X12 275 Attachments

Many healthcare providers have a need to send additional information to support prior authorizations outside of the typical business day and business hours. Additionally, many institutional providers are now allocating staff resources to performing administrative and financial back-office activities on weekends and evenings. As a result, providers have a business need to be able to submit additional information to support a prior authorization transaction at any time.

On the other hand, HIPAA-covered health plans have a business need to periodically take their additional information processing and other systems offline to perform required system maintenance. This typically results in some systems not being available for timely processing of X12 v6020X316 275 Additional Information and X12 v6020X290 999 on certain nights and weekends. This rule requirement addresses these conflicting needs.

[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.

4.3.1 System Availability Requirements

System availability must be no less than 86 percent per calendar week for both Real Time and Batch Processing Modes. 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 and its agent to schedule system updates to take place within a maximum of 24 hours per calendar week for regularly scheduled downtime.

4.3.2 Reporting Requirements

4.3.2.1 Scheduled Downtime

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

4.3.2.2 *Non-Routine Downtime*

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

4.3.2.3 Unscheduled Downtime

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

4.3.2.4 No Response Required

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

4.3.2.5 Holiday Schedule

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

4.4 Payload Acknowledgements and Response Time Requirements for X12 275 Attachments

Providers are often not aware whether an attachment sent to support a prior authorization Request was received. As a result, providers often re-send the attachment or revert to manual processes (e.g., fax, phone, etc.) to determine the status of the prior authorization Request and corresponding attachment. The following rule requirements address the method and response time for a health plan and its agent to return an acknowledgement of receipt to providers and their agents when sending a X12 v6020X316 275 or non-X12 attachment (e.g., HL7 C-CDA, PDF, etc.).

4.4.1 Payload Acknowledgements for X12 275 Attachments

4.4.1.1 Use of the X12 999 Implementation Acknowledgement

The requirements in this section apply to a HIPAA-covered health plan and its agent when it receives an X12 v6020X316 275 in Real Time or Batch to support an X12 v5010X217 278 Prior Authorization Request.[8]

When any Functional Group of a X12 v6020X316 275 Attachment Transaction Set is accepted, accepted with errors, or rejected the HIPAA-covered health plan and its agent must return a X12 v6020X290 999 transaction. The X12 v6020X290 999 transaction must report each error detected to the most specific level of detail supported by the X12 v6020X290 999 transaction.

4.4.1.2 Response Time Requirements for Availability of Acknowledgements

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

Each HIPAA-covered entity and its agent must 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.

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

4.4.1.3 Batch Mode Response Time Requirements

Maximum elapsed time for the availability of an X12 v6020X290 999 transaction to any X12 v6020X316 275 Attachment transaction that is submitted by a provider, or on a provider's behalf by a clearinghouse/switch in Batch Processing Mode, by 9:00 pm Eastern Time of a business day must be no later than 7:00 am Eastern Time the second business day following submission.

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

[8] Health plans and their agents should refer to the CAQH CORE Prior Authorization & Referrals (278) Infrastructure Rule ~~vPA2.0~~ and CAQH CORE Prior Authorization & Referrals (278) Data Content Rule ~~vPA1.0~~ for specific requirements pertaining to response times to notify providers and their agents 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.

4.4.1.4 Real Time Response Time Requirement

Maximum response time for the receipt of an X12 v6020X290 999 Response from the time of submission of an X12 v6020X316 275 must be 20 seconds when processing in Real Time Processing Mode. The recommended maximum response time between each participant in the transaction routing path is 4 seconds or less per hop as long as the 20-second total roundtrip *maximum* requirement is met.

4.4.1.5 Basic Requirements for Receivers of Acknowledgments

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

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

  And

- Recognize all error conditions that can be specified using all standard acknowledgements named in this rule

  And

- Pass all such error conditions to the end user as appropriate

  Or

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

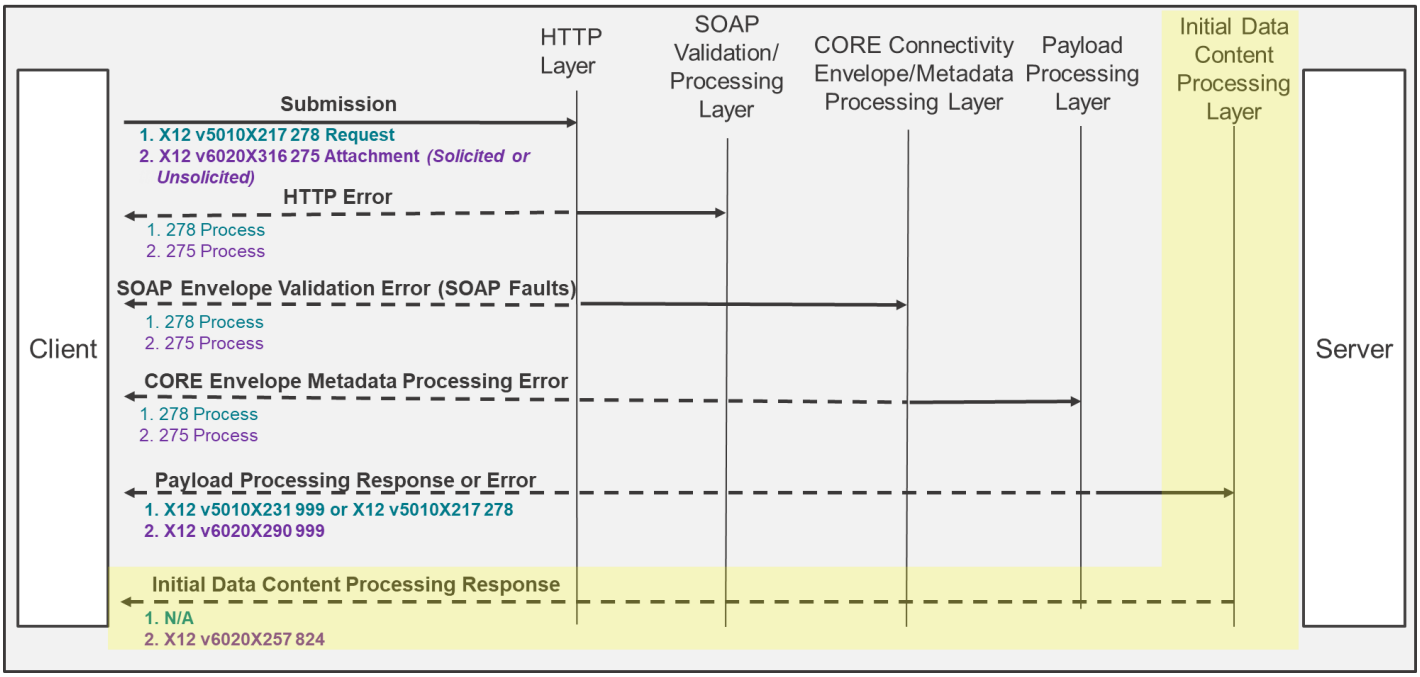
The actual wording of the text displayed is at the discretion of the HIPAA-covered provider and its agent.

4.5 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.

CAQH CORE Connectivity 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 4.5 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 4.5 CAQH CORE Connectivity – Data Error Handling



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 ~~processes the content of the payload~~ 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 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, it must also return a X12 v6020X257 824 to notify providers and their agents (submitter/client) of ~~the~~ the acceptance, acceptance with error, or rejection of the X12 v6020X316 275 transaction and the content of the Binary Data Segment (BDS) segment in the X12 v6020X316 275 transaction in addition to the X12 v6020X290 999 and the X12 v5010X217 278 Response.[9]

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.

[9] Usage of the X12 v6020X257 824 is independent from other X12 responses to the X12 v5010X217 278 Response and X12 v6020X290 999.

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. The X12 v6020X290 999 must report each error detected to the most specific level of detail supported by the 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 v6020X316 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.

4.7 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.

~~Although CAQH CORE believes that a standard template/common structure is desirable, it recognizes that different HIPAA-covered 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.~~ The requirements specified in this section do not ~~currently~~ apply to retail pharmacy.

4.7.1 Companion Guide Requirements for X12 275 Attachments

If a HIPAA-covered entity and its agent publishes a Companion Guide covering the X12 v6020X316 275, the Companion Guide must follow the format/flow as defined in the CAQH CORE Master Companion Guide Template for X12 ~~T~~transactions ~~(CAQH CORE Master Companion Guide Template~~ available HERE~~)~~.

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

5 Infrastructure Rule Requirements for Additional Documentation Without Using the X12 275 ~~using the Non-X12 Method~~

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

5.1 Connectivity Requirements for Additional Documentation using CORE Connectivity

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

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

All HIPAA-covered entities and their agents must demonstrate the ability to implement connectivity as described in the CAQH CORE Connectivity Rule. ~~vC4.0.0.~~ The CAQH CORE Connectivity Rule ~~vC4.0.0~~ is designed to provide a “Safe Harbor” that application vendors, HIPAA-covered providers and their agents and HIPAA-covered health plans and their agents (or other information sources) can be assured will be supported by any trading partner. Supported means that the entity is capable and ready at the time of the request by a trading partner to exchange data using the CAQH CORE Connectivity Rule as described in this section. These requirements are not intended to require trading partners to remove existing connections that do not match the rule, nor are they intended to require that all 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 those described by these requirements.

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

5.2 System Availability and Reporting Requirements for Additional Documentation using the Non-X12 Method

Many ~~healthcare~~ HIPAA-covered providers and their agents have a need to send additional information to support prior authorizations outside of the typical business day and business hours. Additionally, many institutional providers are now allocating staff resources to performing administrative and financial back-office activities on weekends and evenings. As a result, providers have a business need to be able to submit additional information to support a prior authorization transaction at any time.

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

5.2.1 System Availability Requirements

System availability must be no less than 86 percent per calendar week for both Real Time and Batch Processing Modes. 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 and its agent to schedule system updates to take place within a maximum of 24 hours per calendar week for regularly scheduled downtime.

5.2.2 Reporting Requirements

5.2.2.1 Scheduled Downtime

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

5.2.2.2 Non-Routine Downtime

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

5.2.2.3 Unscheduled Downtime

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

5.2.2.4 No Response Required

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

5.2.2.5 Holiday Schedule

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

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

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.

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

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 a non-X12 method.

5.3.2 Internal Document Management System File Size Requirement for Additional Documentation using the Non-X12 Methods

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