Table of Contents

1. NEW: CAQH CORE Health Care Claims (837) Data Content Rule Test Scenario

1.1. Key Requirements

Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.

Requirements for Providers (§4.1)

Remote Care Delivery Claims (§4.1.1)

- A provider and its agent must use CORE-defined combinations of corresponding POS + modifier codes when billing a telehealth claim with POS 02 or 10 for the X12 v5010 837 Professional.

Coordination of Benefits (§4.1.2)

- A provider and its agent involved in ***Provider to Health Plan COB Interactions*** must submit appropriate data content from the X12 v5010 837 transaction for coordination of benefits as defined in Table 3 and Table 4 of §3.5, when submitting claims to subsequent health plans.
- A provider and its agent must submit the following information to the primary health plan in the X12 v5010 837 transaction to support ***Health Plan to Health COB Interactions:***
    - Data for the subscriber holding the policy with the primary health plan in the Subscriber loop (Loop ID-2000B).
    - Details about the secondary health plan and associated subscriber in Loop ID-2320.
    - Relevant data from Table 3 and Table 4 of §3.5 if known to the secondary plan.

Matching Information Between an Initial and Supplementary Claim to Submit Additional Diagnoses for a Single Encounter (§4.1.3)

- A provider and its agent must match the information included in an initial claim and the information included in a supplementary claim consistent with the data elements indicated in §4.1.3 for the X12 v5010 837 Professional or X12 v5010 837 Institutional.

Requirements for Health Plans (§4.2)

Remote Care Delivery Claims (§4.2.1)

- A health plans and its agent must accept CORE-defined combinations of corresponding POS + modifier codes for qualifying service type codes covered for telemedicine when a X12 v5010 837 Professional is received with POS 02 or 10.

Coordination of Benefits (§4.2.2)

- A primary health plan and its agent must accept the information as specified in §4.2.2.1 for Provider to Health Plan COB Interactions.
- A secondary health plan and its agent must accept the information as specified in §4.2.2.1 for Provider to Health Plan COB Interactions.
- A tertiary health plan and its agent must accept the information as specified in §4.2.2.1 for Provider to Health Plan COB Interactions.
- A primary health plan and its agent must submit the information specified §4.2.2.2 to a secondary health plan in an X12 v5010 837 transaction for Health Plan to Health Plan COB Interactions.
- A secondary or tertiary health plan and its agent must accept information received as specified in §4.2.2.2 from a primary health plan in an X12 v5010 837 transaction for Health Plan to Health Plan COB Interactions.

1.1. Key Requirements

- A Companion Guide covering the X12 v5010 837 for COB published by a health plan or its agent must follow the format/flow as defined in the CAQH CORE Master Companion Guide Template. Minimum data content requirements for COB shall be organized in section 10 of the CAQH CORE Master Companion Guide Template – "10. Transaction Specific Information".
- A health plan and its agent must offer a readily accessible electronic method for identifying the data needed to support a coordination of benefit claims request by any trading partner.

Matching Information Between an Initial and Supplementary Claim to Submit Additional Diagnoses for a Single Encounter (§4.2.3)

- When a health plan or its agent accepts the submission of additional claims for a single encounter, they must require the following information to match between the initial claim and supplementary claim.
    - Rendering Provider NPI (for X12 v5010 837P)
    - Billing Provider NPI
    - Member Identification Number
    - Dates of Service
- A health plan and its agent must make this data easily accessible to submitters of an X12 v5010 837 transaction, either on the plan website or in the transaction-specific companion guide.

Detection and Display of X12 v5010 837 Claim Transaction Data Elements (4.3)

- Detect and extract all data elements to which the rule applies.
- Display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the data content.

1.2. Conformance Testing Requirements

These scenarios test the following conformance requirements of the CAQH CORE Health Care Claims (837) Data Content Rule. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario.

- The ability to process an X12 v5010 837 transaction generated using the CORE Master Test Bed Data providing the following information to support:
    - Remote Care Delivery Claims
    - Coordination of Benefits
    - Matching Information Between an Initial and Supplementary Claim to Submit Additional Diagnoses for a Single Encounter
- Provide a copy or electronic access to companion guides or other documents. Such submission may be in the form of a hard copy paper document, an electronic document, or a URL.
- System receiving the X12 v5010 837 must demonstrate its capability to detect and extract the data elements addressed in this rule and display such data and appropriate text to the end user.

1.3. Test Scripts Assumptions
• The test scripts do not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

1.4. Detailed Step-By-Step Test Scripts

CORE Certification Testing is not exhaustive. The CAQH CORE Certification Test Suite does not include comprehensive testing requirements that test for all possible permutations of each rule. An individual test script may be testing for more than one item, and, as noted in the "Stakeholder" column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

The Detailed Step-by-Step Test Scripts below specify the stakeholder type to which each test script applies. A stakeholder may indicate that a specific test script does not apply to it. In this case the stakeholder is required to provide a rationale for why a specific test script is not applicable and be prepared for a review of the rationale with CAQH CORE staff.

When establishing a Certification Test Profile with a CORE-authorized Testing Vendor a Vendor will be given the option to indicate if the product it is certifying is a Provider-facing product or a Health Plan-facing product. Therefore, the Detailed Step-by-Step Test Scripts applicable to a Provider apply to a Provider-facing product. Similarly, Detailed Step-by-Step Test Scripts applicable to a Health Plan apply to a Health Plan-facing product.

Remote Care Delivery Claims										
Test #	**Criteria**	**Expected Result**	**Actual Result**	**Pass**	**Fail**	**N/A**	**Stakeholder** *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	**Health Plan**	**Clearinghouse**	**Vendor**
1	Extract from a submitted X12 v5010 837 Professional transaction data indicating that remote delivery claims may be accepted as defined in the CORE rule using CORE Master Test Bed Data.	Provide a screen print of the output from Test #1 showing that the required information can be processed and displayed.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
2	Health plans must align its systems to accept CORE-defined POS + modifier code combinations that must be used when billing a telehealth claim with POS 02 or 10.	Submission of a signed attestation form that systems have been modified to accept CORE-defined POS + modifier code combinations when billing a telehealth claim with POS 02 or 10.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒

Remote Care Delivery Claims										
Test #	**Criteria**	**Expected Result**	**Actual Result**	**Pass**	**Fail**	**N/A**	**Stakeholder** *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	**Health Plan**	**Clearinghouse**	**Vendor**
3	Create a valid X12 v5010 837 Professional transaction indicating billing of a telehealth claim as defined by the CORE Rule using CORE Master Test Bed Data.	Output a valid X12 v5010 837 Professional transaction containing telehealth billing information that can be processed and accepted without errors.		☐ Pass	☐ Fail	☐	☒	☐	☒	☒
4	Providers must align its systems to submit CORE-defined POS + modifier code combinations that must be used when billing a telehealth claim with POS 02 or 10.	Submission of a signed attestation form that systems have been modified to use CORE-defined POS + modifier code combinations when billing a telehealth claim with POS 02 or 10.		☐ Pass	☐ Fail	☐	☒	☐	☒	☒

Coordination of Benefits										
Test #	Criteria	Expected Result	Actual Result	Pass	Fail	N/A	Stakeholder *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	Health Plan	Clearinghouse	Vendor
5	Health plans must align its systems to follow Coordination of Benefits requirements as defined by the CORE Rule.	Submission of a signed attestation form that systems have been modified to align to Coordination of Benefit rule requirements.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
6	Minimum data content requirements for COB shall be organized in Section 10 of the CAQH CORE Master Companion Guide Template – "10. Transaction Specific Information."	Submission of a page of the 837 companion guide depicting the presentation of minimum data content requirements for COB.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
7	A health plan and its agent must offer a readily accessible electronic method to for identifying the data needed to support a coordination of benefit claims request.	Enable the CAQH CORE-authorized Testing Vendor to access and view health plan's electronic method for identifying the data needed to support a coordination of benefit claim request. OR Submit description that is shared with providers of how electronic methods for identifying the data needed to support a coordination of benefit claim request may be accessed.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒

Coordination of Benefits										
Test #	**Criteria**	**Expected Result**	**Actual Result**	**Pass**	**Fail**	**N/A**	**Stakeholder** *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	**Health Plan**	**Clearinghouse**	**Vendor**
8	Providers must align its systems to follow Coordination of Benefits requirements as defined by the CORE Rule.	Submission of a signed attestation form that systems have been modified to align to Coordination of Benefit rule requirements.		☐ Pass	☐ Fail	☐	☒	☐	☒	☒

Matching Information Between an Initial and Supplementary Claim to Submit Additional Diagnoses for a Single Encounter										
Test #	**Criteria**	**Expected Result**	**Actual Result**	**Pass**	**Fail**	**N/A**	**Stakeholder** *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	**Health Plan**	**Clearinghouse**	**Vendor**
9	Health plans must require that Rendering Provider NPI, Billing Provider NPI, Member Identification Number, and Date of Services match between an initial and supplementary claim submissions when accepting claims for additional diagnoses related to a single encounter.	Submission of documentation (e.g. companion guide) that health plans require that Rendering Provider NPI, Billing Provider NPI, Member Identification Number, and Dates of Services must match between initial and supplementary claim submissions for a single encounter involving additional diagnoses		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
10	A health plan and its agent must offer an easily accessible method to identify the data needed to support matching information between an initial and supplementary claim to submit additional diagnoses for a single encounter for submitters of an X12 v5010 837 Claim transaction, either on the plan website or in the transaction-specific companion guide.	Provide a hyperlink to the website that identifies the data needed to support matching information between an initial and supplementary claim. OR Submit page from companion guide that identifies the data needed to support matching information between an initial and supplementary claim.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒

Matching Information Between an Initial and Supplementary Claim to Submit Additional Diagnoses for a Single Encounter										
Test #	**Criteria**	**Expected Result**	**Actual Result**	**Pass**	**Fail**	**N/A**	**Stakeholder** *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	**Health Plan**	**Clearinghouse**	**Vendor**
11	Create two valid X12 v5010 837 Professional transactions with corresponding matching information to indicate the submission of additional diagnoses for a single encounter as defined by the CORE Rule using CORE master Test Bed Data. The first transaction should serve as an initial claim and the second transaction should serve as a secondary claim.	Output two valid X12 v5010 837 Professional Transactions showing that the required matching information can be processed and accepted without errors.		☐ Pass	☐ Fail	☐	☒	☐	☒	☒

Matching Information Between an Initial and Supplementary Claim to Submit Additional Diagnoses for a Single Encounter										
Test #	**Criteria**	**Expected Result**	**Actual Result**	**Pass**	**Fail**	**N/A**	**Stakeholder** *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	**Health Plan**	**Clearinghouse**	**Vendor**
12	Create two valid X12 v5010 837 Institutional transactions with corresponding matching information to indicate the submission of additional diagnoses for a single encounter as defined by the CORE Rule using CORE master Test Bed Data. The first transaction should serve as an initial claim and the second transaction should serve as a secondary claim.	Output two valid X12 v5010 837 Institutional Transactions showing that the required matching information can be processed and accepted without errors.		☐ Pass	☐ Fail	☐	☒	☐	☒	☒

2. NEW: CAQH CORE Health Care Claim Acknowledgement (277CA) Data Content Rule Test Scenario

2.1. Key Requirements

Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.

Requirements for Health Plans (§4.1)

Association of the X12 v5010 277CA with Its Corresponding Health Care Claim (§4.1.2)

- A health plan and its agent must return any data elements from Table 2 of §3.5 that were included in the X12 v5010 837 Professional, X12 v5010 837 Institutional, and X12 v5010 837 Dental submissions from providers along with the X12 v5010 277CA data elements from Table 3 of §3.5 to support association of the X12 v5010 277CA transaction with its corresponding X12 v5010 837 transaction.

Alignment of Claim Category Status Codes and Claim Status Codes to Health Care Claim Line Items (Services) (§4.1.3)

- A health plan and its agent must receive and process X12 v5010 837 Professional, X12 v5010 837 Institutional, or X12 v5010 837 Dental transactions from providers containing the data content in the loops and segments indicated in Table 4 of §3.5.
- A health plan and its agent must return any data elements from Table 4 of §3.5 that were included in the X12 v5010 837 Professional, X12 v5010 837 Institutional, and X12 v5010 837 Dental submissions from providers along with the X12 v5010 277CA data elements from Table 5 of §3.5 to support aligning error codes on a X12 v5010 277CA to line items (services) on its corresponding X12 v5010 837 transaction.
- When health plans and their agents return X12 v5010 277CA transactions with claim-level (2200D-STC) CSCCs and CSCs to providers, they must include the data content in the claim-level loops and segments indicated in Table 3 of §3.5, when the data is submitted on the X12 v5010 837 transaction.
- When health plans and their agents return X12 v5010 277CA transactions with line level (2220D-STC) CSCCs and CSCs to providers, they must include the data content in the line level loops and segments indicated in Table 5 of §3.5, when the data is submitted on the X12 v5010 837 transaction.

Uniform Use of Claim Status Category Codes & Claim Status Codes (§4.1.5)

- A health plan or its agent must align its internal codes and corresponding business scenarios to the CORE-defined Claim Rejection Business Scenarios specified in §4.1.4 and the CSCC + CSC code combinations specified in the *CORE-required Error Code Combinations for CORE-defined Claim Rejection Business Scenarios.xlsx.*
- A health plan or its agent must support the maximum CORE-required CSCC + CSC combinations in the X12 v5010 277CA as specified in *CORE-required Error Code Combinations for CORE-defined Claim Rejection Business Scenarios.xlsx*.

Claim Acknowledgement Response Scenarios (§4.1.6)

- When a health plan and its agent detect an error related to the claim, the most specific CSCC + CSC code combination must be returned in Loop ID 2200B STC segment.
- When the health plan and its agent detect an error related to a specific provider's group of claims, the most specific CSCC + CSC code combination must be returned in Loop ID 2200C STC segment.
- When a health plan and its agent detect an error related to any other error, the most specific CSCC + CSC code combination must be returned in Loop ID 2200D STC segment.

2.1. Key Requirements

- When a health plan and its agent detect an error related to the line item (service), the most specific CSCC + CSC code combination must be returned in Loop ID 2220D STC segment.

General Requirements *(§4.2)*

Detection and Display of 277CA Data Elements (§4.2.2)

- Detect and extract all data elements to which the rule applies.
- Display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the data content.

Detection and Display of CORE-required Code Combinations for CORE-defined Claim Rejection Business Scenarios (§4.2.2)

- When receiving a X12 v5010 277CA, a product extracting the data (e.g., a vendor's provider-facing system or solution) from the X12 v5010 277CA for manual processing must make available to the end user:
    - Text describing the CSCC + CSC reject error codes included in the transaction, ensuring that the actual wording of the text displayed accurately represents the corresponding code description specified in the code lists without changing the meaning and intent of the description.

  AND

    - Text describing the corresponding CORE-defined Claim Rejection Business Scenario.

2.2. Conformance Testing Requirements

These scenarios test the following conformance requirements of the CAQH CORE Health Care Claims Acknowledgement (277CA) Data Content Rule. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario.

- The ability to associate a X12 v5010 277CA with its corresponding X12 v5010 837 using CORE Master Test Bed Data.
- The ability to align Claim Category Status Codes and Claim Status Codes included on a X12 v5010 277CA to Health Care Claim Line Items on a corresponding X12 v5010 837 using CORE Master Test Bed Data
- Health plan must align its internal codes and corresponding business scenarios to the CORE-defined Claim Rejection Business Scenarios and maximum CORE-required CSCC + CSC combinations in the X12 v5010 277CA.
- A vendor's provider-facing system or solution must be able to extract and make available to the end-user appropriate text accurately describing the business scenario and meaning of the code combination.

2.3. Test Scripts Assumptions

- The test scripts do not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

2.4. Detailed Step-By-Step Test Scripts

CORE Certification Testing is not exhaustive. The CAQH CORE Certification Test Suite does not include comprehensive testing requirements that test for all possible permutations of each rule. An individual test script may be testing for more than one item, and, as noted in the "Stakeholder" column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

The Detailed Step-by-Step Test Scripts below specify the stakeholder type to which each test script applies. A stakeholder may indicate that a specific test script does not apply to it. In this case the stakeholder is required to provide a rationale for why a specific test script is not applicable and be prepared for a review of the rationale with CAQH CORE staff.

When establishing a Certification Test Profile with a CORE-authorized Testing Vendor a Vendor will be given the option to indicate if the product it is certifying is a Provider-facing product or a Health Plan-facing product. Therefore, the Detailed Step-by-Step Test Scripts applicable to a Provider apply to a Provider-facing product. Similarly, Detailed Step-by-Step Test Scripts applicable to a Health Plan apply to a Health Plan-facing product.

Association of the X12 v5010 277CA with Its Corresponding Health Care Claim										
Test #	**Criteria**	**Expected Result**	**Actual Result**	**Pass**	**Fail**	**N/A**	**Stakeholder** *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	**Health Plan**	**Clearinghouse**	**Vendor**
1	Create a valid X12 v5010 277CA transaction that can be associated to a submitted X12 v5010 837 Professional transaction using CORE Master Test Bed Data.	Output a valid X12 v5010 277CA transaction containing association information from a corresponding X12 v5010 837 Professional transaction.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
2	Create a valid X12 v5010 277CA transaction that can be associated to a submitted X12 v5010 837 Institutional transaction using CORE Master Test Bed Data.	Output a valid X12 v5010 277CA transaction containing association information from a corresponding X12 v5010 837 Institutional transaction.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
3	Create a valid X12 v5010 277CA transaction that can be associated to a submitted X12	Output a valid X12 v5010 277CA transaction containing association information from a		☐ Pass	☐ Fail	☐	☐	☒	☒	☒

Association of the X12 v5010 277CA with Its Corresponding Health Care Claim										
Test #	Criteria	Expected Result	Actual Result	Pass	Fail	N/A	Stakeholder *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	Health Plan	Clearinghouse	Vendor
	v5010 837 Dental transaction using CORE Master Test Bed Data.	corresponding X12 v5010 837 Dental transaction.								

58

Alignment of Claim Category Status Codes and Claim Status Codes to Health Care Claim Line Items (Services)										
Test #	Criteria	Expected Result	Actual Result	Pass	Fail	N/A	Stakeholder *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	Health Plan	Clearinghouse	Vendor
4	Create a valid X12 v5010 277CA transaction that align error codes to line items on a submitted X12 v5010 837 Professional transaction using CORE Master Test Bed Data.	Output a valid X12 v5010 277CA transaction that align CSCCs and CSCs to a corresponding X12 v5010 837 Professional transaction.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
5	Create a valid X12 v5010 277CA transaction that align error codes to line items on a submitted X12 v5010 837 Institutional transaction using CORE Master Test Bed Data.	Output a valid X12 v5010 277CA transaction that align CSCCs and CSCs to a corresponding X12 v5010 837 Institutional transaction.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒

Alignment of Claim Category Status Codes and Claim Status Codes to Health Care Claim Line Items (Services)										
Test #	**Criteria**	**Expected Result**	**Actual Result**	**Pass**	**Fail**	**N/A**	**Stakeholder** *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	**Health Plan**	**Clearinghouse**	**Vendor**
6	Create a valid X12 v5010 277CA transaction that align error codes to line items on a submitted X12 v5010 837 Dental transaction using CORE Master Test Bed Data.	Output a valid X12 v5010 277CA transaction that align CSCCs and CSCs to a corresponding X12 v5010 837 Dental transaction.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒

59

Uniform Use of Claim Status Category Codes & Claim Status Codes										
Test #	**Criteria**	**Expected Result**	**Actual Result**	**Pass**	**Fail**	**N/A**	**Stakeholder** *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	**Health Plan**	**Clearinghouse**	**Vendor**
7	Health plan must align its internal codes and corresponding business scenarios to the CORE-defined Claim Rejection Business Scenarios and maximum CORE-required CSCC + CSC combinations in the X12 v5010 277CA.	Submission of a signed attestation form that systems have been modified to map the CORE-defined Claim Rejection Business Scenarios and maximum CORE-required CSCC + CSC combinations.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒

Detection and Display of Data										
Test #	**Criteria**	**Expected Result**	**Actual Result**	**Pass**	**Fail**	**N/A**	**Stakeholder** *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	**Health Plan**	**Clearinghouse**	**Vendor**
8	A vendor's provider-facing system or solution must be able to extract and make available to the end-user appropriate text accurately describing the business scenario and meaning of the code combinations.	Submit a screen shot of the claim acknowledgement showing that the required information is displayed.		☐ Pass	☐ Fail	☐	☒	☐	☒	☒