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

1.1. Key Rule 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 Delivery Claims (§4.1.1)

- A provider and its agent must submit appropriate 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 if known, 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 Delivery Claims (§4.2.1)

- A health plans and its agent must accept CORE-defined combinations of corresponding POS + modifier codes for qualifying categories of service 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 and return appropriate data back to a provider in a X12 v5010 837 transaction 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 and return appropriate data back to provider in a X12 v5010 837 transaction 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 and return appropriate data back to a provider in a X12 v5010 837 transaction 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 a X12 v5010 837 transaction for Health Plan to Health Plan COB Interactions.

1.1. Key Rule Requirements

- A secondary health plan and its agent must accept information received as specified in §4.2.2.2 from a primary health plan in a X12 v5010 837 transaction for Health Plan to Health Plan COB Interactions.
- A primary health plan and its agent must submit the information specified §4.2.2.1 to a secondary health plan in a X12 v5010 837 transaction for Health Plan to Health Plan COB Interactions.
- 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 CORE Master Companion Guide Template. Minimum data content requirements for COB shall be organized in section 10 of the CORE Master Companion Guide Template – "10. Transaction Specific Information
- 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 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
    - Billing Provider NPI
    - Member Identification Number
    - Dates of Service
- A health plans 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.

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1.2. Conformance Testing Requirements

These scenarios test the following conformance requirements of the 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 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

1.2. Conformance Testing Requirements
• 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 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 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 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 an easily accessible electronic method for identifying the data needed to support a coordination of benefit claims request 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 a coordination of benefit claim request. OR Submit page from companion guide that identifies the data needed to support a coordination of benefit claim request.		☐ 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	☐	☒	☐	☒	☒