CAQH CORE Health Care Claims Subgroup

Meeting #3

June 22,2023

Agenda

Agenda Items	
1.	Welcome, Antitrust Guidelines and Roll Call
2.	Straw Poll Results – Telehealth
3.	Straw Poll Results – Submission of Additional Claims
4.	Rule Development Discussion – 277CA
5.	Rule Development Discussion – Coordination of Benefits (COB)
6.	Next Steps

Telehealth

Straw Poll Results

Health Care Claims Subgroup – Straw Poll #2
Straw Poll background

Purpose of Straw Poll:
To provide feedback on opportunity areas and rule options

Format:
- **Support for Opportunity Areas:** Indicate level of support for each opportunity area.
- **Feedback on Potential Rule Options:** Provide feedback on potential rule options for each opportunity area.

Summary of Opportunity Areas:
- **Telehealth Place of Service Codes (POS) and Modifier Codes:** A data content operating rule could help align the industry around consistent use of POS and modifier codes for telehealth claims. Straw Poll #1 respondents indicated high levels of support for two POS codes (**02** and **10**) and three modifier codes (**93**, **95**, and **GT**) for use when billing telehealth claims. Straw Poll #2 contained additional polling on telehealth claim billing topics including situational use of POS and Modifier codes and utilization of Modifier codes to differentiate between synchronous and asynchronous services rendered.

- **Additional Claim Submission:** Currently, providers are unable to send more than 12 diagnosis codes on a claim via the X12 v5010 837P transaction. For many value-based payment billing and reporting scenarios, providers are requested to return more than 12 diagnosis codes; however, the 837 Professional v5010 claim only allows 12 to be submitted. Providers need to be able to submit diagnosis data to meet reporting requirements, so participants were asked how the submission of multiple claims for a single encounter could be supported through the submission of multiple claims.

Health Care Claims Subgroup – Straw Poll #2
Respondent breakdown

Distribution of Responses	*Total Straw Poll Responses*	*Percent of Total Participants*
Provider/Provider Associations	4	17%
Health Plan/Health Plan Associations	6	26%
Vendor/Clearinghouses	9	39%
Government/Other	4	17%
Total Responses	**23**	**52% of participating organizations**

1) The Health Care Claims Subgroup has 44 total unique participating organizations

Health Care Claims Subgroup – Straw Poll #2
Comment categorization

Comments received on the Health Care Claims Straw Poll #2 are grouped into three categories:

- **Substantive Comments:** May impact rule requirements; some comments require Subgroup discussion on potential adjustments to the draft requirements.
- **Points of Clarification:** Pertain to areas where more explanation for the Subgroup is required; may require adjustments to the rule which do not change rule requirements.
- **Non-substantive Comments:** Pertain to typographical/grammatical errors, wordsmithing, clarifying language, addition of references; do not impact rule requirements.

The Health Care Claims Subgroup will discuss substantive comments, points of clarification and CAQH CORE Co-chair and staff recommendations.

Straw Poll #2 did not solicit any non-substantive comments

Prioritization and Support for Telehealth Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #2

Question: *Which methodology does your organization support for the development of an operating rule to identify a claim as billed for telehealth?*

	Telehealth Claim Identification Methodology	Support
1.	POS Code + Modifier	**64%**
2.	Modifier Only	**23%**
3.	Other (please specify)	**13%**

Health Care Claims Subgroup – Straw Poll #2
Telehealth billing code assignment

Question: *Which methodology does your organization support for the development of an operating rule to identify a claim as billed for telehealth?*

Substantive Comments	Co-chair and CAQH CORE Response
1. One organization does not support using POS 02 or 10, but does support the use of other POS Codes + Modifiers together.	1. CAQH CORE Cochairs and staff recommend a combination of POS + Modifier when billing a Telehealth claims as **64%** of respondents support this method. Subgroup participants will be able to provide additional feedback on this opportunity in subsequent calls and straw polls.
2. One organization recommends using POS Code only for telehealth claim submission.	2. In Straw Poll #2, **64%** of participants supported using a combination of POS + Modifier when billing a Telehealth claim. Subgroup participants will be able to provide additional feedback on this opportunity in subsequent calls and straw polls.
3. One organization recommends using either POS or Modifier but not both.	3. In Straw Poll #2, **64%** of participants supported using a combination of POS + Modifier when billing a Telehealth claim. Subgroup participants will be able to provide additional feedback on this opportunity in subsequent calls and straw polls.

Prioritization and Support for Telehealth Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #2

Question: *For each place of service or modifier code, please indicate what if any limitations on applicable services your organization supports.*

	POS or Modifier Code	All Services	Categories of Services	Do Not Support
1.	POS 10	**59%**	18%	23%
2.	POS 02	**62%**	14%	24%
3.	Modifier 95	**63%**	32%	5%
4.	Modifier 93	**63%**	32%	5%
5.	Modifier GT	**58%**	32%	10%

POS and Modifier Code Definitions

POS 10	Telehealth provided in a patient's home.
POS 02	Telehealth provided other than in a patient's home.
Modifier 95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system.
Modifier 93	Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system.
Modifier GT	Provided via interactive audio and video telecommunications systems.

Health Care Claims Subgroup – Straw Poll #2
POS code limitation comments

Question: *For POS codes 02 and 10, please indicate what if any limitations on applicable services your organization supports.*

Substantive Comments	Co-chair and CAQH CORE Response
1. Five organizations noted that the service code limitations vary by product business line (commercial vs. Medicare).	1. The Subgroup can make recommendations and inform industry discussion on consistent modifier code use for specific service code limitations.
2. Two organizations commented that not all services are eligible for telehealth, and those that are often differ by encounter and specialty.	2. The Subgroup leadership appreciates this distinction between eligible and ineligible telehealth services. However, this Subgroup's focus is to identify POS Codes specifically for telehealth eligible services and advocate for uniform use.
3. One organization commented that industry should not use more than one POS code for telehealth and should use modifiers to communicate modality of the visit.	3. In Straw Poll #2, **64%** of participants supported using a combination of POS + Modifier when billing a Telehealth claim.
4. One organization commented they supported use of all procedure codes that are approved as telehealth via CMS documentation.	4. The Subgroup leadership thanks this organization for sharing their opinions on telehealth procedure code methodology.

Health Care Claims Subgroup – Straw Poll #2
Modifier code limitation comments

Question: *For modifier codes 93, 95, and GT, please indicate what if any limitations on applicable services your organization supports.*

Substantive Comments	Co-chair and CAQH CORE Response
1. Three organizations noted that the service code limitations vary by product business line (commercial vs. Medicare).	1. The Subgroup can make recommendations and inform industry discussion on consistent modifier code use for specific service code limitations.
2. Three organizations commented that not all services are eligible for telehealth, and telehealth eligible service codes often differ by encounter and specialty.	2. The Subgroup appreciates this distinction between eligible and ineligible telehealth services because it is aligned with the Subgroup's focus to identify codes specifically for telehealth eligible services and advocate for uniform use.
3. Two organizations commented that they supported the use of modifier 93 or 95 in conjunction with the CPT Appendix P code list.	3. The Subgroup acknowledges this note regarding conjunctive use with the CPT Appendix P code list to inform service code limitation discussions.
4. One organization commented that they do not support the use of modifier GT, noting that the modifier was retired by CMS in 2018 noting that modifier 95 should instead be used.	4. The Subgroup Co-chairs and CAQH Staff note that the GT modifier received high support in Straw Poll #2, at **58%**, suggesting that many health plans use modifier GT. Additionally, the GT modifier is required to bill Critical Access Hospital (CAH) under Medicare.
5. One organization commented that the use GT is specified by health plan, but mostly seen with RHC/FQHCs.	5. The Subgroup appreciates the context from this comment, which aligns with research conducted by CAQH staff.

Modifier Usage

Opportunity for standardization may lie in development of supplemental definitions or use cases

Question: *Please indicate which modifier codes are used by your organization when indicating synchronous or asynchronous delivery of telehealth services.*

	Modifier Code	Synchronous	Asynchronous	Both	Neither
1.	Modifier 95	**47%**	0%	32%	21%
2.	Modifier 93	**43%**	5%	26%	26%
3.	Modifier GT	37%	0%	**42%**	21%

Next steps on this topic from Subgroup leadership include:

To support industry's understanding of appropriate code assignment, define POS + modifier use cases for the Subgroup to vote on

Additional Claim Submission

Straw Poll Results

Prioritization and Support for Additional Claim Submission Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #2

Question: *To what degree does your organization support standardizing the information that must match between an initial and additional claim?*

	Matching Information	Support / Partially Support	Neutral	Partially Do Not Support / Do Not Support
1.	Member ID	**73%**	21%	6%
2.	Billing Provider NPI	**73%**	21%	6%
3.	Rendering Provider NPI	**67%**	22%	11%
4.	Date of Service	**71%**	23%	6%

Health Care Claims Subgroup – Straw Poll #2
Matching information additional comments

Question: *To what degree does your organization support standardizing the information that must match between an initial and additional claim?*

Substantive Comments	Co-chair and CAQH CORE Response
1. One organization suggested that the claim sequence number to be considered as additional matching information.	1. CAQH CORE Cochairs and staff encourages discussion on using claim sequence number to support claim matching.
2. One organization recommends that the matching information be defined as best practice rather than requirements. It notes that internal claim systems logic can vary based on downstream reporting needs.	2. CAQH CORE Cochairs and staff is considering this matching information as a minimum required set of data elements to support standardization and predictability across the industry to find the best approach to uniformity.
Point of Clarification	**Co-chair and CAQH CORE Response**
3. One organization commented that they would first need to understand the use case as clearinghouses already have basic and complex processes to check for duplicate claims and to match claims.	3. The use case for this rulemaking opportunity is to support providers who need to submit more than 12 diagnoses for a single encounter while using an X12 837 v5010 claim. Within the v5010 837 standard, submitting more than 12 diagnoses requires submitting multiple claims for the same encounter that will need to be matched.
4. One organization commented that they don't think using different provider or patient IDs is the correct solution for matching information. They noted that there are better elements for association such as those used for subsequent report only claims for PACE. Using IDs could require more manual work for providers.	4. CAQH CORE Cochairs and staff appreciate the context regarding data elements included to support the matching of additional and initial claims. Patient ID and provider IDs are potential data elements to support claim association as the IDs would be the same on both claims. The Subgroup welcomes discussion to identify elements that accomplish matching.
5. One organization commented that the data are key elements between claims that would not change, and there are more data to consider. Sending a PWK on an initial claim with a reference to the other is one resolution, with a risk that the PWK may trigger checks and workflows that are not applicable here.	5. CAQH CORE Cochairs and staff appreciates the suggestion of including additional data in the PWK; however, as the intent is not to include an attachment, we recommend not using the PWK for the purpose of reporting additional diagnosis codes.

Prioritization and Support for Additional Claim Submission Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #2

Question: *If on an additional claim you must include one of these diagnosis categories, such as factors influencing heath status, what do you populate as the principal diagnosis to avoid rejection for inappropriate principal diagnosis?*

	Principal Diagnosis Population Method	Support / Partially Support	Neutral	Partially Do Not Support / Do Not Support
1.	Carry-over of a principal diagnosis	48%	37%	15%
2.	Allowance of select secondary diagnosis to be included	43%	42%	15%

Subgroup leadership acknowledges the guidance from Health Care Claim Subgroup participants regarding principal diagnosis assignment. CAQH CORE Cochairs and staff is referring this topic to the Value-Based Payment Subgroup for further evaluation.

Prioritization and Support for Additional Claim Submission Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #2

Question: *To what degree does your organization support the development of requirements limiting the CPT codes that would qualify for an initial claim submission?*

Support / Partially Support	Neutral	Partially Do Not Support / Do Not Support
27%	52%	21%

Due to ambiguity of responses and submitted comments and questions, CAQH CORE Cochairs and staff recommend repolling this question for clarity.

Prioritization and Support for Additional Claim Submission Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #2

Question: *Please indicate which CPT codes your organization supports for inclusion on additional claims to facilitate supplemental claim data processing.*

	CPT Code	Support / Partially Support	Neutral	Partially Do Not Support / Do Not Support
1.	99499 – *"Unlisted evaluation and management service."*	18%	53%	29%
2.	99080 – *"Special Reports, such as insurance forms, that require more information than standard medical communications or reporting forms."*	28%	39%	33%

Due to ambiguity of responses and submitted comments and questions, CAQH CORE Co-chairs and staff recommend repolling this question for clarity.

Prioritization and Support for Additional Claim Submission Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #2

Question: *Please indicate which situations your organization supports for the use of CFC 0, "non-payment" and/or CFC 1, "new or original claim".*

	CFC Code/Scenario	Support / Partially Support	Neutral	Partially Do Not Support / Do Not Support
1.	CFC 1 Only	47%	37%	16%
2.	CFC 0 Only	21%	63%	16%
3.	CFC 1, when supplemental claim is submitted concurrently with the initial claim	28%	50%	22%
4.	CFC 0, when supplemental claim is submitted after initial claim	17%	61%	22%

Due to ambiguity of responses and submitted comments and questions, CAQH CORE Co-chairs and staff recommend repolling this question for clarity.

277CA

Rule Development Discussion

277CA for 837 Transactions

Helping provider efficiently understand errors in 837 transmissions

- The 277 Claim Acknowledgement (277CA) supports pre-adjudication claim validation for healthcare stakeholders. The 277CA allows health plans to notify providers when an electronic claim (837 I, P, D) is valid and accepted into the claim adjudication system or rejected and not moved to the adjudication system.
    - **When a claim is accepted:** These claims have been successfully accepted into the system and will move forward for adjudication (which may result in payment or denial).
    - **When a claim is rejected:** A rejection may provide detailed error codes and explanations to help identify and address issues with the claim submission.
    - The 277CA is distinct from the 999 acknowledgement.
- CAQH CORE research suggests that data quality for the 277CA is inconsistent. For example, upon initial rejection, some plans only use one codes to report rejection reasons, while others use several. Additionally, some health plans use basics codes that are unclear for the exact reason of a rejections. ***By improving data quality through the development of a 277CA data content operating rule, CAQH CORE hopes to increase adoption of the transaction and reduce the burden of claim resubmission.***

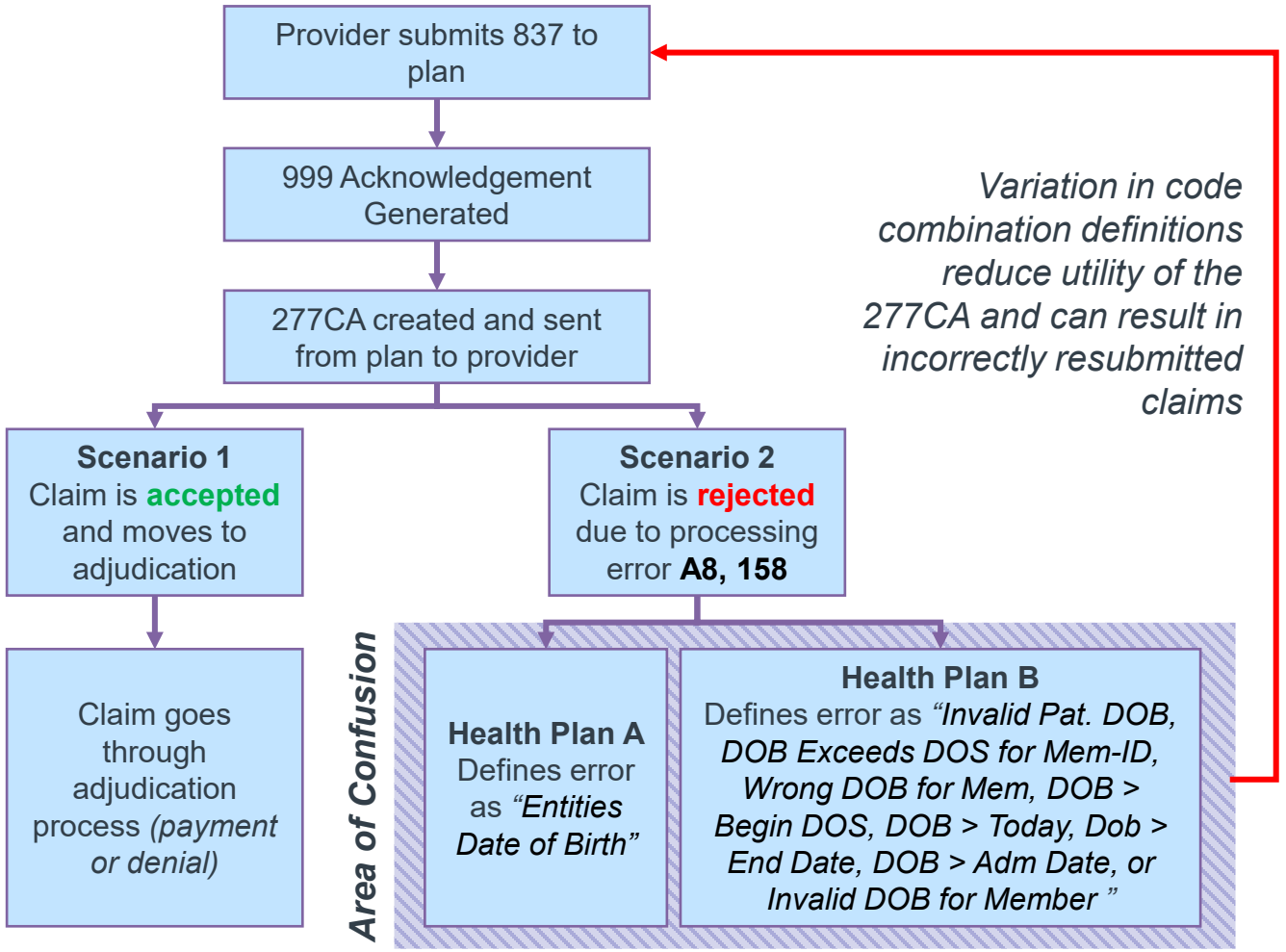
Administrative Burden – 277CA Code Variability

Health plans currently require a mix of CSCCs and CSCs to communicate similar claim errors

Examples of Health Plan 277CA Companion Guides						
		Plan A 277CA Reporting		**Plan B 277CA Reporting**		
	Error	*CSCC/CSC*	*Plan A Description*	*CSCC/CSC*	*Plan B Description(s)*	
1.	*Date of Birth*	A8, 158 =	Entities Date of Birth	A8, 158 =	***Description can be any of the below*** DOB > Begin DOS DOB > Today DOB > End Date DOB > Adm Date Invalid DOB for Member	*Two plans have matching CSCC/CSC code combinations with different descriptions*
2.	*Provider NPI*	A3, 562 =	Unable to find Billing Provider NPI	A7, 562 =	Invalid Provider NPI	*Two plans have matching/similar descriptions with different CSCC/CSC code combinations*
3.	*Subscriber ID*	A7, 33 =	Subscriber and Subscriber ID not found	A3, 33 =	Subscriber/Patient ID not found	

Impacts of 277CA Code Variability on Claims Processing

Clear rejection reasons for claims can expedite the claims adjudication process



- The 277CA process ensures that providers are notified when claims are received by health plans/clearinghouses and offers an in-depth reason for why claims are accepted or rejected.
- While 277CAs are widely used, there is significant variation in Claim Status Category Codes (CSCC) and Claim Status Codes (CSC) usage for similar errors across organizations.
- This variation leads to confusion among providers and health plan specific claims rework processes adds time and costs. Standardization of combinations, their meaning, and use can help streamline this process.

Operating Rule Guidance Strengthens Usability and Relevance of the 277CA

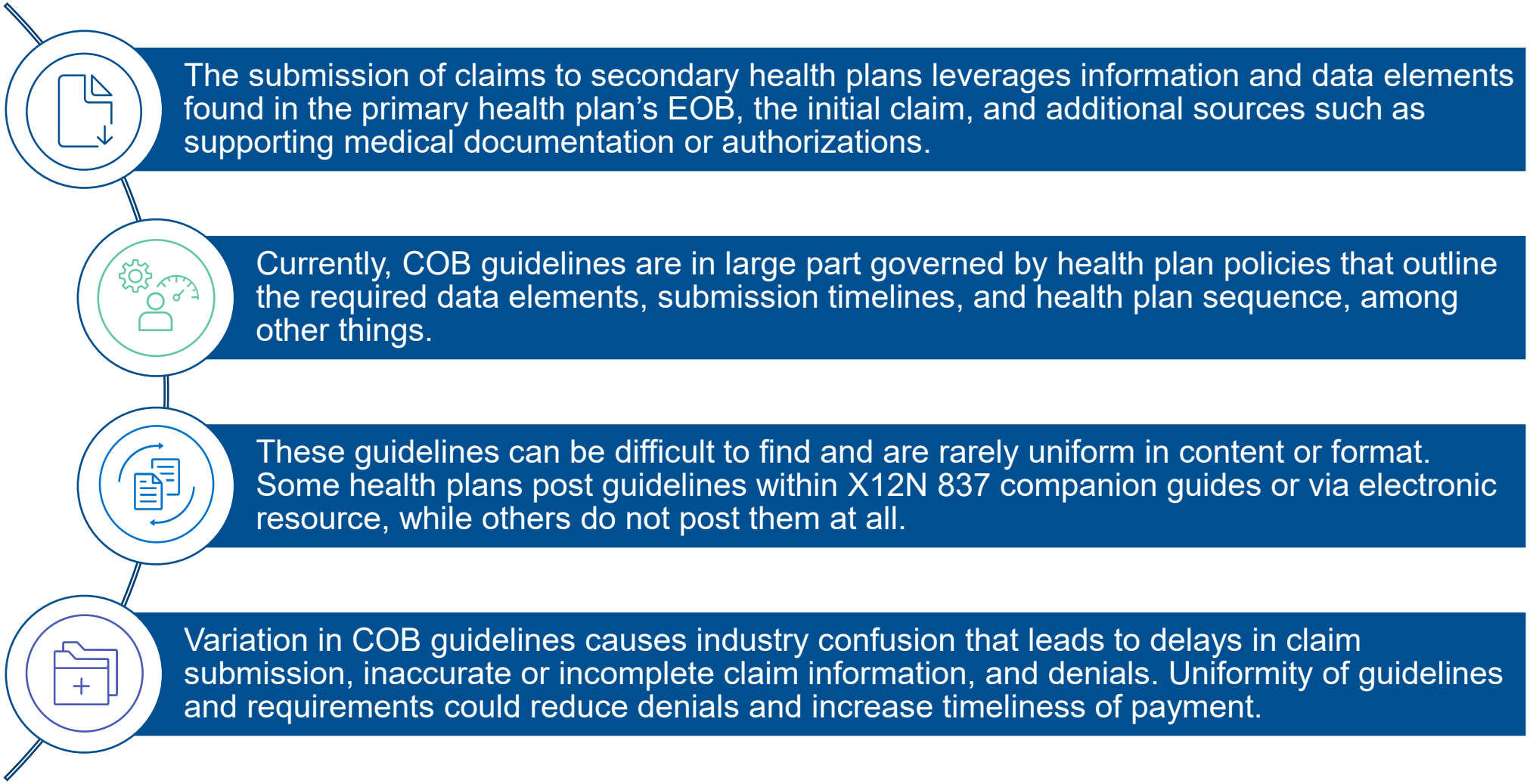
	1. Standardize Code Combinations	2. Align 837 & 277CA Data
Opportunities to Address	CAQH CORE operating rule outlining business cases and standard Claim Status Category Code (CSCC) + Claim Status Code (CSC) combinations.	CAQH CORE operating rule specifying connection between 277CA error codes and 837 data.
Industry Context	When health plans use CSCC and CSC combinations, providers can deploy robotic process automation (RPA) to correct claims for resubmission. 277CA with CSCC A3 – *Acknowledgement/returned as unprocessable claim* + CSC 21 – *At least one other status code is required to identify the missing or valid information.* Despite standardization, **this error combination does not share the additional status code needed** for RPA to correct and resubmit.	A claim with over 20 charge items is billed. The 277CA is returned with CSCC A7 – *Acknowledgement/rejected for invalid information* + CSC 598 – *non-payable professional component billed amount.* **The provider cannot tell which charge is invalid.**

CAQH CORE CARC + RARC Code Combinations resolve a similar issue for Payment & Remittance transactions. See the code combinations here.

Coordination of Benefits (COB)

Rule Development Opportunity

Streamlining the Submission of COB Claims



The submission of claims to secondary health plans leverages information and data elements found in the primary health plan's EOB, the initial claim, and additional sources such as supporting medical documentation or authorizations.

Currently, COB guidelines are in large part governed by health plan policies that outline the required data elements, submission timelines, and health plan sequence, among other things.

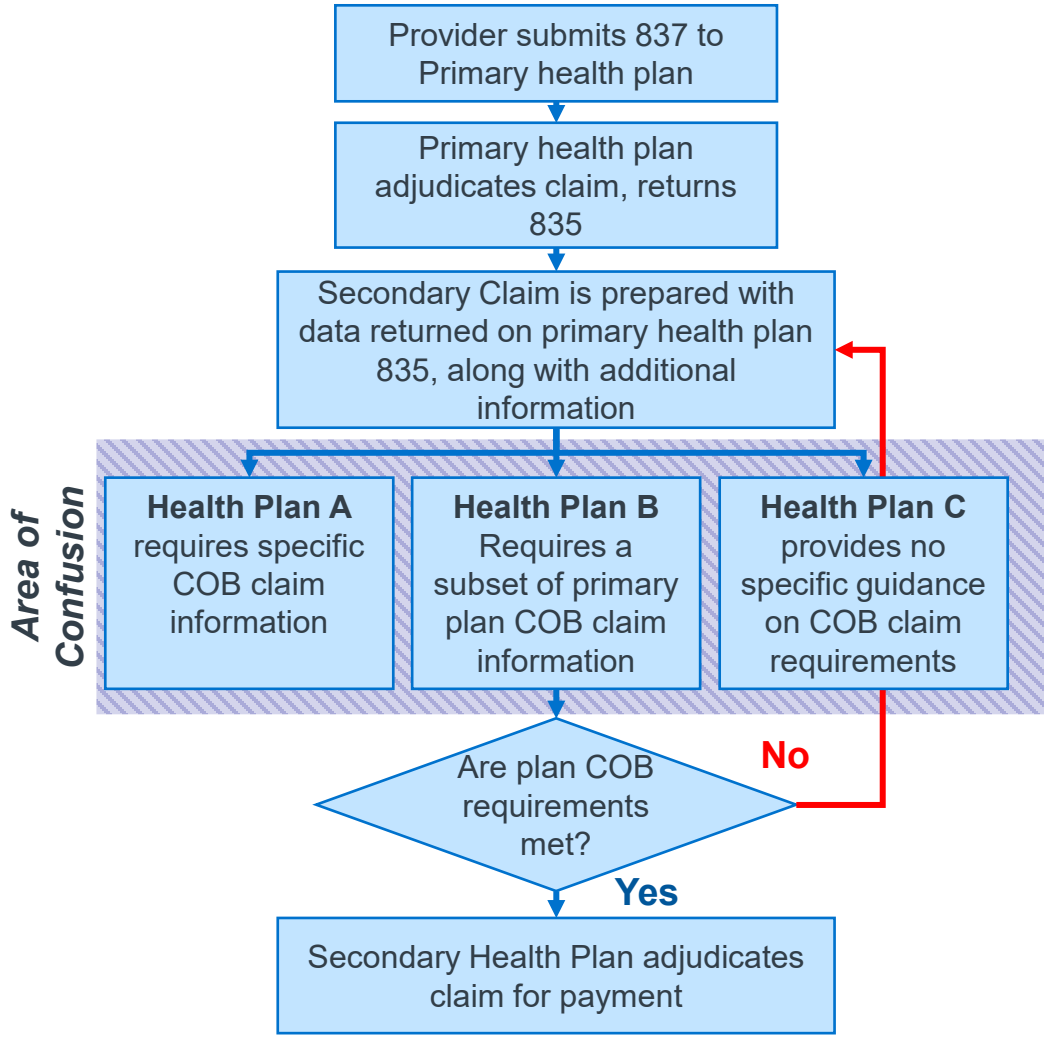
These guidelines can be difficult to find and are rarely uniform in content or format. Some health plans post guidelines within X12N 837 companion guides or via electronic resource, while others do not post them at all.

Variation in COB guidelines causes industry confusion that leads to delays in claim submission, inaccurate or incomplete claim information, and denials. Uniformity of guidelines and requirements could reduce denials and increase timeliness of payment.

Administrative Burden – Variation of COB Claim Data Requirements

Areas for operating rule consideration include but are not limited to standardization of data requirements

Snapshot of COB Claim Data Requirements by Health Plan			
Sample Data Elements	**Plan A**	**Plan B**	**Plan C**
COB Amount Paid	✓	✓	No Specific COB Claim Data Requirement Guidelines
Monetary Amount	✓	✓	
Other Health Plan Name	✓	Not required	
Claim Adjustment Group Code	✓	✓	
Claim Check or Remittance Date	✓	Not required	
Patient Responsibility Amount	✓	Not required	



Variation in COB claim submission requirements can cause a denial, requiring manual intervention

COB Claim Submission Considerations

Three areas to support consistency across all health plans for secondary claim submission

	1. Primary Health Plan Determination	2. Adjudication and Secondary Health Plan Submission	3. Infrastructure Requirements
Opportunities to Address	CORE operating rule for determining health plan primacy.	CAQH CORE operating rules establishing SLA guidance between health plans for communicating data needs, including patient data and payment.	CAQH CORE operating rule specifying method of transmission for claims going from primary to secondary plans. CAQH CORE operating rule establishing companion guide requirements for COB processes, data content, and related items.
Industry Context	For a variety of reasons, front desk representatives at provider clinics continue to incorrectly assign insurance coverage, leading to coverage-related denials. A reason is conflicting messages from industry sources regarding health plan order of determination.	Primary plans may take up to nearly 12 months to adjudicate claims, at which point a secondary claim cannot be submitted to the next health plans because timely filing limits have passed.	In some instances, the burden is on the provider to submit a claim to a secondary health plan after the primary adjudication; however, Medicare, and some BCBS plans, and other health plans have automated some crossover claims.

Next Steps

Action Items and Timelines

Next Steps from Subgroup Meeting #3

	Action Item	Timeline
1.	**Participants** to connect with colleagues at their organizations to align on feedback	--
2.	**CORE team** to distribute Straw Poll #3 to Participants; **Participants** to complete Straw Poll #3	**Straw Poll #3 Submission Dates** Friday, July 14th
3.	**Participants** to attend next Subgroup meeting	**Meeting Information** 9:30-11AM ET Thursday, July 27th