CAQH CORE Value-based Payment Subgroup

Meeting #4

X12 v5010X220 & X318 834: Infrastructure Requirements

X12 v5010 837: Additional Claim Submission for a Single Encounter

CAQH CORE VBP Subgroup Co-chairs and Staff

June 29, 2023

Agenda and Objectives

2:00 PM	• Welcome, antitrust guidelines, roll call and housekeeping • Review of Straw Poll #3: Semantic Interoperability

2:10 PM	• Evaluation of CAQH CORE Infrastructure Requirements for X12 834 VBP updates
	  • CAQH CORE Benefit Enrollment and Maintenance Infrastructure Rule
	  • HIPAA-mandated X12 v5010X220 834
	  • CAQH CORE Attributed Patient Roster Infrastructure Rule
	  • Voluntary X12 v5010X318 834

3:00 PM	• Data content requirements for additional claim submission (X12 v5010 837)
	  • CAQH CORE Health Care Claim Subgroup findings
	  • CAQH CORE Data Content Rule opportunities

3:25 PM	• Follow-ups and next steps • Straw Poll #3: Semantic interoperability • Straw Poll #4: X12 834 infrastructure and X12 837 data content requirements • **Both** open until July 17, 2023

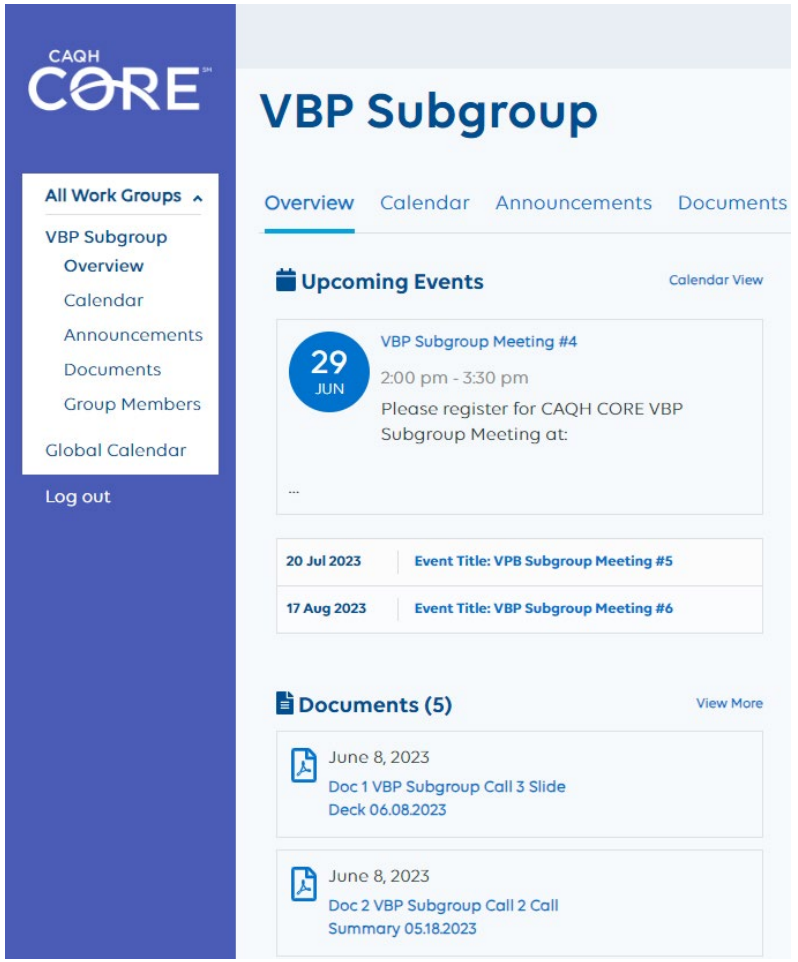
Objectives

1. Understand content and expectations for Straw Poll #3 (Semantic Interoperability).
2. Align CAQH CORE Infrastructure Requirements for the X12 834 with data content proposals.
3. Identify candidate data content opportunities for additional claim submissions for the X12 837.

CAQH CORE Participant Dashboard

Comprehensive resource of VBP Subgroup materials and information

- The dashboard is accessible only to CAQH CORE Participants.
- Participants can:
  - View the workgroups they are currently involved in.
  - Add themselves to new groups.
  - Interact with announcements, upcoming events, documents and other information relevant to workgroup participation.
- Please email CORE@caqh.org if you need a login.



Exclusive Event: Health Plans, Providers and the Data Revolution
CAQH Connect 2023

Join us for **CAQH Connect 2023**, an event bringing together healthcare industry experts, thought leaders, and executives from the nation's government, health plans, and industry associations.

Save the Date! September 27-29, 2023, *Westin Georgetown, Washington, D.C.*

Attend our first-ever in-person CORE Participant Forum:

Open to all individuals from CORE Participating Organizations and any individual who is interested in joining CORE the afternoon of September 27th.

Event speakers include current and former CAQH CORE Board Members:

Anika Gardenhire

Chief Customer Experience Officer
Centene Corporation

Linda Reed

SVP and Chief Information Officer
St. Joseph's Health

Margaret Schuler

SVP, Practice Support Operations and Revenue Cycle Management
Aspen Dental

Troy Smith

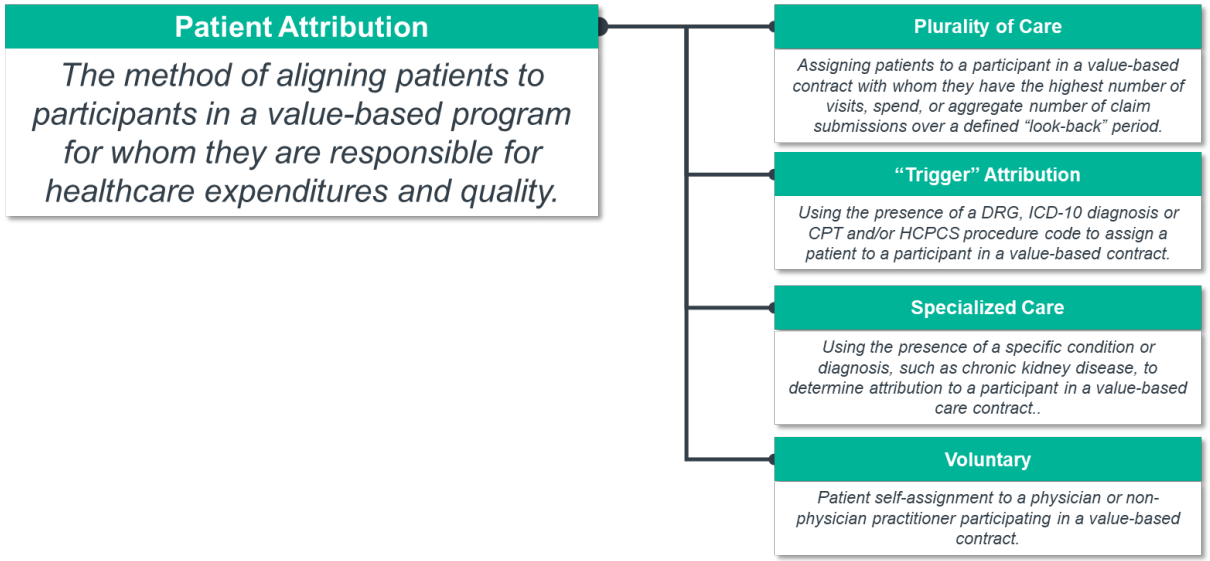
VP, Cost of Care and Value Programs
Blue Cross Blue Shield of North Carolina

Register Here!
go.caqh.org/CAQHConnect2023

Straw Poll #3: Framework for Semantic Interoperability in VBP

- **Straw Poll Period:** Straw Poll #3 was sent to Subgroup Participants on Friday, June 16; scheduled **to close on Monday, July 17**.
- **Background:** Contains a comprehensive set of definitions and terms meant to contribute to the development of the **CAQH CORE Framework for Semantic Interoperability in VBP.**
- **Feedback Requested:** Subgroup Participants are encouraged to suggest edits and additions based on personal experience or other industry best practices.

Example Framework for a Semantically Interoperable Definition of Patient Attribution



CAQH CORE Infrastructure Requirements

CAQH CORE Benefit Enrollment and Maintenance Infrastructure Rule

HIPAA-mandated X12 v5010 834 Benefit Enrollment and Maintenance (X220)

CAQH CORE Attributed Patient Roster Infrastructure Rule

Voluntary X12 v5010 834 Plan Member Reporting (X318)

CAQH CORE Infrastructure Rules

Technical and organizational requirements to facilitate secure, uniform exchange

- Comprehensive operating rule set for infrastructure requirements that are agnostic to the data content but establish basic expectations on how data exchange "system" works.
- Standard CORE requirements pair with specific considerations for uniform exchange practices across mandated and voluntary transactions.
  - CORE Connectivity
  - Companion guide templates
  - System availability
  - Processing requirements
    - Real-time and Batch
  - Monthly Exchange
- **Goal:** Align CAQH CORE infrastructure requirements for X12 v5010 834 Transactions with VBP-specific updates proposed for data content operating rules.

Infrastructure Requirement	Benefit Enrollment (X220)	Attributed Roster (X318)
CORE Connectivity HIPAA-covered health plans and their agents must demonstrate ability to implement the CAQH CORE Connectivity Rule covering communication, security, and safe harbor requirements.	X	X
CORE Companion Guide Template Standardized formatting of companion guide templates. Sections 1-9 contain general information and section 10 contains transaction specific information.	X	X
Batch Processing Acknowledgment and/or response time requirements using X12 999 within 3 business days 90% of the time.	X	X
System Availability 90% weekly uptime with optional 24 hours of scheduled downtime per quarter. Reporting requirements for scheduled, non-routine, and unscheduled downtime, as well as holiday schedules.	X	X
Real-time Processing **[If Applicable]** Acknowledgment and/or response time requirements using X12 999 within 20 seconds 90% of the time.	X	
Elapsed Time to Processing Must process benefit and enrollment and maintenance data within 5 days following receipt and validation of the data	X	
Monthly Exchange Attributed patient roster must be updated and shared with providers on a monthly basis.		X

Proposed updates to CAQH CORE Infrastructure Rules

Technical and organizational requirements to facilitate secure, uniform exchange

Proposed Updates to CAQH CORE Benefit Enrollment and Maintenance & Attributed Patient Roster Infrastructure Rules

Section	Change Type	X12 834 Infrastructure Rules Impacted	Updates
Section 1: Background	Non-substantive	Both	Update VBP language
		Both	Conformance updates
		Both	Inclusion of socio-demographic language
Section 2: Business Justification	Non-substantive	Both	Update VBP language
		Both	Conformance updates
		Both	Inclusion of socio-demographic language
Section 3: Scope	Non-substantive	Both	Alignment to current initiatives
		Both	Conformance updates
		Both	Inclusion of socio-demographic language
Section 4: Rule Requirements	**Substantive**	Attributed Patient Roster	Application of CAQH CORE real-time response and processing.
	Periodic, routine maintenance*	Both	Socio-demographic disclosure in companion guide
Section 5: Conformance	**NO UPDATES PROPOSED**		

***May result in substantive, non-substantive, or typographical changes**

Summary of Proposed Updates

Application of CAQH CORE Real-time Processing Requirements

If supporting exchange through real-time processing mode, receivers of the X12 v5010X318 must respond with an X12 v5010 999 within 20 seconds, 90% of the time measured across a calendar month.

Socio-demographic Disclosure in Companion Guide

Requirement to disclose use and exchange of socio-demographic data in Section 10 of the transaction companion guide following the flow and format of the CAQH CORE Companion Guide Template.

Update VBP Language

Include information gathered from the updated CAQH CORE VBP environmental scan and Subgroup discussions to augment background and business justification.

Inclusion of Socio-demographic Language

Informational inclusion stating that the exchange and use of socio-demographic information has been disclosed to enrollees; facilitating alignment with proposed data content requirements.

Alignment with Current Initiatives

Update language in section 3.6 of the CAQH CORE Benefit Enrollment and Maintenance Infrastructure Rule to include references to current CAQH CORE initiatives. Update both rules to include "The Framework" in definitions.

Conformance Updates

General updates to align content, section headers, and references between both X12 834 Infrastructure Rules.

CAQH CORE Data Content Requirements: Additional Claim Submission for a Single Encounter

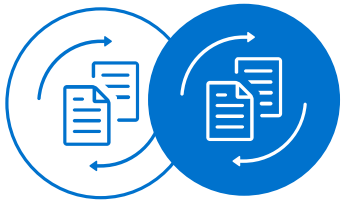
Aligning with CAQH CORE Health Care Claims Subgroup

X12 v5010 837 Health Care Claim Submission Transaction

Additional Claims for a Single Encounter Using the X12 v5010 837

- **Utility of ICD-10 Diagnoses in VBP**
  - Chronic conditions, factors influencing healthcare, and social determinants of health **influence treatment decisions and support the administrative components of value-based care programs**.
- **Non-inclusion of Supplementary Diagnoses on a Claim**
  - Often supplementary to a patient's clinical presentation, inclusion of this information can be **de-prioritized** on an X12 837 claim submission.
  - Non-inclusion of supplemental diagnoses on claims is **perpetuated by limited diagnosis fields** on the X12 v5010 837.
- **Opportunity for Standardization**
  - Health plans incorporate methods to submit supplemental diagnoses using additional claims for a single encounter, **but workflows and requirements differ.**
  - Standardized requirements support additional claim submissions for a single encounter, **supports the implementation and growth of VBP,** and reduces industry abrasion.

Patient Encounter
Presentation requires recording and submitting greater than 12 ICD-10 diagnoses.



Claim Submission
Multiple X12 v5010 837P must be submitted to account for greater than 12 diagnoses at a single encounter.

Adjudication
Health plan submission requirements for acceptance of multiple claims tied to a single encounter differ, leading to unnecessary rejections and denials.

Additional Claim Submission Opportunities
Summary from the CAQH CORE Health Care Claims Subgroup

Points of variation observed in existing workflows for additional claim submissions.

Data Content		Opportunity	Guidance from CAQH CORE Health Care Claims Subgroup
1	**Initial claim requirements**	Require that additional claims only be submitted for select set or range of CPT codes (e.g., evaluation and management '99' codes).	• Clarify the 'why' of this requirement and, if supported, refine qualifying initial claim CPT code submissions.
2	**Matching information**	Require that initial and additional claims "match" on select demographic and identifying information.	Data content requirement for claims to match the following information: • Patient identifier • Billing provider NPI • Rendering provider NPI • Dates of service Additional refinement necessary prior to advancing to operating rule requirements.
3	**Claim frequency code**	Require inclusion of claim frequency codes (CFC) on an additional claim to specify its relationship to an initial claim. • '1' - initial or admit thru discharge claim and/or • '0' - non-payment/zero claim	• Identify what code is **most** appropriate for an additional claim submission supporting VBP arrangements. • Determine if timing of additional claim submission affects use of either '1' or '0'.
4	**CPT inclusions**	Require inclusion of CPT codes that justify a nominal billed amount: • 99499 – Other evaluation and management services or • 99080 – Miscellaneous medicine services (used for special reports).	• Identify what CPT code is **most** appropriate for an additional claim submission supporting VBP arrangements.
5	**Secondary diagnosis**	Develop requirements for the submission of additional claims that **do not** include a qualifying principal diagnosis.	• Determine the best practice workflow for inclusion of a non-qualifying principal diagnosis on an additional claim submission.

Polling Question and Discussion: Additional Claim Submission
Initial claim requirements

Opportunity: Require that additional claims for a single encounter can only be submitted for initial claims that include CPT codes from a specified set or range.

Additional claims for a single encounter should only be accepted when (select one)

a. *The initial claim includes an evaluation and management CPT code (99202 – 99499).*
b. *The initial claim includes a CPT code used for attribution in a health plan's episodic or population health VBP model.*
c. *The initial claim includes **ANY** CPT code.*
d. *The initial claim should include some other set or combination of CPT codes (enter in chat or come off mute to discuss!).*

Polling Question and Discussion: Additional Claim Submission
Matching information

Opportunity: Require that initial and additional claims “match” on select demographic and identifying information.

At a MINIMUM, additional claims must match the initial claim on the following data elements (select all that apply)

*a. Patient identifier; billing provider NPI; rendering provider NPI; dates of service **ONLY.***
*b. Patient identifier; billing provider NPI; rendering provider NPI; dates of service **AND** claim sequence number.*
*c. Data from selection A **AND** additional information (enter in chat or come off mute to discuss!).*
*d. Data from selection B **AND** additional information (enter in chat or come off mute to discuss!).*

Polling Question and Discussion: Additional Claim Submission
Claim frequency code

Opportunity: Require inclusion of **SELECT** claim frequency codes (CFC) on an additional claim to specify its relationship to an initial claim.

- '1' – Payment admit thru discharge and/or
- '0' – Non-payment / zero claim.

An additional claim must include a claim frequency code that matches one of the following scenarios (select one)

*a. CFC 1 for **ALL** additional claims.*
*b. CFC 0 for **ALL** additional claims.*
***c. Conditional:** CFC 1 for additional claims submitted **concurrently** with an initial claim; CFC 0 for additional claims submitted **retrospectively** following an initial claim within a submission period specified by the health plan.*
d. Other (please enter in chat or come off mute to discuss!).

Polling Question and Discussion: Additional Claim Submission
CPT inclusions

Opportunity: Require inclusion of CPT codes that justify a nominal billed amount.
- 99499 – Other evaluation and management services or
- 99080 – Miscellaneous medicine services (used for special reports).

An additional claim must include one of the following CPT codes (select one)

a. 99499
b. 99080
c. Other (please enter in chat or come off mute to discuss!).

Polling Question and Discussion: Additional Claim Submission
Secondary diagnosis

Opportunity: Develop requirements for the submission of additional claims that **do not** include a qualifying principal diagnosis.

An additional claim that does not include a qualifying principal diagnosis must include one of the following to avoid rejection and/or denial (select one)

a. "Carry-over" qualifying principal diagnosis from the initial claim.
b. Only the non-qualifying principal diagnosis (-es).
c. Other (please enter in chat or come off mute to discuss!).

Next Steps from Subgroup Meeting #3

CAQH CORE Team

- Develop and distribution **Straw Poll #4 by EOD Monday, July 3, 2023.**

Subgroup Participants

- Complete and submit Straw Poll #3 **and** Straw Poll #4 by **EOD Monday July 17, 2023**.
  - Straw Poll #3: Engage with value-based payment administrators to complete.

Next Meeting

- Thursday, July 20, 2023, from 2pm – 3:30pm ET.

Appendix

Today's Call Documents

Document Name
Doc 1 VBP Subgroup Call 4 Deck 06.29.2023
Doc 2 VBP Subgroup Call 3 Call Summary 06.08.2023

CORE Staff*	Email Address
Erin Weber, VP, CORE	eweber@caqh.org
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Kayla Cooper, Associate, CORE	kcooper@caqh.org

CAQH CORE VBP Subgroup
Activity schedule for call #4 and #5

Meeting/Straw Poll	Description
Straw Poll #3 ***Open June 16 – July 17, 2023***	• CAQH CORE Semantic Interoperability Framework in VBP.
Subgroup Call #4 ***Thursday, June 29, 2023, 2p-3:30p ET***	• X12 v5010X220 & X318 834 infrastructure requirements. • X12 v5010 837 data content requirements.
Straw Poll #4 ***Open July 3 – July 17, 2023***	• Support for substantive updates to X12 v5010X220 & X318 Infrastructure Requirements. • Support for data content requirements for X12 v5010 837.
Subgroup Call #5 ***Thursday, Jul 20, 2023, 2p-3:30p ET***	• Results of Straw Poll #3 and #4. • Refinement of X12 v5010 837 requirements.
Straw Poll #5 ***Open July 24 – August 3, 2023***	• Draft rule language.

CAQH CORE Value-based Payments Subgroup
Roster

Participant		Organization
Elyse	**Pegler**	Aetna
Terrence	**Cunningham**	American Hospital Association (AHA)
Andrea	**Preisler**	American Hospital Association (AHA)
Nancy	**Spector**	American Medical Association (AMA)
Linda	**Walsh**	American Medical Association (AMA)
Lauren	**Scott**	American Medical Association (AMA)
Heather	**McComas**	American Medical Association (AMA)
Robert	**Otten**	American Medical Association (AMA)
Erica	**Martin**	American Medical Association (AMA)
Era	**Rodriguez**	Arizona Health Care Cost Containment System
Danielle	**Vincent**	Aultcare
Jacob	**Boron**	Aultcare
Kathy	**Sites**	Availity, LLC
Heather	**Sammons**	BCBSNC
Deborah	**Swain**	BCBSNC
Troy	**Smith**	BCBSNC
Natasha	**Sallie**	BCBSMI
Ron	**Knapp**	BCBSMI
Carol	**Larson**	BCBSMI
Cynthia	**Monarch**	BCBSMI
Jack	**Green**	BCBSMI
Paul	**Ozdarski**	BCBSMI
Susan	**Langford**	BCBSTN
Naveen	**Maram**	Centene Corporation
Chuck	**Chervitz**	Centene Corporation
Charlene	**Parks**	CMS
Sadaf	**Ali**	CMS
Genevieve	**Morris**	Change Healthcare
Mike	**Denison**	Change Healthcare
Summerpal	**Kahlon**	Change Healthcare
Annette	**Kemplin**	CIGNA
Jeffrey	**Narog**	CIGNA
Gunes	**Raack**	Cleveland Clinic
Michelle	**Medina**	Cleveland Clinic
Robert	**Jones**	Cleveland Clinic
Adam	**Keating**	Cleveland Clinic
Sanjeev	**Suri**	Cleveland Clinic
Scott	**Dynda**	Cleveland Clinic

Participant		Organization
Kyle	**Kroening**	Cognizant
Tania	**Mason**	Cognizant
Vincent	**Carrillo**	Cognizant
Andrew	**Schulz**	Cognizant
Patricia	**Wijtyk**	Cognizant
James	**Murray**	CVS Health
Alka	**Arcari**	CVS Health
Michael	**Pattwell**	Edifecs
Kevin	**Day**	Edifecs
Vik	**Sachdev**	Edifecs
Tushar	**Nair**	Edifecs
Anitha	**Aerabati**	Elevance Health
Joe	**McGuire**	Epic
Megan	**Soccorso**	Gainwell Technologies
Olga	**Khabinskay**	Healthcare Business Management Association (HBMA)
Katie	**Gilfillan**	Healthcare Financial Management Association
Rashmi	**Bokkasada**	Healthedge Software Inc
Christopher	**Gracon**	HEALTHeNET
Gheisha-Ly	**Rosario Diaz**	Laboratory Corporation of America
Denny	**Brennan**	Massachusetts Health Data Consortium/NEHEN
David	**Delano**	Massachusetts Health Data Consortium/NEHEN
Janice	**Karin**	Massachusetts Health Data Consortium/NEHEN
Kenia	**Cruz**	Montefiore Medical Center
Charles	**Hawley**	NAHDO
Amy	**Costello**	NAHDO
Margaret	**Weiker**	NCPDP
Nancy	**Team**	NextGen Healthcare Information Systems, Inc.
Michael (Mike)	**Alwell**	St. Joseph's Health
Nikita	**Williams-Woods**	Tata Consultancy Services Ltd
Alison	**Schambach**	Tata Consultancy Services Ltd
Pinki	**Patel**	Tata Consultancy Services Ltd
Dorothy	**Egan**	Tata Consultancy Services Ltd
Mary	**Sussman**	Tata Consultancy Services Ltd
Brian	**Petry**	TRICARE
Dawn	**Erckenbrack**	TRICARE
Kiran	**Kalluri**	UnitedHealthGroup
Lynn	**Chapple**	UnitedHealthGroup
Robert	**Tennant**	WEDI
Kristina	**Berger**	Zelis

Avoiding Rejection or Denial of Non-Qualifying Principal Diagnoses

- Select categories of diagnosis codes cannot be used in the principal diagnosis position.
- Non-qualifying principal diagnoses will be denied and/or rejected.
- What steps can health plans take to accommodate additional claims submissions that *only* contain non-qualifying principal diagnoses?
  - Carry-over principal diagnosis from initial claim.
  - Allow VBP-related codes.
  - Other.
- Next Steps

Non-qualifying Principal Diagnosis Code Types

Code Category	Description
Manifestation codes	When clinical presentation has manifested due to an underlying condition
“Code first” notes	Clinical presentation arose due to underlying condition that is not a manifestation code
Sequela codes	Sequela generally requires two codes sequenced with the condition or nature of the sequela being coded first
Malignant neoplasm associated with transplanted organ	First code is complications of transplanted organs
Conditions due to external or toxic agents	Assign code for external or toxic agent first
Gout	Lead-induced, renal impairment, or other condition to which gout is secondary should be coded first
Symptoms and signs of systemic inflammation and infection	Underlying conditions of non-infectious SIRS or Severe Sepsis must be coded first
Burns and Corrosions of external body surfaces or those confined to eye and internal organs	Assign first the chemical and intent, followed by corrosion burn code.
Poisoning (adverse and underdosing)	Nature of the adverse event should be coded first and codes for underdosing should never be coded first
External causes of morbidity	External causes should never be sequenced first
Factors influencing health status	***Broadly, Z-code categories, including indicators of social risk.***

Example list compiled from multiple health plans, shared for illustrative purposes.