CAQH CORE Health Care Claims Subgroup

Meeting #4

July 27,2023

Agenda

Agenda Items	
1.	Welcome, Antitrust Guidelines and Roll Call
2.	Straw Poll Results – 277CA Error Reporting
3.	Straw Poll Results – Coordination of Benefits (COB)
4.	Straw Poll Results – Telehealth
5.	Next Steps

Health Care Claims Subgroup – Straw Poll #3
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:
- **277CA Error Reporting:** A data content operating rule outlining business cases and standard Claim Status Category Code (CSCC) + Claim Status Code (CSC) combinations and specifying connection between 277CA error codes and 837 data could help to improve data quality and uniformity. 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.
- **COB Claim Submission:** A data content operating rule outlining potential rule requirements for determining health plan primacy, setting standards for data needs and expectations in service-level agreements (SLAs) between health plans and providers, setting infrastructure requirements specifying method of claims transmission between primary and secondary health plans, and setting requirements for COB in companion guides could help industry to streamline the COB claim submission process.
- **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 #2 respondents reaffirmed 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 #3 contained polling on drafted rule language for place of service (POS) and modifier assignment when billing a telehealth claim, and a resource intended to clarify when and how to use each POS + modifier combination.

Health Care Claims Subgroup – Straw Poll #3
Respondent breakdown

Distribution of Responses	Total Straw Poll Responses	Percent of Total Participants
Provider/Provider Associations	3	13%
Health Plan/Health Plan Associations	9	39%
Vendor/Clearinghouses	8	35%
Government/Other	3	13%
Total Responses	**23**	**51% of participating organizations**

1) The Health Care Claims Subgroup has 45 total unique participating organizations

Health Care Claims Subgroup – Straw Poll #3
Comment categorization

Comments received on the Health Care Claims Straw Poll #3 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 CORE Co-chair and staff recommendations.

277CA Error Reporting

Straw Poll Results

Prioritization and Support for 277CA Error Reporting Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #3

Question: *To what degree does your organization support the development of a CAQH CORE operating rule for uniform use of 277CA Claim Status Category Code (CSCC) + Claim Status Code (CSC) combinations?*

Support	Partially Support	Neutral	Partially Do Not Support	Do Not Support
64%	18%	18%	0%	0%

Context: To resolve a pain point regarding use of error codes with EDI transactions, CAQH CORE maintains an industry resource outlining proper use of X12N 835 transaction CARC and RARC Codes (see this page on CAQH's website). CAQH CORE research suggests that industry would value a similar resource for the X12N 277CA.

Prioritization and Support for 277CA Error Reporting Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #3

Question: *To what degree does your organization support the development of CSCC + CSC code combinations for the following business scenarios*

	Business Scenario	Support	Neutral	Do Not Support
1.	*Acknowledgment/Returned as unprocessable claim – The claim/encounter was rejected and has not been entered into the adjudication system* (**CSCC A3**)	**74%**	26%	0%
2.	*Acknowledgment/Not Found – the claim/encounter can not be found in the adjudication system* (**CSCC A4**)	**61%**	26%	13%
3.	*Acknowledgement/Rejected for Missing Information - the claim/encounter is missing information specified in the Status details and has been rejected.* (**CSCC A6**)	**70%**	22%	9%
4.	*Acknowledgment/Rejected for Invalid Information – the claim/encounter has invalid information as specified in the Status details and has been rejected.* (**CSCC A7**)	**70%**	30%	0%
5.	*Acknowledgement/Rejected for relational field in error.* (**CSCC A8**)	**65%**	30%	5%
6.	*Response Not Possible – error on submitted requested data.* (**CSCC E0**)	**48%**	30%	22%

Context: To resolve a pain point regarding use of error codes with EDI transactions, CAQH CORE maintains an industry resource outlining proper use of X12N 835 transaction CARC and RARC Codes (see this page on CAQH's website). CAQH CORE research suggests that industry would value a similar resource for the X12N 277CA.
The first step in developing CSCC + CSC code combinations is identifying the "business scenarios" to prioritize for industry alignment. CAQH CORE recommends using the X12 CSCCs returned on the X12 277CA to outline business scenarios for error communication.

Health Care Claims Subgroup – Straw Poll #3
277CA CSCC + CSC business scenario comments

Question: *Please share your organization's opinion on additional CSCCs that can be used as business scenarios to support CSCC + CSC code combination mapping. Examples are located here on X12's website.*

Substantive Comments	Co-chair and CAQH CORE Response
1. Three organizations request clarification of the current CSCC descriptions; for example, A4 states an encounter cannot be found, yet the claim was submitted into an adjudication system and solicited a response. This is counterintuitive and unclear.	**1. Agree**. The utility of the 277CA depends on industry's understanding of the reported errors. CORE welcomes discussion on how to remediate confusion of error definitions.
2. Two organizations suggested using a CCSC+CSC code combination methodology for **A6-Rejected for Missing Information** is not best practice. A better resolution could use the 277RFAI to request additional information, as the name of the transaction suggests.	**2. Discussion:** CORE welcomes discussion on the value that responding to an 837 with a 277RFAI brings, and in what instances it is appropriate. Additionally, CORE is conducting environmental scanning on the X12 276/277 Claim Status for potential data content operating rules, and inclusion of the 277RFAI may be welcome.
3. One organization recommended aligning draft operating rule language with potential impacts to the X12 276/77 Claim Status and provided several examples of the benefits this could bring.	**3. Discussion:** CORE welcomes discussion on the value that responding to an 837 with a 277RFAI brings, and in what instances it is appropriate. Additionally, CORE is conducting environmental scanning on the X12 276/277 Claim Status for potential data content operating rules, and the inclusion of the 277RFAI may be welcome.
Point of Clarification	**Co-chair and CAQH CORE Response**
4. Three organizations commented that CSCC E0 is not supported as it is excluded by the X12N X214 TR3.	**4. Agree.** In environmental scanning, CORE saw CSCC E0 used by health plans in 277CA responses. CORE works within existing X12 standards in rule development and appreciates this guidance.
5. One organization questioned why CSCCs A1, A2, and A5 are not part of the listed business scenarios.	**5. Discussion:** Environmental scanning included a review of health plan companion guides, and CSCC A1, A2, and A5 were not identified as regularly used by health plans in 277CA responses. A goal of this initiative is to cover the most frequently seen business scenarios, and CORE welcomes feedback on meeting this goal.

Prioritization and Support for 277CA Error Reporting Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #3

Question: *To what degree does your organization support the development of CAQH CORE operating rule requirements establishing a minimum set of data that can be used to match 277CA and 837 transactions?*

Support	Partially Support	Neutral	Partially Do Not Support	Do Not Support
65%	22%	13%	0%	0%

Context: CAQH CORE research suggests that providers sometimes receive 277CA transactions that they are unable to associate with an 837.

Health Care Claims Subgroup – Straw Poll #3
277CA and 837 transaction matching data comments

Question: *Please share your organization's opinion on data that can be used to match 277CA and 837 transactions. Examples include and are not limited to Provider ID, Patient ID, DOS, and Charge Amount.*

Substantive Comments	Co-chair and CAQH CORE Response
1. Eight organizations suggested data elements that could be used to match the 277CA and 837 transactions. Data elements suggested include: • Patient ID, Patient control number, Patient DOB, Gender, DOS, Charge Amount, Procedure Code, Claim Identification Number, Member ID, Provider IDs, Claim Control Number, Billing Provider Tax ID and NPI, Rendering Provider Tax ID and NPI, POS, and Internal Claim ID.	1. **Agree.** CORE can outline data recommended by Subgroup participants in Straw Poll #4 and assess support for including the information in a draft operating rule.
2. Two organizations recommended that matching data align with 837 submission standards.	2. **Agree.** CORE can outline data required for 837 submission and assess support for alignment between 837 data and 277CA data.
3. One organization commented that associating a 277CA with an 837 is difficult if the health plan splits the claim. This makes data like charge amount unreliable.	3. **Discussion**. CORE encourages the Subgroup to consider the benefits and limitations of specific data elements' ability to aid in matching 277CA and 837 transactions.
4. One organization cautioned against using any sensitive data for matching such as diagnosis, gender identity, or sexual orientation.	4. **Agree**. CORE will support participants' efforts to protect health information.
5. One organization commented in support of matching 277CA and 837 transaction data efforts and acknowledged that while the matching criteria should be specific, extreme specificity decreases likeliness of making a good match.	5. **Agree.** CORE can poll participants on the degree to which a datapoint is both essential vs non-essential for associating the 837 and 277CA and supporting understanding of claim errors.

Prioritization and Support for 277CA Error Reporting Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #3

Question: *To what degree does your organization support the development of CAQH CORE operating rule requirements specifying the connection between 277CA error codes and their corresponding 837 charge items?*

Support	Partially Support	Neutral	Partially Do Not Support	Do Not Support
57%	13%	30%	0%	0%

Context: CAQH CORE research suggests that 277CA responses to 837s with multiple charge items do not have enough information to help providers associate 277CA error codes with their corresponding charge on the 837.

Health Care Claims Subgroup – Straw Poll #3
277CA and 837 line-item matching data comments

Question: *Please share your organization's methodology to align 277CA error codes and 837 charge items.*

Substantive Comments	Co-chair and CAQH CORE Response
1. Four organizations provided data elements that they use to align the 277CA error codes with the associated 837 charge items. Those data elements include: • Service Code, DOS, Modifiers, Charge Amount, Units, Service Line number, Line Control Number, Claim ID, Member ID, and the 277CA REF D*9 from the 837.	1. **Discussion**. CORE can outline data recommended by Subgroup participants for Straw Poll #4 to determine usability for associating 277CA error codes and 837 charge items.
2. One organization commented that aligning 277CA errors with 837 line items is mainly a manual process. If they cannot understand how to update a claim based on response information, they call health plan customer support.	2. **Agree**. A part of CORE's mission is to reduce the instances of manual intervention in the claim adjudication process. In this instance, a clear understanding of errors is a goal.
3. One organization shared that when only one or two service lines cause the claim to not be accepted for processing, rather than all the service lines submitted on the 837, they only include the service line(s) in error on the 277CA.	3. **Agree**. CORE seeks to support the matching of 277CA error codes to 837 charge items in a manner that is both a step towards administrative simplification and a feasible standardization opportunity for industry to implement.
4. One organization shared that they provide responses on information to the extent that the data is present on the submitted 837.	4. **Discussion.** Specifying how to leverage data already within the 837 standard is one way to increase the value of the 277CA.
5. To automate certain actions at the line level, one organization encouraged use of the line control number to match errors with submitted claim lines.	5. **Discussion**. Operating rule requirements can be written to support future-state revenue cycle operations and automation in the space.
6. One organization shared that their 277CA rejections are only at the claim level.	6. **Agree**. Claim-level 277CA responses were identified during environmental scanning as a contributor to the low adoption of the 277CA, because it can be difficult to understand what to fix within the claim submission.
Point of Clarification	**Co-chair and CAQH CORE Response**
7. One organization shared that they strive to get to the lowest level of specificity to provide actionable responses.	7. **Agree.** CORE appreciates this response; research suggests that the inability to take action using 277CA response data is a reason for low adoption.

Coordination of Benefits (COB) Claim Submission

Straw Poll Results

Prioritization and Support for COB Claim Submission Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #3

Question: *Please indicate which of the below data elements your organization supports for inclusion in a minimum required set of data elements for COB claim submission*

Data Elements	Support	Partially Support	Neutral	Partially Do Not Support	Do Not Support
Primary Payer Paid Amount	**87%**	0%	13%	0%	0%
Adjustment Group Code	**74%**	4%	18%	0%	4%
Adjustment Reason Code	**74%**	4%	22%	0%	0%
Adjustment Amount	**83%**	0%	17%	0%	0%
COB Patient Responsibility	**83%**	0%	17%	0%	0%
Other Payer Name	**87%**	0%	13%	0%	0%
Primary Plan Claim Paid Date	**78%**	5%	17%	0%	0%

Context: CAQH CORE research suggests that health plans commonly require some similar data in secondary claim submission. Below are examples of data somewhat consistently requested for secondary claim submission.

Health Care Claims Subgroup – Straw Poll #3
COB minimum required data set comments

Question: *Please share your organization's recommendations for a minimum required set of data elements for COB claim submission outside of the items listed in question 17*

Substantive Comments	Co-chair and CAQH CORE Response
1. Six organizations commented that they currently support all data elements listed in question 17.	**1. Agree**. CORE will draft rule language for Subgroup review in alignment with support levels.
2. Three organizations commented that the COB data guidelines within the 837 TR3s should be the model for secondary claim submission.	**2. Agree**. CORE identified this data during environmental scanning as being transmitted by some health plans, and not by others. CORE encourages Subgroup discussion on the appropriate, minimum set of data elements to be included on COB claim submission.
3. One organization recommended adding primary payer allowed amount as a COB minimum data requirement.	**3. Agree**. CORE can poll participants on adding primary payer allowed amount as a COB minimum data requirement.
4. One organization commented that data should be submitted at a line level, not just the claim header level.	**4. Discussion:** CORE encourages Subgroup discussion on specifying data transmission standards for COB.
5. One organization noted that the ability to report primary payer paid amount and patient responsibility amount depends on information the primary payer provides on the 835.	**5. Agree**. CORE acknowledges that a successful COB claim depends on primary health plan data. An operating rule should clearly associate dependencies between primary and secondary health plans.
Point of Clarification	**Co-chair and CAQH CORE Response**
6. One organization commented that reporting Medicare overpayments or negative payments as result of sequestration, incentive payments, or cost sharing withholds to the secondary plan is inconsistent and results in denials.	**6. Agree**. CORE acknowledges that many factors complicate COB and emphasizes that this specific question is focused on a minimum set of data to include on a COB claim.

Prioritization and Support for COB Claim Submission Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #3

Question: *To what degree does your organization support updating the CAQH CORE Master Companion Guide Template to include requirements for locating COB information?*

Support	Partially Support	Neutral	Partially Do Not Support	Do Not Support
52%	22%	22%	0%	4%

Context: CAQH CORE research suggests that a health plan's secondary claim submission requirements can be difficult to find and can vary in formatting from one plan to the next. CAQH CORE has a Master Companion Guide Template that can be leveraged to include requirements for COB processes, data content, and related items.

Prioritization and Support for COB Claim Submission Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #3

Question: *To what degree does your organization support establishing guidance for service level agreements (SLAs) between health plans for communicating data needs including patient data requirements and payment timelines through the development of CAQH CORE operating rule requirements?*

Support	Partially Support	Neutral	Partially Do Not Support	Do Not Support
43%	4%	26%	9%	17%

Context: For submission of secondary claims, health plans have guidelines that outline data requirements for adjudication. These guidelines can vary between health plans. In order to submit a claim to a secondary plan, information from the primary plan's remittance advice like total amount paid is often required. If a primary plan is slow to adjudicating a claim, it can impact a patient's secondary claim submission.

Subgroup leadership acknowledges the guidance from Health Care Claim Subgroup participants regarding health plan SLAs. CAQH CORE Co-chairs and staff are deferring this topic for continued research and further evaluation.

Prioritization and Support for COB Claim Submission Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #3

Question: *To what degree does your organization support the development of CORE operating rule requirements for determining health plan primacy?*

Support	Partially Support	Neutral	Partially Do Not Support	Do Not Support
48%	9%	30%	0%	13%

Context: Determining primacy, or which health plan is primary, and which is secondary for a given patient, is a difficult task because of the high number of sources with guidelines.

Subgroup leadership acknowledges the guidance from Health Care Claim Subgroup participants regarding health plan primacy standards. CORE Co-chairs and staff are deferring this topic for continued research and further evaluation.

Prioritization and Support for COB Claim Submission Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #3

Question: *To what degree does your organization support specifying the method of transmission for claims going from primary to secondary plans through the development of CAQH CORE operating rule requirements that enable automation of the submission of secondary claim?*

Support	Partially Support	Neutral	Partially Do Not Support	Do Not Support
57%	9%	22%	0%	12%

Context: Health plans can either electronically cross over the secondary claim to the secondary health plan for adjudication or expect the patient or provider to submit the secondary claim to the secondary health plan. For example, Medicare has a standard for electronically sending crossover claims.

Subgroup leadership acknowledges the guidance from Health Care Claim Subgroup participants regarding methods of transmission for COB claims. CORE Co-chairs and staff are deferring this topic for continued research and further evaluation.

Telehealth

Straw Poll Results

Support for Telehealth Draft Rule Requirements

Support levels for draft telehealth rule language and requirements assessed in Straw Poll #3

Question: *Please indicate your organization's level of approval on the below POS + modifier definitions and example use cases*

#	POS	Modifier	Combined Definition	Example Use Case	Approve
1.	02	93	Synchronous telehealth services provided other than in patient's home, rendered via a telephone or other real-time interactive audio-only telecommunications system.	A patient has a phone appointment with their therapist (behavioral health) from the patient's workplace.	**76%**
2.	02	95	Synchronous telehealth services provided other than in a patient's home, rendered via a real-time interactive audio and video telecommunications system.	While on vacation and from their hotel, a patient securely uses Zoom video conferencing to have an urgent care appointment to get a prescription for a rash that appeared.	**71%**
3.	02	GT	Telehealth services rendered via interactive audio and video telecommunications systems other than in a patient's home.	While at the airport, a patient use's a provider's secure video conferencing to connect from with a nurse from the provider office and review results from a recent series of diagnostic tests.	**70%**
4.	10	93	Synchronous telehealth services provided in a patient's home, rendered via a telephone or other real-time interactive audio-only telecommunications system.	A patient has a phone appointment with their therapist (behavioral health) from the patient's home.	**71%**
5.	10	95	Synchronous telehealth services provided in a patient's home, rendered via a real-time interactive audio and video telecommunications system.	From the patient's own home, a patient securely uses Zoom video conferencing to discuss with an ophthalmologist a potential eye infection.	**73%**
6.	10	GT	Telehealth services rendered via interactive audio and video telecommunications systems in a patient's home.	A patient uses a provider's secure video conferencing from their in-home office so the provider can screen for signs of depression and remotely assess vital signs.	**73%**

Health Care Claims Subgroup – Straw Poll #3

Telehealth POS + modifier definitions and example use case comments

Question: *Please share your recommended edits for the POS + modifier Table*

Substantive Comments	Co-chair and CAQH CORE Response
1. Three organizations noted that some CPT codes associate with a place of service, and restricting POS Code assignment to 02 or 10 could cause problems in adjudication.	1. **Agree.** CORE acknowledges that there may be instances where place of service is associated with a CPT, and with Subgroup support will draft rule language to accommodate these scenarios.
2. Two organizations suggested that modifiers describing telehealth service delivery may not be necessary if the CPT is specific for telehealth.	2. **Agree.** CORE acknowledges that there may be instances where a place of service is associated with a modifier and with Subgroup support will draft rule language to accommodate these scenarios.
3. One organization requested that additional guidance on determining a patient's place of service be included in support documents.	3. **Discussion**: Methodology for assigning POS is a distinct issue from defining what POS + modifier combinations mean and how to use them. CORE welcomes discussion on the need for industry guidance on determining a patient's place of service.
Point of Clarification	**Co-chair and CAQH CORE Response**
4. One organization commented that modifiers provide additional information, but do not determine payment.	4. **Agree.** CAQH CORE acknowledges how modifiers are used, and drafted POS + modifier combination definitions to assist with uniform interpretation of common telehealth POS codes and modifier combinations.
5. One organization emphasized the need for provider support of items drafted in support of operating rule development.	5. **Agree.** Provider organizations and associations continue to provide feedback on rule development. CAQH CORE drafted language of POS + modifier definitions and their example use cases come with high levels of support, as seen in Straw Polls 1 and 2.

Prioritization and Support for Telehealth Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #3

Question: *Please indicate your organization's level of approval for the following DRAFT rule language for **Specifying Telehealth Billing** as it is written*

Support	Recommend Edits
64%	36%

Draft 1 of Specifying Telehealth Billing Rule Language (as written in Straw Poll #3):

*To indicate telehealth services were rendered, when a service type code is covered for telemedicine per AMA's Appendix P CPT Code Set, a health plan and its agent must accept the Centers for Medicare and Medicaid Services External Place of Service Codes for Professional Claims: Place of Service Code **02** (Telehealth Provided Other than in Patient's Home) or **10** (Telehealth Provided in Patient's Home), along with AMA CPT Appendix A Modifier Code **93** (Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system), **95** (Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system), or **GT** (Service rendered via interactive audio and video telecommunications systems).*

CORE-defined combinations of these codes describe each telehealth billing scenario and the corresponding POS + modifier code combination that must be used to bill the claim.

Health Care Claims Subgroup – Straw Poll #3
DRAFT Specifying Telehealth Billing rule language comments

Question: Please indicate your organization's level of approval for the following *DRAFT* rule language for *Specifying Telehealth Billing* as it is written

Substantive Comments	Co-chair and CAQH CORE Response
1. Three organizations shared their own methodologies for modifier 93 assignment, or suggested a reference to AMA CPT Appendix T.	1. **Agree.** CAQH CORE develops draft operating rule language at the direction of Subgroup participants. Language can specify industry guidance to follow, suggest that a standard be followed, or provide other flexibility in support of reducing administrative burden and such citations will be included.
3. Three organizations shared varied preferences on the degree to which a POS and modifier combination should be required when submitting a CPT or HCPCS for remote care delivery.	2. **Agree**. The POS + modifier guidance is meant to clarify which codes can be combined and what the combinations mean for remote care delivery. CPT codes usage in association with the code combinations can be a separate discussion as several variables need to be considered including accommodating flexibilities in care delivery and health plan CPT billing methodologies while maintaining burden reduction efforts.
4. One organization requested that additional guidance on determining a patient's place of service be included in support documents.	4. **Discussion**: Methodology for assigning POS is a distinct issue from defining what POS + modifier combinations mean and how to use them. CORE welcomes discussion but acknowledges this is out of scope for data content rule development
5. One organization commented that only requiring the use of POS codes 02 and 10 could result in an increase in coding-related denials for CPTs that are associated with more specific places of service (e.g., emergency, SNF).	5. **Agree**. The goal of operating rule development is to reduce administrative burden and CORE will draft operating rule language at the direction of Subgroup participants. Language can specify industry guidance to follow for specific scenarios and provide flexibility to allow for other scenarios not covered or out of scope for the draft rule.

Next Steps

Action Items and Timelines

Next Steps from Subgroup Meeting #4

	Action Item	Timeline
1.	• **Participants** to connect with colleagues at their organizations to align on feedback	--
2.	• **CORE team** to distribute Straw Poll #4 to Participants • **Participants** to complete Straw Poll #4	**Straw Poll #4 Submission Dates** Friday, August 18th
3.	• **Participants** to attend next Subgroup meeting	**Meeting Information** 2-3:30 PM ET Thursday, August 24th

Appendix

Prioritization and Support for COB Claim Submission Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #3

Question: *To what degree does your organization support establishing guidance for service level agreements (SLAs) between health plans for communicating data needs including patient data requirements and payment timelines through the development of CAQH CORE operating rule requirements?*

Support	Partially Support	Neutral	Partially Do Not Support	Do Not Support
43%	4%	26%	9%	17%

Context: For submission of secondary claims, health plans have guidelines that outline data requirements for adjudication. These guidelines can vary between health plans. In order to submit a claim to a secondary plan, information from the primary plan's remittance advice like total amount paid is often required. If a primary plan is slow to adjudicating a claim, it can impact a patient's secondary claim submission.

Subgroup leadership acknowledges the guidance from Health Care Claim Subgroup participants regarding health plan SLAs. CAQH CORE Co-chairs and staff are deferring this topic for continued research and further evaluation.

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Health Care Claims Subgroup – Straw Poll #3
COB-related issues, timely filing, and SLA comments

Question: *Please share your organization's experience with timely filing denials.*

Respondent Comment	Co-chair and CAQH CORE Response
1. Four organizations shared they either practice, observe, or would like to see health plans giving exceptions for timely filing restrictions on secondary payments. Two organizations commented with timely filing windows they observe, ranging from 12 months to 24 months.	1. **Discussion**: Agreement on limitations to COB-related denials could have impacts on members and health plans, and addressing root causes driving the need for a timely filing exception may also eliminate the need for waivers – both are manual processes and time consuming. Additionally, state, federal, and health-plan specific guidelines should be considered.
2. Two organizations commented that inconsistency with primary payment information (e.g., CAS, AMT, SVD segments) impact a secondary plan's ability to determine payment.	2. **Agree.** CORE supports leveraging the X12 standards to remediate COB-related issues.
3. Three organizations shared retroactive adjustments that appear to two years post-adjudication and missed timely filing windows are examples of COB-related issues.	3. **Agree**. Retroactive adjustments and missed timely filing windows are two examples of COB-related issues that cause financial strain on providers and increase administrative burden on heath plans and providers. A CORE operating rule may be able to address these issues.
4. Two organizations commented that an operating rule would need to account for state prompt pay requirements.	4. **Agree.** CORE agrees that local and federal laws must be considered where regulations exist on a certain topic.

Prioritization and Support for COB Claim Submission Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #3

Question: *To what degree does your organization support the development of CORE operating rule requirements for determining health plan primacy?*

Support	Partially Support	Neutral	Partially Do Not Support	Do Not Support
48%	9%	30%	0%	13%

Context: Determining primacy, or which health plan is primary, and which is secondary for a given patient, is a difficult task because of the high number of sources with guidelines.

Subgroup leadership acknowledges the guidance from Health Care Claim Subgroup participants regarding health plan primacy standards. CORE Co-chairs and staff are deferring this topic for continued research and further evaluation.

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Health Care Claims Subgroup – Straw Poll #3
Determining health plan primacy comments

Question: *Please share your organization's opinion on possible primacy standards to follow. Examples include and are not limited to NAIC Model Regulations (by state), the X12N 271 response primary and secondary plan information, CMS Medicare Secondary Payer guidelines, or some combination of standards.*

Respondent Comment	Co-chair and CAQH CORE Response
1. Four organizations recommend following Medicare's lead for secondary payer guidelines (MSP) and coordination of benefits agreements (COBA) while three organizations use or recommend using a combination of standards to align on coordination of benefits (COB).	1. **Discussion:** MSP and COBA are widely used templates that standardize portions of the COB process for government-insured individuals. Are these also guidelines for dual commercial-insured patients? Can they be used in combination with others for clarity?
2. One organization recommended developing a methodology that addresses both commercial and government lines of business.	2. **Agree.** An ideal operating rule would simplify the COB process for health plans of all types across the industry.
3. Three organizations commented that additional guidelines are not necessary because federal and state law exist.	3. **Discussion:** CORE research suggests that state and federal standards in place for COB are among those that contribute to industry administrative burden. A resolution must include considerations for state and federal regulations.
4. Two organizations commented that creating operating rules could further complicate COB issues.	4. **Discussion:** Operating rules are developed to promote administrative simplification for shared industry burdens. Resolutions that increase administrative burden are not considered.
5. Two organizations use or recommend using the 271 response to determine health plan primacy.	5. **Discussion:** The widespread use of the 271 transaction makes it an appealing vehicle for transmitting health plan primacy information. However, the methodology by which the health plans are named primary or secondary must be discussed.

Prioritization and Support for COB Claim Submission Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #3

Question: *To what degree does your organization support specifying the method of transmission for claims going from primary to secondary plans through the development of CAQH CORE operating rule requirements that enable automation of the submission of secondary claim?*

Support	Partially Support	Neutral	Partially Do Not Support	Do Not Support
57%	9%	22%	0%	12%

Context: Health plans can either electronically cross over the secondary claim to the secondary health plan for adjudication or expect the patient or provider to submit the secondary claim to the secondary health plan. For example, Medicare has a standard for electronically sending crossover claims.

Subgroup leadership acknowledges the guidance from Health Care Claim Subgroup participants regarding methods of transmission for COB claims. CORE Co-chairs and staff are deferring this topic for continued research and further evaluation.

Copied from earlier slide

Health Care Claims Subgroup – Straw Poll #3
COB submission methodology comments

Question: *Please share additional comments regarding alignment of the methodology for COB claims submission to enable automation*

Respondent Comment	Co-chair and CAQH CORE Response
1. Three organizations commented they would support automating submissions for COB related claims through technology or other efforts.	1. **Agree.** CORE appreciates this response and flexibility to accommodate industry direction.
2. Two organizations commented about the best method to align on COB claim submission to enable automation, suggesting either COB data guidelines within the 837 TR3s or a methodology similar to CMS COBA.	2. **Discussion**: CAQH CORE encourages Subgroup discussion on alignment of the methodology for COB claim submission to better help with automation.
3. One organization emphasized that for data content problems associated with crossover claims, support from a health system to fix an issue leads to delays and administrative burden because the health plan does not have control over claim transmission. Resolutions should include efficient claim resubmission.	3. **Discussion:** CORE encourages Subgroup participants to both consider root causes of crossover claim issues and contribute to standards development that can be used to prevent breakdowns in process.
4. One organization only accepts crossover claims from government payers. For commercial health plans, they do not support health plan to health plan submissions or automation but do allow e-filing of COB claims from providers or members. As a secondary, this avoids receiving claims unnecessarily (i.e., secondary has zero liability because the primary paid in full).	4. **Discussion**: CORE recognizes that automation can have unintended risks like a rise in claim volumes that have been paid by other health plans and encourages Subgroup participants to think through potential EDI workflows to standardize data that reduces burden on provider and members.
5. One organization shared they automate COB claims based on an indication in the remittance.	5. **Discussion**: CORE encourages discussion on data to include in a remittance to automate determination of whether a primary claim should be crossed over.
6. One organization suggested using a centralized database with Payer ID mapping for crossover claims to support COB claim alignment.	6. **Discussion**: Automating claim workflows is key to reducing administrative burden; CORE rule development may positively impact data exchange.