CAQH CORE Health Care Claims Subgroup

Meeting #6

September 21, 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) Claim Submission
4.	Draft Rule Requirement Overview
5.	Next Steps

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

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Health Care Claims Subgroup – Straw Poll #5

Straw Poll background

Purpose of Straw Poll:

To provide feedback on opportunity areas and rule options

Format:

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

Summary of Opportunity Areas:

1. **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(I,D) data could help to improve data quality and uniformity.
2. **COB Claim Submission:** A data content operating rule outlining potential rule requirements for establishing a minimum set of data for inclusion on COB 837 (I,D) claim submission.

Health Care Claims Subgroup – Straw Poll #5
Respondent breakdown

Distribution of Responses	Total Straw Poll Responses	Percent of Total Participants
Provider/Provider Associations	4	18%
Health Plan/Health Plan Associations	6	27%
Vendor/Clearinghouses	8	36%
Government/Other	4	18%
Total Responses	**22**	**49% of participating organizations[1]**

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

Health Care Claims Subgroup – Straw Poll #5
Comment categorization

Comments received on Health Care Claims Straw Poll #5 are grouped into three categories:

1. **Substantive Comments:** May impact rule requirements; some comments require Subgroup discussion on potential adjustments to the draft requirements.

2. **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.

3. **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 #5 Results

Health Care Claims Subgroup – Straw Poll #5
277CA CSCC + CSC Business Scenario comments

Question: *Please share any feedback your organization has on the updated code combinations and additional CSCs to align with the CORE-defined Claim Rejection Business Scenarios:*

Substantive Comments	Co-chair and CORE Response
1. Three organizations commented that the CORE-defined combination definitions should align with the X12's CSC definitions[1] as closely as possible and allow for the inclusion of entity code requirements.	**1. Agree.** CORE operating rule development works within existing X12 standards. This effort aims to strengthen understanding and usability of code combinations by aligning CSCC + CSC code combination definitions with business scenarios without changing X12's intended use for the codes or their definitions. **Discussion.** Where code combinations suggest the need for an entity code, Subgroup Co-chairs and CORE recommend not specifying a requirement in this version of the 277CA rule, allowing stakeholders to interpret the code combination definition in the manner that aligns with their business processes. The need for specification of an entity code requirement will be re-evaluated for future 277CA rule development.
2. Two organizations provided specific recommendations for edits to the CORE-defined code combination definitions, as well as the Business Scenario descriptions.	**2. Agree.** With the goal being increased understanding of 277CA responses, the next version of the CORE-defined *Claim Rejection Business Scenarios.xlsx* sheet for Review Work Group review includes updates that strengthen consistency and usability of the codes. Additionally, draft rule language outlines the process for updating the code combinations as necessary moving forward.
Point of Clarification	**Co-chair and CORE Response**
3. Two organizations commented that for some of the code combination scenarios, their process is to ingest the claim and return a denial rather than an up front, 277CA rejection.	3. Subgroup Co-chairs and CORE understand that different trading partners (clearinghouses v. health plans v. vendors, etc.) have different roles within the claim adjudication process and manage errors accordingly. The CORE 277CA code combinations are intended to relate how an entity has processed the claim at their respective system.

1. https://x12.org/codes/claim-status-codes

Prioritization and Support for 277CA Error Reporting Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #5

Question: *Please indicate your level of support for adjusted CORE defined CSCC + CSC combination definition for their new corresponding CORE defined Business Scenario:*

#	Claim Status Code	Original Business Scenario	Updated Business Scenario	Updated CORE-defined Definition	Approve	Do Not Support
1.	97 – Patient eligibility not found with entity.	A6 – Claim Rejected: Missing Information	A3 – Claim Rejected: Will Not be Adjudicated	Claim was rejected due to patient eligibility information not found.	90%	10%
2.	481 – Claim/submission format was invalid.	A3 – Claim Rejected: Will Not be Adjudicated	A7 – Claim Rejected: Invalid Information	Claim was rejected due to invalid claim/submission format.	81%	19%
3.	34 – Subscriber and policy holder name not found.	A6 – Claim Rejected: Missing Information	A3 – Claim Rejected: Will Not be Adjudicated	Claim was rejected due to missing subscriber and policyholder name.	81%	19%

Context: As a complement to the high levels of support from participating organizations on Straw Poll #4, CORE also received recommendations from Subgroup participants to adjust the following CSC codes from their original Business Scenarios to updated Business Scenarios.

Prioritization and Support for 277CA Error Reporting Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #5

Question: *Please indicate which of the below data elements your organization supports for inclusion in a draft operating rule outlining data to return on a 277CA to help support matching to its corresponding 837 service line item:*

#	Data Element	Support	Do Not Support
1.	Price (Line Item Charge Amount) 2220D-SVC02	70%	30%
2.	Quantity (Original Units of Service Count) 2220D-SV07	65%	35%

Context: In addition to the four data elements supported by the Subgroup in Straw Poll #4, Subgroup participants shared that Price and Quantity are two additional data elements that could be helpful when matching 277CA error codes to their corresponding 837 service lines. CORE requests further evaluation on these items from the Subgroup.

Prioritization and Support for 277CA Error Reporting Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #5

Question: *Please indicate which of the below 837I specific data elements your organization supports for inclusion in a draft operating rule outlining data to return on a 277CA to help support matching to its corresponding 837I service line item:*

#	Data Element	Support	Do Not Support
1.	Facility Type Code (Facility Code Value) 2300-CLM05-01	88%	12%
2.	Claim Frequency Code (Claim Frequency Type Code) 2300-CLM05-03	88%	12%
3.	Service Line Revenue Code 2400-SV201	78%	22%
4.	Line Item Charge Amount 2400-SV203	78%	22%
5.	Admission Date and Hour 2300-DTP02	63%	37%
6.	Patient Status Code 2300-CL103	59%	41%

Context: In addition to the four data elements supported by the Subgroup in Straw Poll #4, participants also provided feedback that data elements specific to the 837I and 837D may be useful to support matching of 277CA error codes to service lines on the 837I and 837D.

Health Care Claims Subgroup – Straw Poll #5
277CA and 837 transaction matching data comments

Question: *Please share any feedback your organization has on 837I-specific data elements to use to match 277CA error codes to service lines on the 837I:*

Substantive Comments	Co-chair and CORE Response
1. Two organizations shared thoughts on the usability of the data elements listed. These include: ➢ Data elements listed do not apply to a service line item and therefore would not help to identify errors at a service line level. ➢ Data is situational and may not be present to return in a 277CA.	1. **Agree.** Co-chairs and CORE staff remind the Subgroup that many data elements were proposed by participants to use for matching during straw polling. Some loops and segments are unique identifiers that are more helpful than others and can help provide confidence in matching. The Operating Rule can make the distinction between unique identifiers and attributes. The rule will denote when scenarios with specific data elements should be returned for the purpose of matching as not all are required, some are situational.

Prioritization and Support for 277CA Error Reporting Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #5

Question: *Please indicate which of the below 837D specific data elements your organization supports for inclusion in a draft operating rule outlining data to return on a 277CA to help support matching to its corresponding 837D service line item:*

#	Data Element	Support	Do Not Support
1.	Tooth Number (Reference Identification) 2300-DN201	69%	31%
2.	Tooth Code 2400-TOO02	65%	35%
3.	Tooth Status Code (Tooth Status Code) 2300-DN202	56%	44%

Health Care Claims Subgroup – Straw Poll #5
277CA and 837 transaction matching data comments

Question: *Please share any feedback your organization has on 837D-specific data elements to use to match 277CA error codes to service lines on the 837D:*

Point of Clarification Comments	Co-chair and CORE Response
1. One organization noted that the Tooth (TOO) segment is not included in the v5010 version of the 277CA, and therefore would not apply to this operating rule.	1. **Agree.** Co-Chairs and CORE recognize that this segment is not in the v5010 version of the 277CA, so it will not be considered for inclusion.

Coordination of Benefits – COB Claim Submission

Straw Poll #5 Results

Prioritization and Support for COB Claim Submission Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #5

Question: *Please indicate which of the below data elements your organization supports for inclusion in a draft operating rule outlining a minimum set of data to promote standardization in COB 837I claim submission:*

#	Data Element	Support	Do Not Support
1.	Claim Payment Remark Code 2320-MIA05	78%	22%
2.	HCPCS Payable Amount 2320-MOA02	78%	22%
3.	Claim Payment Remark Code 2320-MOA03	78%	22%
4.	Claim Frequency Code (Claim Frequency Type Code) 2300-CLM05-03	74%	26%
5.	Facility Type Code (Facility Code Value) 2300-CLM05-01	72%	28%
6.	Admission Date and Hour 2300-DTP02	71%	29%
7.	Claim DRG Amount 2320-MIA04	71%	29%
8.	Patient Status Code 2300-CL103	59%	41%

Health Care Claims Subgroup – Straw Poll #5
277CA and 837 transaction matching data comments

Question: *Please share any feedback your organization has on 837I-specific data elements to use in a draft operating rule outlining a minimum set of data to promote standardization in COB 837I claim submission:*

Point of Clarification	Co-chair and CORE Response
1. One organization commented that some of the data elements polled are already required by the TR3 and that their inclusion in rule language may be redundant.	1. **Agree.** CORE operating rules work within the scope of X12 standards and do not contradict or repeat the requirements in the standards; any draft rule will not repeat the standard.
2. One organization commented they were unclear what data elements are currently being exchanged between trading partners to support claims submission to secondary health plans and seeks to better understand these baseline elements for the COB business case before supporting additional data elements.	2. **Discussion.** Environmental scanning indicates that there is quite a bit of variability amongst health plans on specific data requirements and processing of COB claims. CORE will partner with industry leaders to identify best practices and support industry education efforts. Additionally, CORE will identify specific data that can supports consistency across the industry to support COB.
3. One organization commented that data elements highlighted in yellow on the previous call should not have been considered for inclusion in draft operating rule language due to low support levels.	3. Co-chairs and Subgroup participants agreed that data elements receiving more than 50% support would be included in draft operating rule language, as appropriate. CORE Participants have additional opportunities to edit rule language both in Straw Poll #6 and in the Review Work Group. CORE staff uses green to indicate high levels of support, yellow to indicate items that received medium levels of support but still greater than 50%, and red to indicate levels below 50%.

Prioritization and Support for COB Claim Submission Opportunity Areas

Support levels for rule development opportunities assessed in Straw Poll #5

Question: *Please indicate which of the below data elements your organization supports for inclusion in a draft operating rule outlining a minimum set of data to promote standardization in COB 837D claim submission:*

#	Data Element	Support	Do Not Support
1.	Tooth Number (Reference Identification) 2300-DN201	81%	19%
2.	Tooth Status Code (Tooth Status Code) 2300-DN202	75%	25%
3.	Tooth Code 2 400-TOO02	69%	31%
4.	Assistant Surgeon NPI (Assistant Surgeon Primary Identifier) 2310D-NM109 or 2420B-NM109	63%	37%
5.	Assistant Surgeon Tax ID (Assistant Surgeon Secondary Identifier) 2310D-REF02 or 2420B-REF02	50%	50%

Health Care Claims Subgroup – Straw Poll #5
277CA and 837 transaction matching data comments

Question: *Please share any feedback your organization has on 837D-specific data elements to use in a draft operating rule outlining a minimum set of data to promote standardization in COB 837D claim submission:*

Point of Clarification	Co-chair and CORE Response
1. One organization shared that some of the data are situational and therefore may not be included in the primary health plan's 835 response.	1. **Agree.** Draft rule requirements will not repeat standard requirements but may address situational or optional data. The draft operating rule requirements will specify use cases and business scenarios to support uniform and consistent COB claims receipt and processing.
2. One organization commented that data elements highlighted in yellow on the previous call should not have been considered for inclusion in draft operating rule language due to low support levels.	2. Co-chairs and Subgroup participants agreed that data elements receiving more than 50% support would be included in draft operating rule language, as appropriate. CORE Participants have additional opportunities to edit rule language both in Straw Poll #6 and in the Review Work Group. CORE staff uses green to indicate high levels of support, yellow to indicate items that received mid levels of support but still greater than 50%, and red to indicate levels below 50%.

Draft Rule Requirement Overview

CORE Draft Rules to Support Health Care Claims

Health Care Claim Submission – 837 *(X12 v5010X222, 223, 224 837)*	**Health Care Claim Acknowledgment – 277CA** *(X12 v5010X214 277)*
Provides clarity on place of service and modifier alignment for telehealth claim submission and brings uniformity to 837 COB claim submissions. Key components include: **1. POS 02 and 10, and modifier assignment standardization** **2. POS + modifier combination definitions (industry guidance)** **3. Minimum standard required COB claim data elements.** **4. Standardization of format and listing requirements for COB data.** This provides clarity for providers having to submit this data and can help to remediate any questions on payment or care upfront, reducing costly downstream errors.	Brings standardization to the use of Claim Status Category Codes and Claim Status Codes to communicate the status of a claim in a uniform manner. **1. Created CORE-defined Business Scenarios to organize code combinations.** **2. Standardized data used to associate the 277CA with its corresponding 837.** **3. Standardized data used to associate a 277CA error code with its corresponding 837 service line item.** This is significant because standardization of the 277CA's use could increase its industry adoption. With improved data quality and greater transaction adoption comes clean claim submissions and simplified claim resubmissions.

Next Steps

Action Items, Timelines, and Review Work Group Information

Next Steps from Subgroup Meeting #6

	Action Item	Timeline
1.	**Participants** to connect with colleagues at their organizations to align on feedback	--
2.	**CORE team** to distribute Straw Poll #6 to Participants	Friday, September 29th
3.	**Participants** to complete Straw Poll #6	**Due:** Friday, October 13th

CORE Review Work Group Information

CORE Review Work Group

- The Review Work Group is asked to refine operating rule requirements for balloting.
- Launched 9/14; Value-based Payment rule review is first on the docket.
- Next meeting on 10/19, with Health Care Claims Focus.
- Questions? Please reach out to CORE@CAQH.org.

1. New/Updated Rules: Draft Value-based Payment Operating Rules and Industry Resource

- New: Draft CORE Benefit Enrollment (834) Data Content Rule
- Updated: Draft CORE Benefit Enrollment (834) Infrastructure Rule
- Updated: Draft CORE Attributed Patient Roster (X12 005010X318 834) Data Content Rule
- Updated: Draft CORE Attributed Patient Roster (X12 005010X318 834) Infrastructure Content Rule
- New: CORE Framework for Semantic Interoperability in Value-based Payment Models

2. New Rules: Health Care Claims Data Content Rules

- New: Draft CORE Health Care Claims (837) Data Content Rule
- New: Draft CORE Health Care Claims Acknowledgment (277CA) Data Content Rule

3. Updated Rules: EFT & ERA Enrollment Data Rules

- Updated: Draft CORE Payment & Remittance EFT Enrollment Data Rule
- Updated: Draft CORE Payment & Remittance ERA Enrollment Data Rule