CAQH CORE Claim Acknowledgement (277CA) Data Content Rule Version CA.1.0

October 2023

Revision History for CAQH CORE Claim Acknowledgement (277CA) Data Content Rule

Version	Revision	Description	Date
CA.1.0	Major	• Development of the Claim Acknowledgement Data Content Rule	October 2023

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1. Background Summary

1.1. CAQH CORE Overview

CAQH CORE is an industry-wide facilitator committed to the creation and adoption of healthcare operating rules that support standards, accelerate interoperability, and align administrative and clinical activities among providers, health plans and patients. Guided by over 130 participating organizations – including healthcare providers, health plans, government entities, vendors, associations, and standards development organizations – CAQH CORE Operating Rules drive a trusted, simple, and sustainable healthcare information exchange that evolves and aligns with market needs.

To date, this cross-industry commitment has resulted in operating rules addressing many pain points of healthcare business transactions including eligibility and benefits verification, claims and claims status, claim payment and remittance, health plan premium payment, enrollment and disenrollment, prior authorization, and aspects of value-based healthcare such as patient attribution methodologies and addressing social determinants of health (SDOH).

1.2. Industry Interest in Claim Acknowledgement Operating Rules

In 2015, CORE published the Health Care Claim (837) Infrastructure Rule, which was updated in April 2022[1]. The rule is a byproduct of years of research on improvement opportunities related to health care claim processing.

To complement the CORE Health Care Claim (837) Infrastructure Rule vHC.2.0, CORE undertook a comprehensive environmental scan to identify industry challenges surrounding the submission and adjudication of claims that could be addressed by specifying data content requirements in a data content operating rule for the Health Care Claim (837) transaction. Research identified standardization opportunities for multiple transactions supporting claim submission and claim acknowledgement.

CORE convened the Health Care Claims Focus Group in 2022 to collect insights and discuss addressing industry challenges through rule development. At the conclusion of the Focus Group, participants were asked to confirm their support for the development of data content operating rules for a refined list of claims-related opportunities. The X12 v5010 277CA transaction, which informs clean claim submission, was a focus of the Health Care Claims Focus Group conversations. Participants answered questions that interrogated specific use-cases within identified opportunity areas and provided comments with context on each subject. The input and opinions shared by Focus Group Participants directly informed the launch agenda for the Health Care Claims Subgroup for Claim Acknowledgement (277CA) Data Content Operating Rule Development.

Building on the CORE Health Care Claim (837) Infrastructure Rule vHC.2.0 which established the "electronic highway" for claims and claims acknowledgement processing, the CORE Health Care Claim Acknowledgement (277CA) Data Content Rule outlines requirements for the data payloads that are processed when conducting the X12 v5010X214 277CA Health Care Claim Acknowledgement Technical Report Type 3 (TR3) and associated errata (hereafter X12 v5010 277CA).

2. Issues to Be Addressed and Business Requirement Justification

2.1. Problem Space

The X12 v5010 277CA is used by a health plan to send an acknowledgment of the receipt of a claim as it enters a health plan's pre-adjudication or adjudication system. An acknowledgement can communicate the transaction is accepted, accepted with errors, or rejected. Used correctly, providers can receive clear and unambiguous reporting if a claim is rejected, which allows for speedy correction and resubmission. CORE's environmental scanning found that data elements required for claims submission vary between health plans. This variability can take many forms, such as data formatting, content requirements, and information interpretation. Variability increases the administrative burden for providers and their staff as

[1]See CAQH CORE Health Care Claim (837) Infrastructure Rule vHC.2.0.

they sort through different health plan requirements for data content in a claim and applicable claim billing policy. In an attempt to better report errors in such data, the industry agreed through consensus to standardize specific error scenarios and their associated code combinations within the X12 v5010 277CA transactions to alleviate administrative burden in interpreting ambiguous definitions, code combinations, and scenarios.

2.1.1. Barriers to Automation of the Claim Acknowledgement Process

The X12 v5010 277CA is an important complement to the X12 v5010 837 Claim transaction that is not HIPAA mandated[2]. As a result, its utility varies in practice. CORE Participants agreed that an opportunity exists for an operating rule to align reporting requirements across health plans, minimizing stakeholder confusion around submission requirements and lowering the need to maintain costly, manual workflows. Ultimately, this would result in a decrease in overall adjudication times and faster billing processes to make the revenue cycle more efficient.

CORE Participants also identified opportunities to increase uniformity of pre-adjudication error reporting delivered via the X12 v5010 277CA. Some vendors and health plans use the transaction simply as an acknowledgment of submission and acceptance or rejection. Others use a combination of Claim Status Category Codes and Claim Status Codes to communicate greater detail about why a claim was rejected from pre-adjudication systems, helping providers focus on errors and accelerate resubmission. While the latter example has clear utility, code combinations are not uniformly applied between health plans, which leads to inconsistencies in error interpretation and the perpetuation of manual workflows.

Standardizing the use of the X12 v5010 277CA could reduce the need for manual intervention and support development of updated workflows for clean claims submission or even robotic process automation (RPA). For example, if transactions are rejected, X12 v5010 277CA data content requirements can outline consistent error messaging for providers to review and use when reworking and resubmitting a claim for payment. In tandem with efficient use of the health care claim (X12 v5010 837 Claim transaction) and building on the Health Care Claim (837) Infrastructure Rule vHC.2.0, the Health Care Claim Acknowledgement (277CA) Data Content Rule can streamline claim submissions and minimize costly manual workflows associated with addressing errors and resubmitting claims.

2.2. Focus of the CAQH CORE Claim Acknowledgement (X12 v5010 277CA) Data Content Rule

The following rules addressing data content of the claim acknowledgement transaction received the highest support from the CAQH CORE Health Care Claims Subgroup:

- Specification of a minimum set of information to include on an X12 v5010 277CA response that supports matching the **transaction** to its corresponding health care claim (X12 v5010 837 Claim transaction).
- Specification of information to include on an X12 v5010 277CA that supports matching an error code to its corresponding **line item (service)** on a health care claim (X12 v5010 837 Claim transaction).
- Requirements outlining **uniform use** of X12 Claim Status Category Code (hereafter referred to as CSCC) + Claim Status Code (hereafter referred to as CSC) combinations in the X12 v5010 277CA when communicating errors in X12 v5010 837 Claim transaction submission.

3. Scope

3.1. What the Rule Applies To

This CAQH CORE Health Care Claim Acknowledgement (277CA) Data Content Rule applies to the conduct of:

[2] See Health Insurance Portability and Accountability Act of 1996 for more information on HIPAA mandated transactions.

- X12 Interchanges containing functional groups of any HIPAA-mandated X12 v5010 837 Claim transaction including the X12 v5010 837 Health Care Claim: Professional (hereafter referred to as X12 v5010 837 Professional), X12 v5010X223 837 Health Care Claim: Institutional (hereafter referred to as X12 v5010 837 Institutional), and X12 v5010X224 837 Health Care Claim: Dental (hereafter referred to as X12 v5010 837 Dental) (collectively hereafter the X12 v5010 837 Claim transactions).
- X12 Interchanges containing functional groups of any X12 v5010X214 277CA Claim Acknowledgement transaction (hereafter referred to as the X12 v5010 277CA).

Table 1 defines the transactions that would be considered in scope for each set of data content requirements addressed by this rule:

Table 1 – In Scope X12 v5010 Transactions for Health Care Claim Data Content Requirements

Data Content Requirements	X12 v5010 277CA	X12 v5010 837 Professional	X12 v5010 837 Institutional	X12 v5010 837 Dental
Transaction Data Matching	Y	Y	Y	Y
Line Item (Service) Matching	Y	Y	Y	Y
CSCC + CSC Code Combinations	Y	N	N	N

3.2. When the Rule Applies

This rule applies when any HIPAA-covered entity and its agent uses, conducts, or processes the X12 v5010 277CA to report a rejection of a claim by a health plan or its agent from a pre-adjudication or adjudication system.

3.3. What the Rule Does Not Address

This rule does not address[3]:

- The X12 v5010X212 Health Care Claim Status Request and Response (276/277) where the X12 v5010 277 is a response to a request for claim status information.
- The X12 v5010X213 Health Care Claim Request for Additional Information (277) which is a payer's request for additional information to support a health care claim.
- The X12 v5010X228 Health Care Claim Pending Status Information (277), which is used as a listing of pended claims in a payer's system.
- Infrastructure requirements applicable to the X12 v5010 277CA or X12 v5010 Claim transactions.
- The scenarios when an X12 v5010 277CA is reporting the acceptance of a claim or the acceptance with errors of a claim into an adjudication system.

3.4. What the Rule Does Not Require

This rule does not require any HIPAA-covered entity to modify its use and content of other loops and data elements that may be submitted in the X12 v5010 277CA that are not addressed in this rule.

3.5. Applicable Loops, Data Elements & Code Sources

To support association of the X12 v5010 277CA to its corresponding X12 v5010 837 Claim transaction, this rule covers the following specified loops, segments, and data elements in the X12 v5010 837 Professional, X12 v5010 837 Institutional, and X12 v5010 837 Dental:

[3] The X12 v5010X214 277 TR3 §1.4.3. highlights differences of transaction usages for each Health Care Information Status transaction. The Health Care Claim Acknowledgement (277CA) Data Content rule only addresses the business needs of the X12 v5010 277CA transaction.

Table 2 – X12 v5010 837 Claim Transaction Applicable Loops and Segments (Transaction Matching)			
Data Element Name	**X12 v5010 837 Professional**	**X12 v5010 837 Institutional**	**X12 v5010 837 Dental**
Originator Application Transaction Identifier	BHT03	BHT03	BHT03
Billing Provider Identifier	2010AA-NM109	2010AA-NM109	2010AA-NM109
Billing Provider Tax Identification Number	2010AA-REF02	2010AA-REF02	2010AA-REF02
Subscriber Primary Identifier	2010BA-NM109	2010BA-NM109	2010BA-NM109
Patient Last Name	2010CA-NM103	2010CA-NM103	2010CA-NM103
Patient First Name	2010CA-NM104	2010CA-NM104	2010CA-NM104
Patient Birth Date	2010CA-DMG02	2010CA-DMG02	2010CA-DMG02
Patient Control Number (Claim Submitter's Identifier)	2300-CLM01	2300-CLM01	2300-CLM01
Total Claim Charge Amount	2300-CLM02	2300-CLM02	2300-CLM02
Place of Service Code	2300-CLM05-01	Facility Type Code 2300-CLM05-01	2300-CLM05-01
Payer Claim Control Number	2300-REF02	2300-REF02	2300-REF02
Value Added Network Trace Number	2300-REF02	2300-REF02	2300-REF02
Rendering Provider Identifier	2310B-NM109	2310D-NM109	2310B-NM109
Procedure Code (Product/Service ID)	2400-SV101-02	2400-SV202-02	2400-SV301-02
Line Item Charge Amount	2400-SV102	2400-SV203	2400-SV302
Place of Service Code	2400-SV105	N/A	2400-SV303
Service Date	2400-DTP03	2400-DTP03	2400-DTP03
Line Item Control Number	2400-REF02	2400-REF02	2400-REF02
Rendering Provider Identifier	2420A-NM109	2420C-NM109	2420A-NM109

To support association of the X12 v5010 277CA to its corresponding X12 v5010 837 Claim transaction, this rule covers the following specified loops, segments, and data elements in the X12 v5010 277CA:

Table 3 – Applicable X12 v5010 277CA Loops and Segments (Transaction Matching)	
Data Element	**X12 v5010 277CA**
Claim Transaction Batch Number	2200B-TRN02
Billing Provider Identifier	2100C-NM109
Billing Provider Additional Identifier	2200C-REF02
Patient Identification Number	2100D-NM109
Patient Last Name	2100D-NM103
Patient First Name	2100D-NM104
Patient Control Number (Claim Submitter's Identifier)	2200D-TRN02
Total Claim Charge Amount	2200D-STC04
Payer Claim Control Number	2200D-REF02
Clearinghouse Trace Number	2200D-REF02
Procedure Code (Product/Service ID)	2220D-SVC01-02
Line Item Charge Amount	2220D-SVC02
Service Line Date	2220D-DTP03
Line Item Control Number	2220D-REF02

To support association of X12 v5010 277CA error codes with their corresponding line item (service) on an X12 v5010 837 Claim transaction, this rule covers the following specified loops, segments, and data elements in in the X12 v5010 837 Professional, X12 v5010 837 Institutional, and X12 v5010 837 Dental:

Table 4 – Applicable X12 v5010 837 Claim Transaction Loops and Segments (Line Item Service Matching)			
Data Element	**X12 v5010 837 Professional**	**X12 v5010 837 Institutional**	**X12 v5010 837 Dental**
Patient Control Number (Claim Submitter's Identifier)	2300-CLM01	2300-CLM01	2300-CLM01
Payer Claim Control Number	2300-REF02	2300-REF02	2300-REF02
Value Added Network Trace Number	2300-REF02	2300-REF02	2300-REF02
Line Item Control Number	2400-REF02	2400-REF02	2400-REF02

To support association of X12 v5010 277CA error codes with their corresponding line item (service) on an X12 v5010 837 Claim transaction, this rule covers the following specified loops, segments, and data elements in the X12 v5010 277CA:

Table 5 – Applicable X12 v5010 277CA Loops and Segments (Line Item Service Matching)	
Data Element	**X12 v5010 277CA**
Patient Control Number (Claim Submitter's Identifier)	2200D-TRN02
Payer Claim Control Number	2200D-REF02

Table 5 – Applicable X12 v5010 277CA Loops and Segments (Line Item Service Matching)	
Data Element	**X12 v5010 277CA**
Clearinghouse Trace Number	2200D-REF02
Line Item Control Number	2220D-REF02

To support error reporting, this rule covers the following specified loops, segments, and data elements in the 277CA transaction:

Table 6 – Applicable X12 v5010 277CA Error Reporting Loops and Segments	
Data Element	**Applicable Loop & Segment**
Health Care Claim Status Category Code	2200B-STC01-01
Health Care Claim Status Code	2200B-STC01-02
Health Care Claim Status Category Code	2200B-STC10-01
Health Care Claim Status Code	2200B-STC10-02
Health Care Claim Status Category Code	2200B-STC11-01
Health Care Claim Status Code	2200B-STC11-02
Health Care Claim Status Category Code	2200C-STC01-01
Health Care Claim Status Code	2200C-STC01-02
Health Care Claim Status Category Code	2200C-STC10-01
Health Care Claim Status Code	2200C-STC10-02
Health Care Claim Status Category Code	2200C-STC11-01
Health Care Claim Status Code	2200C-STC11-02
Health Care Claim Status Category Code	2200D-STC01-01
Health Care Claim Status Code	2200D-STC01-02
Health Care Claim Status Category Code	2200D-STC10-01
Health Care Claim Status Code	2200D-STC10-02
Health Care Claim Status Category Code	2200D-STC11-01
Health Care Claim Status Code	2200D-STC11-02
Health Care Claim Status Category Code	2220D-STC01-01
Health Care Claim Status Code	2220D-STC01-02
Health Care Claim Status Category Code	2220D-STC10-01
Health Care Claim Status Code	2220D-STC10-02
Health Care Claim Status Category Code	2220D-STC11-01
Health Care Claim Status Code	2220D-STC11-02

3.5.1. Code Sources Addressed

This rule addresses the following code sources:

- X12 External 507 Health Care Claim Status Category Codes in each STC Status Information Segment of the Loops identified in Table 6 above.[4]
- X12 External 508 Health Care Claim Status Codes in each STC Status Information Segment of the Loops identified in Table 6 above.[5]

3.6. Maintenance of This Rule

Any substantive updates to the rule (i.e., change to rule requirements) will be made in alignment with federal processes for updating versions of the operating rule, or as determined by industry need or CORE Participants.

[4] See X12 External 507 Health Care Claim Status Category Codes for a complete list of Claim Status Category Codes.

[5] See X12 External 508 Health Care Claim Status Codes for a complete list of Claim Status Codes.

3.6.1. CAQH CORE Process for Maintaining CORE-defined Claim Status Category Code and Claim Status Code Combinations

The Claim Status Category Codes (CSCC) and Claim Status Codes (CSC) codes sets are returned in the X21 v5010 277CA to report errors in the submission of the X12 v5010 837 transaction. These code lists are external code lists maintained by X12 and therefore are subject to revision and maintenance numerous times a year. Such revision and maintenance activity can result in new codes, revision to existing codes' definitions and descriptions, or a stop date assigned to a code after which the code should no longer be used.

Given this code list maintenance activity, CORE recognizes that the focus of this rule will require a process and policy to enable the various CSCC + CSC combinations specified in the companion document to this rule, *CORE-required Code Combinations for CORE-defined Claim Rejection Business Scenarios.xlsx*, to be revised and modified. CORE will establish an open process for soliciting feedback and input from the industry on a periodic basis for the CSCC + CSC code combinations in *CORE-required Code Combinations for CORE-defined Claim Rejection Business Scenarios.xlsx* and convene a Taskgroup to agree on appropriate revisions. As part of this process, it will be expected that health plans/providers/vendors report for consideration any additional Business Scenarios that health plans or their agents may be using on a frequent basis that are not already covered by this rule to CORE. A public request will be made to receive this real-world data and the analysis of the data will incorporate traditional Quality Improvement (QI) reviews as well as commitment to CORE Guiding Principles.

CORE is committed to continually improving the process for reporting claim rejections to providers consistently and uniformly across the industry. To further this commitment, CORE will continue to collaborate and take lessons learned from the industry to develop and enhance an ongoing QI process for maintaining, updating, and supporting a stable, industrywide code set.

3.7. Abbreviations and Definitions Used in this Rule

CORE-defined Claim Rejection Business Scenarios: In general, a business scenario provides a complete description of a business problem such that requirements can be reviewed in relation to one another in the context of the overall problem. Business scenarios provide a way for the industry to describe processes or situations to address common problems and identify technical solutions. By making obvious what is needed, and why, the trading partners and vendors can solve problems using open standards and leveraging each other's skills.

Thus, in the context of this rule, a CORE-defined Claim Rejection Business Scenario describes at a high level the category of the rejection of a healthcare claim within the health plan's pre-adjudication system to which various combinations of CSCC + CSC codes can be applied so that details can be conveyed to the provider using the X12 v5010 277CA. The CORE-defined Rejection Business Scenarios are specified in §4.1.4.

3.8. Assumptions

A goal of this rule is to adhere to the principles of electronic data interchange (EDI) in assuring that transactions sent are accurately received and to facilitate correction of errors for electronically submitted health care claims.

The following assumptions apply to this rule:

- A successful communication connection has been established.
- This rule is a component of the larger set of CAQH CORE Health Care Claims (837) Operating Rules.
- The CAQH CORE Guiding Principles apply to this rule and all other rules.
- This rule is not a comprehensive companion document addressing any content requirements of the X12 v5010 277CA transaction, the X12 v5010 837 Professional, X12 v5010 837 Institutional, and X12 v5010 837 Dental transactions.

- Compliance with all CAQH CORE Operating Rules is a minimum requirement; any entity is free to offer more than what is required in the rule.
- Health care claim transactions are submitted electronically using the X12 v5010 837 Claim transaction standard with all required data elements.

4. Technical Requirements

4.1. Requirements for Health Plans

4.1.1. Basic Requirements for Uniform Use of Claim Status Category Codes & Claim Status Codes

This section addresses the requirements for a health plan when sending an X12 v5010 277CA with a claim rejection in response to an X12 v5010 837 Claim transaction submitted in either real time or in batch.

4.1.2. Association of the X12 v5010 277CA with Its Corresponding Health Care Claim

Health plans and their agents receive and process an X12 v5010 837 Professional, X12 v5010 837 Institutional, or X12 v5010 837 Dental from providers containing the data content in the loops and segments indicated in Table 2 of §3.5, as appropriate.

Health plans and their agents must return any data elements from Table 2 of §3.5 that were included in the X12 v5010 837 Professional, X12 v5010 837 Institutional, and X12 v5010 837 Dental submissions from providers along with the X12 v5010 277CA data elements from Table 3 of §3.5 to support association of the X12 v5010 277CA transaction with its corresponding X12 v5010 837 Claim transaction. These data elements are not required to be used for internal processing to generate a X12 v5010 277CA.

4.1.3. Alignment of Claim Category Status Codes and Claim Status Codes to Health Care Claim Line Items (Services)

In addition to the requirements outlined in §4.1.2, health plans and their agents receive and process an X12 v5010 837 Professional, X12 v5010 837 Institutional, or X12 v5010 837 Dental transactions from providers containing the data content in the loops and segments indicated in Table 4 of §3.5.

In addition to the requirements outlined in §4.1.2, health plans and their agents must return any data elements from Table 4 §3.5 that were included in the X12 v5010 837 Professional, X12 v5010 837 Institutional, and X12 v5010 837 Dental submissions from providers along with the X12 v5010 277CA data elements from Table 5 of §3.5 to support aligning error codes on a X12 v5010 277CA to line items (services) on its corresponding X12 v5010 837 Claim transaction.

When health plans and their agents return X12 v5010 277CA transactions with claim-level (2200D-STC) CSCCs and CSCs to providers, they must include the data content in the claim-level loops and segments indicated in Table 3 of §3.5.

When health plans and their agents return X12 v5010 277CA transactions with line level (2220D-STC) CSCCs and CSCs to providers, they must include the data content in the line level loops and segments indicated in Table 5 of §3.5.

4.1.4. CORE-defined Claim Rejection Business Scenarios

Table 7 – CORE-defined Rejection Business Scenarios and Descriptions	
CORE-defined Claim Rejection Business Scenario	**CORE Business Scenario Description**
Business Scenario #1 – Claim Rejected: Will Not be Adjudicated.	Business Scenario 1 is based upon CSCC A3 - Acknowledgment/Returned as unprocessable claim – The claim/encounter was rejected and has not been entered into the adjudication system.
Business Scenario #2 – Claim Rejected: Missing Information.	Business Scenario 2 is based upon CSCC A6 - Acknowledgement/Rejected for Missing Information - The claim/encounter is missing the information specified in the Status details and has been rejected.
Business Scenario #3 – Claim Rejected: Invalid Information.	Business Scenario 3 is based upon CSCC A7 - Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected.
Business Scenario #4 – Claim Rejected: Data Relationship Error.	Business Scenario 4 is based upon CSCC A8 - Acknowledgement/Rejected for relational field in error.

4.1.5. Uniform Use of Claim Status Category Codes & Claim Status Codes

Specific details about a claim rejection are conveyed to the provider by the health plan or its agent in the X12 v5010 277CA by the combined use of a specific CSCC and CSC code combination. These code combinations are defined as CORE-required CSCC + CSC combinations. The CORE-required maximum CORE CSCC + CSC Combinations for each CORE-defined Claim Rejection Business Scenario are specified in the *CORE-required Code Combinations for CORE-defined Claim Rejection Business Scenarios.xlsx*. This document is available at here.

A health plan or its agent must align its internal codes and corresponding business scenarios to the CORE-defined Claim Rejection Business Scenarios specified in §4.1.4 and the CSCC + CSC code combinations specified in the *CORE-required Code Combinations for CORE-defined Claim Rejection Business Scenarios.xlsx*.

A health plan must return applicable code combinations for all errors on a submitted X12 v5010 837 Claim transaction. Please reference Table 6 for specific loops and segments to use in error communication.

A health plan or its agent must support the maximum CORE-required CSCC + CSC combinations in the X12 v5010 277CA as specified in *CORE-required Code Combinations for CORE-defined Claim Rejection Business Scenarios.xlsx*; no other CSCC + CSC combinations are allowed for use in the CORE-defined Claim Rejection Business Scenarios. When specific CORE-required CSCC + CSC combinations are not applicable to meet the health plans or its agent's business requirements within the CORE-defined Claim Rejection Business Scenarios, the health plan and its agent is not required to use them.

In the case where a health plan or its agent wants to use an existing code combination that is not included in the maximum code combination set for a given CORE-defined Claim Rejection Business Scenario, a new CSCC + CSC code combination must be requested in accordance with the CAQH CORE process for updating the CORE-required Error Code Combinations in *CORE-required Code Combinations for CORE-defined Claim Rejection Business Scenarios.xlsx.*

The only exception to this maximum set of CORE-required CSCC + CSC combinations is when the respective code committees responsible for maintaining the codes create a new code or

adjust an existing code. Then the new or adjusted code can be used with the Business Scenarios and a CAQH CORE process for updating the Code Combinations will review the ongoing use of these codes within the maximum set of codes for the Business Scenarios. A deactivated code must not be used.

4.1.6. Claim Acknowledgement Response Scenarios

When the health plan and its agent detect an error related to the claim, the most specific CSCC + CSC code combination must be returned in Loop ID 2200B STC segment.

When the health plan and its agent detect an error related to a specific provider's group of claims, the most specific CSCC + CSC code combination must be returned in Loop ID 2200C STC segment.

When the health plan and its agent detect an error related to any other error, the most specific CSCC + CSC code combination must be returned in Loop ID 2200D STC segment.

4.2. General Requirements

4.2.1. Detection and Display of 277CA Data Elements

The receiver of the X12 v5010 277CA (defined in the context of this CAQH CORE rule as the system originating the X12 v5010 837 Claim transaction) is required to detect and extract all data elements, data element codes, and corresponding code definitions to which this rule applies as returned by the health plan and its agent in the X12 v5010 277CA.

The receiver must display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the X12 v5010 277CA data content.

4.2.2. Detection and Display of CORE-required Code Combinations for CORE-defined Claim Rejection Business Scenarios

When receiving a X12 v5010 277CA, a product extracting the data (e.g., a vendor's provider-facing system or solution) from the X12 v5010 277CA for manual processing must make available to the end user:

- Text describing the CSCC + CSC reject error codes included in the transaction, ensuring that the actual wording of the text displayed accurately represents the corresponding code description specified in the code lists without changing the meaning and intent of the description.

AND

- Text describing the corresponding CORE-defined Claim Rejection Business Scenario.

The requirement to make available to the end user text describing the corresponding CORE-defined Claim Rejection Business Scenario does not apply to retail pharmacy.

This requirement does not apply to an entity that is simply forwarding the X12 v5010 277CA to another system for further processing.

5. Conformance Requirements

Conformance with this rule is considered achieved when all the required detailed step-by-step test scripts specified in the Health Care Claims CORE Certification Test Suite are successfully passed.

6. Appendix

6.1. Operating Rule Mandates

This CAQH CORE Rule is part of a set of rules that addresses requirements in Section 1104 of the Affordable Care Act (ACA). Section 1104 contains an industry mandate for the use of operating rules to support implementation of the HIPAA standards. Using successful, yet voluntary, national industry efforts

as a guide, Section 1104 defines operating rules as "the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications" (ACA, Section 1104). As such, operating rules build upon existing healthcare transaction standards. The ACA outlines three sets of healthcare industry operating rules to be approved by HHS and then implemented by the industry.

The third set of ACA-mandated operating rules address healthcare claims or equivalent encounter information transactions, enrollment and disenrollment in a health plan, health plan premium payments, claims attachments, and referral certification and authorization.[6] The ACA requires HHS to adopt a set of operating rules for these five transactions. In a letter dated 09/12/12 to the Chairperson of NCVHS,[7] the Secretary of HHS designated CAQH CORE as the operating rule authoring entity for the remaining five HIPAA-mandated electronic transactions.

6.2. HIPAA Compliance Requirements

HHS determines whether the system of a covered entity is compliant or noncompliant with the HIPAA Administrative Simplification requirements (which include HIPAA-mandated CAQH CORE Operating Rules). HHS may adjudicate compliance of a covered entity and assess civil money penalties or penalty fees for noncompliance under the following HIPAA Administrative Simplification mandates:

- HIPAA regulations mandate that the Secretary "will impose a civil money penalty upon a covered entity or business associate if the Secretary determines that the covered entity or business associate has violated an administrative simplification provision." (45 CFR 160.402) Under the ACA, HIPAA also mandates that HHS is to "conduct periodic audits to ensure that health plans…are in compliance with any standards and operating rules." (Social Security Act, Title XI, Section 1173(h))

[6] The first set of operating rules under ACA Section 1104 applies to eligibility and claim status transactions. These operating rules became effective January 1, 2013. The second set of operating rules applies to electronic funds transfer and electronic remittance advice. These operating rules became effective January 1, 2014.

[7] See HHS **Letter from the Secretary** to the Chairperson of NCVHS. September 12, 2012.