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CAQH CORE Health Care Claims (837) Data Content Rule

Version HC.1.0

October 2023

1 **Revision History for CAQH CORE Health Care Claims (837) Data Content Rule**
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Version	Revision	Description	Date
HC.1.0	Major	• Development of Health Care Claims 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 Health Care Claims Data Content Operating Rules

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

- Processing mode
- Connectivity
- System availability
- Real time processing mode response time
- Batch processing mode response time
- Real time acknowledgements
- Batch acknowledgements
- Companion guide

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 CORE Operating Rule. Initially identified areas of focus ranged from data content gaps in widely used and accepted transactions to the exchange of patient information using APIs.

To refine these opportunities, CORE convened the Health Care Claims Focus Group in 2022 to collect insights and discuss addressing the opportunities 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 including claim acknowledgement and error reporting, telehealth, value-based payments (VBP), and clean claim requirements. The input and opinions shared by Focus Group participants directly informed the launch agenda for the Health Care Claims Subgroup for data content operating rule development.

Launched in April 2023, the Health Care Claims Data Content Subgroup met six times to continue to specify opportunities that enhance claims transmission for providers, health plans, and vendors. Remote care delivery, coordination of benefits, and matching information between initial and supplementary claims to submit additional diagnoses for a single encounter rose to the top of the priority list for Subgroup participants; each is addressed with data content specifications in this rule. As with all CAQH CORE Operating Rules, these requirements are intended as a base or minimum set of requirements, and it is expected that many entities will go beyond these requirements as they work towards the goal of administrative simplification and interoperability.

[1] CAQH CORE (2022). CAQH CORE Health Care Claim (837) Infrastructure Rule vHC.2.0. CAQH. Retrieved from: https://www.caqh.org/sites/default/files/CAQH CORE Health Care Claim %28837%29 Infrastructure Rule vHC2.0.pdf

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Building on the CORE Health Care Claim (837) Infrastructure Rule vHC.2.0, which established the "electronic highway" for claims processing, the CORE Health Care Claim (837) Data Content Rule outlines requirements for the data payloads that are processed when conducting the X12 005010X222 Health Care Claim: Professional (hereafter referred to as the X12 v5010 837 Professional), X12 005010X223 Health Care Claim: Institutional (hereafter referred to as the X12 v5010 837 Institutional), and X12 005010X224 Health Care Claim: Dental (hereafter referred to as the X12 v5010 837 Dental) transactions and their respective errata (collectively hereafter X12 v5010 837 Claim transaction).

2. Issues to Be Addressed and Business Requirement Justification

2.1. Problem Space

According to the 2022 CAQH Index, 97% of health care claims are submitted electronically using the HIPAA-mandated X12 v5010 837 Claim transaction. This is among the highest electronic adoption rates of all HIPAA administrative standards, yet providers report ongoing challenges with claim submission[2]. According to the Change Healthcare 2022 Revenue Cycle Denials Index, the average initial denial rate across 1,500 hospitals in the United States was almost 12% in the first half of 2022, compared to just 10% in 2020 and 9% in 2016[3]. On the surface, an increase in denial rates stands in direct opposition to the increase in automation reported in the CAQH Index. Causes of the challenges to successful claim submission are many, some of which are rooted in the use of the health care claim transaction itself.

Within the health care claims processing landscape, efficiency remains a key challenge. Over 9 billion claims transactions are sent electronically between providers and health plans each year – even a small change in automating the standards for claims transmission could result in $2.5 billion of savings annually[4]. The Health Care Claims Subgroup's goal is to develop a set of data content operating rules that enhance the electronic exchange of claims-related transactions.

The CORE Health Care Claims (837) Data Content Rule requirements aim to strengthen the standard for a HIPAA transaction that is nearly completely managed electronically[5]. These ensure that healthcare providers, health plans, and clearinghouses can communicate, exchange, and process claims more accurately and efficiently. Enhancements reduce unnecessary back and forth between providers and health plans, enable shorter adjudication timeframes, and reduce staff resources needed for manual follow-up. The rule reduces barriers to adoption by:

- Outlining data needed to submit claims in high frequency but non-standard scenarios like telehealth, coordination of benefits, and multiple claims for a single encounter.
- Using an industry reference to ease the burden of interpretation of telehealth place of service (POS) and modifier code use on the provider.
- Requiring display of claim submission requirements for the scenarios to which the rule applies to ease the burden of claim submission on the provider.

2.1.1. Remote Care Delivery Claims

Telehealth services provide flexibility in care delivery for providers and patients. The growth of telehealth over the past few years introduced complex requirements to indicate where services were delivered and how[6]. Providers use the X12 v5010 837 Claim transaction to indicate these data points, but minor

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[2] CAQH Explorations (2023). The 2022 CAQH Index Report. CAQH, January 31, 2023 Retrieved from: https://staging.caqh.org/sites/default/files/2023-01/2022-caqh-index-report%20FINAL%20SPREAD%20VERSION.pdf

[3] Change Healthcare (2023). The Change Healthcare 2022 Revenue Cycle Denials Index. Change Healthcare, November 15, 2022. Retrieved from: https://www.changehealthcare.com/insights/denials-index

[4] CAQH Explorations (2023). The 2022 CAQH Index Report. CAQH, January 31, 2023 Retrieved from: https://staging.caqh.org/sites/default/files/2023-01/2022-caqh-index-report%20FINAL%20SPREAD%20VERSION.pdf

[5] Ibid.

[6] McKinsey & Company (2021). Telehealth: A Quarter-Trillion-Dollar-Post-COVID-19 reality? Retrieved from: https://www.mckinsey.com/industries/healthcare/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality

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differences in reporting requirements between health plans necessitate costly, manual intervention to confirm what POS codes are required for a claim to be accepted.

The environmental scan identified opportunities to align POS or modality reporting requirements across health plans via operating rules, allowing stakeholders to streamline telehealth claim submission and easily address errors or rejections. A standardized approach to using POS and modifier codes in telehealth billing reduces the administrative burden associated with tracking different coding requirements between different entities. Additional guidance on situational use of modifiers 93, 95, and GT in conjunction with POS 02 or 10 to indicate remote care delivery received the highest support from the Health Care Claims Data Content Subgroup. This guidance serves an industry preparing to contend with confusion around regulatory requirements driven by the expiration of COVID-19 era flexibilities.

2.1.2. Coordination of Benefits

Managing coordination of benefits (COB) billing guidelines and electronic vs manual claim submission to secondary health plans are burdens that, with some standardization of the X12 v5010 837 Claim transaction, could make COB workflows streamlined, predicable, and expeditious, and reduce COB, timely filing, or other denials. In the 2020 Revenue Cycle Denials Index, Change Healthcare found that one in four potentially avoidable denials are registration or eligibility related. Of these denials, over 40% are COB-related[7].

The Health Care Claims Data Content Subgroup participants supported requirements for submitting a claim to a secondary health plan to support coordination of benefits, increase clean claim submission, and reduce COB-related denials.

2.1.3. Matching Information Between an Initial and Supplementary Claim to Submit Additional Diagnoses for a Single Encounter

Health care claim submissions support value-based payment (VBP) methodologies like risk adjustment and quality measurement and contribute to the documentation of social determinants of health (SDOH) through the inclusion of ICD-10 Z-codes. The latter example is of particular importance as VBP is increasingly used to pilot interventions and strategies to combat health inequities. Despite a general reliance on the claims workflow, the addition of chronic conditions, care processes, and non-medical factors that make up these methodologies are limited by the number of diagnosis fields available to providers in the X12 v5010 837 Claim transaction, particularly the X12 v5010 837 Professional that only allows a maximum of 12 diagnosis codes to be included per submission.

As a work around to these limitations, some health plans and their agents permit the submission of multiple claims for a single encounter to empower the inclusion of additional diagnoses that support VBP methodologies and program design. The intended benefit of this workflow is often offset by varying health plan requirements for what information must be included on an “additional” claim for it to not be treated as a duplicate submission and be rejected during adjudication. To reduce variability and create a more predictable submission pathway, the CORE Value-based Payments and Health Care Claims Subgroups collaboratively reached consensus on several standard data elements on an additional claim for a single encounter that must match the original or “initial” claim. This is a requirement for health plans and their agents that accept the submission of additional claims.

3. Scope

3.1. What the Rule Applies To

[7] Change Healthcare (2020). The Change Healthcare 2020 Revenue Cycle Denials Index. Retrieved from: https://www.ache.org/-/media/ache/about-ache/corporate-partners/the_change_healthcare_2020-revenue_cycle_denials_index.pdf

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1 This Health Care Claims (837) Data Content Rule applies to the exchange of data content to support
2 Health Care Claim Submissions sent via the X12 v5010 837 Claim transactions and the X12 v5010X221
3 835 Health Care Claim Payment/Advice transaction (hereafter referred to as the X12 v5010 835) and
4 their associated errata.

5 Table 1 defines the transactions in scope for each set of data content requirements addressed by this
6 rule.

Table 1 - In Scope X12 v5010 837 Claim Transactions for Health Care Claim Data Content Requirements

Data Content Requirements	X12 v5010 837 Professional	X12 v5010 837 Institutional	X12 v5010 837 Dental
Remote Delivery Claims	Y	N	N
Coordination of Benefit	Y	Y	Y
Additional Diagnoses for a Single Encounter	Y	Y	N

7 ## *3.2. When the Rule Applies*

8 ### *3.2.1. Remote Care Delivery Claims*

9 This rule requirement applies when a provider or its agent submits an X12 v5010 837 Professional for
10 care delivered remotely, as indicated by the POS and modifier codes on the claim. Only claims with POS
11 02 and 10 on the claim are addressed in this rule. POS 02 and 10 are defined as:

12 - POS 02: Telehealth provided other than in a patient's home.
13 - POS 10: Telehealth provided in a patient's home.

14 AND

15 This rule requirement applies when a health plan or its agent receives an X12 v5010 837 Professional for
16 care delivered remotely, as indicated by the POS and modifier codes on the claim. Only claims with POS
17 02 and 10 on the claim are addressed in this rule. POS 02 and 10 are defined as:

18 - POS 02: Telehealth provided other than in a patient's home.
19 - POS 10: Telehealth provided in a patient's home.

20 ### *3.2.2. Coordination of Benefits*

21 .

22 This rule requirement applies when a provider or its agent is submitting claims (X12 v5010 837 Claim
23 transaction) to a secondary health plan, and to health plans providing coverage to members as a
24 secondary insurer or when a health plan is sending a secondary claim to a secondary health plan for
25 claims adjudication[8].

26 AND

27 The primary health plan returns a remittance advice (X12 v5010 835).

28 AND

29 When the correspondence between health plan and provider aligns with either of the two below
30 scenarios:

31 - Scenario 1: Provider to Health Plan COB Interaction
32   - In this scenario, the provider submits the transaction and sends the claim information to
33   the primary health plan. The primary health plan adjudicates the claim and sends an

[8] For comprehensive COB requirements, please refer to a health plan companion guides or billing manuals or the X12 TR3s for the respective X12 v5010 837 Claim transaction.

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electronic remittance advice (RA) transaction (X12 v5010 835) back to the provider, which contains any claim adjustment reason codes that apply to that specific claim. Upon receipt of the electronic RA transaction (X12 v5010 835), the provider sends a second health care claim transaction (X12 v5010 837 Claim transaction) to the secondary health plan. The secondary health plan adjudicates the claim and sends the provider an electronic RA transaction (X12 v5010 835).

- Scenario 2: Health Plan to Health Plan COB Interaction
    - In this scenario, the provider submits the transaction and sends claim information to the primary health plan. The primary health plan adjudicates the claim and sends an electronic remittance advice (RA) transaction (X12 v5010 835) back to the provider, which contains any claim adjustment reason codes that apply to that specific claim. The primary health plan reformats the health care claim transaction (X12 v5010 837 Claim transaction) and sends it to the secondary health plan. The secondary health plan receives the health care claim transaction (X12 v5010 837 Claim transaction) from the primary health plan and adjudicates the claim. The secondary health plan sends an electronic RA transaction (X12 v5010 835) to the provider.

3.2.3. Matching Information Between an Initial and Supplementary Claim to Submit Additional Diagnoses for a Single Encounter

This rule requirement applies when:

A health plan accepts multiple claim submissions of the X12 v5010 837 Professional or X12 v5010 837 Institutional for a single encounter.

3.3. What the Rule Does Not Address

This rule does not address infrastructure requirements applicable to the X12 v5010 837 Claim transaction and X12 v5010 835.

Beyond infrastructure requirements, for the *Matching Information Between an Initial and Supplementary Claim to Submit Additional Diagnoses for a Single Encounter* requirements this rule does not address:

- Specific VBP methodologies that health plans and their agents must employ.
- Specific documentation or diagnoses that a health plan and its agent must accept.
- The exchange of a member's longitudinal medical history.

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 837 Claim transaction and X12 v5010 835 that are not addressed in this rule.

AND

- Any health plan or its agent to accept the submission of additional claims for single encounter.

3.5. Applicable Loops, Segments, and Data Elements

This rule covers loops, segments, and data elements in the X12 v5010 837 Professional, X12 v5010 837 Institutional, and X12 v5010 837 Dental transactions in supporting the remote care delivery, COB, and multiple claim submission requirements as indicated in the below tables.

Table 2 – Applicable X12 v 5010 837 Claim Transaction Loops and Segments for Remote Care Delivery Claims	
Data Element Name	**X12 v5010 837 Professional**
Place of Service	2300-CLM05-01

Table 2 – Applicable X12 v 5010 837 Claim Transaction Loops and Segments for Remote Care Delivery Claims	
Data Element Name	**X12 v5010 837 Professional**
Place of Service	2400-SV105-1331
Procedure Modifier	2400-SV101-03
Procedure Modifier	2400-SV101-04
Procedure Modifier	2400-SV101-05
Procedure Modifier	2400-SV101-06

1
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Table 3 – Applicable X12 v5010 837 Claim Transaction Loops and Segments for COB			
Data Element Name	**X12 v5010 837 Professional**	**X12 v5010 837 Institutional**	**X12 v5010 837 Dental**
Subscriber Primary Identifier	2010BA-NM109	2010BA-NM109	2010BA-NM109
Subscriber Supplemental Identifier	2010BA-REF02	2010BA-REF02	2010BA-REF02
Patient Last Name	2010CA-NM103	2010CA-NM103	2010CA-NM103
Patient First Name	2010CA-NM104	2010CA-NM104	2010CA-NM104
Patient Control Number (Claim Submitter's Identifier)	2300-CLM01	2300-CLM01	2300-CLM01
Payer Claim Control Number	2300-REF02	2300-REF02	2300-REF02
Claim Adjustment Group Code	2320-CAS01	2320-CAS01	2320-CAS01
Adjustment Reason Code	2320-CAS02	2320-CAS02	2320-CAS02
Adjustment Amount	2320-CAS03	2320-CAS03	2320-CAS03
Payer Paid Amount	2320-AMT02	2320-AMT02	2320-AMT02
Remaining Patient Liability (COB Patient Responsibility)	2320-AMT02	2320-AMT02	2320-AMT02
Other Payer Organization Name	2330B-NM103	Other Payer Last or Organization Name 2330B-NM103	Other Payer Last or Organization Name 2330B-NM103

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Table 3 – Applicable X12 v5010 837 Claim Transaction Loops and Segments for COB			
Data Element Name	**X12 v5010 837 Professional**	**X12 v5010 837 Institutional**	**X12 v5010 837 Dental**
Other Payer Primary Identifier	2330B-NM109	2330B-NM109	2330B-NM109
Adjudication or Payment Date	2330B-DTP03	2330B-DTP03	2330B-DTP03
Line Item Control Number	2400-REF02	2400-REF02	2400-REF02
Other Payer Primary Identifier	2430-SVD01	2430-SVD01	2430-SVD01
Service Line Paid Amount	2430-SVD02	2430-SVD02	2430-SVD02
Claim Adjustment Group Code	2430-CAS01	2430-CAS01	2430-CAS01
Adjustment Reason Code	2430-CAS02	2430-CAS02	2430-CAS02
Adjustment Amount	2430-CAS03	2430-CAS03	2430-CAS03
Adjudication or Payment Date	2430-DTP03	2430-DTP03	2430-DTP03
Remaining Patient Liability	2430-AMT02	2430-AMT02	2430-AMT02
Facility Type Code (Facility Code Value)	N/A	2300-CLM05-01	N/A
Claim Frequency Code (Claim Frequency Type Code)	N/A	2300-CLM05-03	N/A
Admission Date and Hour	N/A	2300-DTP02	N/A
Claim DRG Amount	N/A	2320-MIA04	N/A
Claim Payment Remark Code	N/A	2320-MIA05	N/A
HCPCS Payable Amount	N/A	2320-MOA02	N/A
Claim Payment Remark Code	N/A	2320-MOA03	N/A

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Table 3 – Applicable X12 v5010 837 Claim Transaction Loops and Segments for COB			
Data Element Name	**X12 v5010 837 Professional**	**X12 v5010 837 Institutional**	**X12 v5010 837 Dental**
Tooth Number (Reference Identification)	N/A	N/A	2300-DN201
Assistant Surgeon NPI (Assistant Surgeon Primary Identifier)	N/A	N/A	2310D-NM109 or 2420B-NM109
Tooth Status Code (Tooth Status Code)	N/A	N/A	2300-DN202

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Table 4 – Applicable X12 v5010 835 Loops and Segments for COB	
Data Element Name	**X12 v5010 835**
Subscriber Identifier	2100-NM109
Other Claim Related Identifier	2100-REF02
Patient Last Name	2100-NM103
Patient First Name	2100-NM104
Patient Control Number (Claim Submitter's Identifier)	2100-CLP01
Payer Claim Control Number	2100-CLP07
Claim Adjustment Group Code	2100-CAS01
Adjustment Reason Code	2100-CAS02
Adjustment Amount	2100-CAS03
Claim Payment Amount	2100-CLP04
Adjustment Amount	2100-CAS03
Coordination of Benefits Carrier Name	2100-NM103
Coordination of Benefits Carrier Identifier	2100-NM109
Check Issue or EFT Effective Date	BPR16
Line Item Control Number	2110-REF02
Coordination of Benefits Carrier Identifier	2100-NM109
Line Item Provider Payment Amount	2110-SVC03
Claim Adjustment Group Code	2110-CAS01

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Table 4 – Applicable X12 v5010 835 Loops and Segments for COB	
Data Element Name	**X12 v5010 835**
Adjustment Reason Code	2110-CAS02
Adjustment Amount	2110-CAS03
Check Issue or EFT Effective Date	BPR16
Adjustment Amount	2110-CAS03

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Table 5 - Applicable X12 v5010 837 Claim Transaction Loops and Segments for Matching Information Between an Initial and Supplementary Claim to Submit Additional Diagnoses for a Single Encounter		
Data Element Name	**X12 v5010 837 Professional**	**X12 v5010 837 Institutional**
Identification Code Qualifier (Designation of CMS NPI – Rendering Provider)	2310B-NM108	2310D-NM108
Identification Code (CMS NPI – Rendering Provider)	2310B-NM109	2310D-NM109
Identification Code Qualifier (Designation of CMS NPI – Billing Provider)	2010AA-NM108	2010AA-NM108
Identification Code (CMS NPI – Billing Provider)	2010AA-NM109	2010AA-NM109
Identification Code Qualifier (Designation of Subscriber Primary Identifier)	2010BA-NM108	2010BA-NM108
Identification Code (Subscriber Primary Identifier)	2010BA-NM109	2010BA-NM109
Date Time Period	Service Date 2400-DTP03	Statement From and To Date 2300-DTP03

2

3 ### *3.6. Code Sources Addressed*

4 This rule addresses the following code sources:

5 #### *3.6.1. Remote Care Delivery Claims*

6 • AMA CPT Appendix A Modifier Codes
7 • Centers for Medicare and Medicaid Services External Place of Service Codes for Professional
8 Claims[9]

9 #### *3.6.2. Coordination of Benefits*

10 • X12 Standard 974 Claim Adjustment Group Codes Data Element in the CAS segments of the
11 X12 v5010 837 Professional identified in Table 3 above.
12 • X12 Standard 139 Claim Adjustment Reason Codes Data Element in the CAS segments of the
13 X12 v5010 837 Professional identified in Tables 3 and 4 above.

[9] Centers for Medicare and Medicaid Place of Service Code Set. Retrieved from: https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

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- X12 Standard 411 Remittance Advice Remark Codes Data Element in the LQ segments of the X12 v5010 837 Professional identified in Table 3 above.

3.7. 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 rules, or as determined by industry need or CORE Participants.

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 electronic X12 v5010 837 Claim transaction functionality by minimizing manual intervention and/or the necessity for paper supporting documents.

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 and Payment and Remittance 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 requirements of TR3 specifications for the X12 v5010 835 transaction, the X12 v5010 837 Professional, the X12 v5010 837 Institutional, or the X12 v5010 837 Dental.
- 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.

4. X12 v5010 837 Claim Transaction Technical Requirements

4.1. Requirements for Providers

4.1.1. Remote Care Delivery Claims

When using 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 to indicate telehealth services were rendered, a provider or its agent must only use the following modifiers for qualifying service type codes covered for telemedicine per AMA’s Appendix P CPT Code Set:

- Modifier GT – Service rendered via interactive audio and video telecommunications systems,

Or

- AMA CPT Appendix A Modifier Code 93 – Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system,

Or

- AMA CPT Appendix A Modifier 95 – Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system.

CORE-defined combinations of these codes in the table below describe each billing scenario and the corresponding POS + modifier code combination that must be used when billing a telehealth claim with POS 02 or 10.

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Table 6 – CORE-defined POS + Modifier Definitions			
POS	Modifier	Combined Definition	Example Use Case
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.
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.
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 provider to review results from a recent series of diagnostic tests.
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.
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.
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.

4.1.2. Coordination of Benefits

General, provider-specific requirements are outlined below. Please refer to health plan companion guides and billing manuals and X12 TR3s for the respective X12 v5010 837 Claim transaction for any additional requirements.

4.1.2.1. *Scenario 1: Provider to Health Plan COB Interaction Data Content Requirements*

A provider and its agent must submit the appropriate data content from the X12 v5010 837 Claim transaction for coordination of benefits as specified in Table 3 and Table 4 of §3.5 to submit claims to subsequent health plans as follows:

Step 1: Primary Health Plan Submission Requirements

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Providers and their agents must submit the following information to the primary health plans in the X12 v5010 837 Claim transaction, if known:

- In the Subscriber loop (Loop ID-2000B), include the data for the subscriber holding the policy with the primary health plan.
- In Loop ID-2320, include information pertaining to the secondary health plan and the subscriber associated with the secondary health plan.
- To ensure health plans and their agents can accurately coordinate benefits, providers and their agents must submit in the X12 v5010 837 Claim transaction any information specified in Table 3 and Table 4 of §3.5.

Step 2: After Receipt of the Electronic Remittance Advice (X12 v5010 835)

Upon receipt of the X12 v5010 835 from the primary health plan, providers and their agents must update the X12 v5010 837 Claim transaction to be submitted to the secondary health plan with the following information:

- In the Subscriber loop (Loop ID-2000B), update the information for the subscriber holding the policy with the secondary health plan.
- In Loop ID-2320, update the information for the subscriber related to the primary health plan.
- In Loop ID-2320, enter all total amounts paid at the claim level in the AMT segment.
- Retrieve any claim-level adjustment codes from the RA transaction (X12 v5010 835) provided by the primary health plan and place them in the CAS (Claims Adjustment) segment within Loop ID-2320.
- Retrieve line level adjustment reason codes from the RA transaction (X12 v5010 835) and insert them into the CAS (Line Adjustment) segment within Loop ID-2430.
- To ensure health plans and their agents can accurately coordinate benefits, providers and their agents must submit in the X12 v5010 837 Claim transaction any information specified in Table 3 and Table 4 of §3.5, if known.

Step 3: Tertiary Health Plans

If there are additional health plans, providers and their agents must:

- Repeat step 2, updating the information for the subscriber holding the policy with the tertiary health plan in the Subscriber Loop (Loop ID-2000B).
- Continue to include COB information specific to the primary health plan in Loop ID-2320, specifying the health plan as primary.
- Include Loop ID-2430 for line-level adjudications specific to the primary health plan, if applicable.
- Include COB information for the secondary health plan by populating Loop ID-2320 and specifying the health plan as secondary.
- Include Loop ID-2430 for line-level adjudications related to the secondary health plan, if necessary.
- To ensure health plans and their agents can accurately coordinate benefits, providers and their agents must submit in the X12 v5010 837 Claim transaction any information specified in Table 3 and Table 4 of §3.5, if known.

4.1.2.2. *Scenario 2: Health Plan to Health Plan COB Interaction Data Content Requirements*

Step 1: Provider Claim Submission Requirements

Providers and their agents must submit the following information to the primary health plan in the X12 v5010 837 Claim transaction:

- In the Subscriber loop (Loop ID-2000B), include the data for the subscriber holding the policy with the primary health plan.
- In Loop ID-2320, include information pertaining to the secondary health plan and the subscriber associated with the secondary health plan.

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- To ensure health plans and their agents can accurately coordinate benefits, providers and their agents must submit in the X12 v5010 837 Claim transaction any information specified in Table 3 and Table 4 of §3.5, if known to the secondary health plan.

4.1.3. Matching Information Between an Initial and Supplementary Claim to Submit Additional Diagnoses for a Single Encounter[10]

Submitters must match the information included in an initial claim and the information included in a supplementary claim consistent with the data elements indicated in §4.2.3. using the following loops, segments, and data elements from the X12 v5010 837 Professional and X12 v5010 837 Institutional claims. CORE requirements indicate the data elements that must match. Submitters are responsible for meeting the requirements of the X12 v5010 837 Professional and X12 v5010 837 Institutional TR3s, including the submission of required fields and attendant situational fields in each data segment.

X12 v5010 837 Professional Submission Requirements.

- **Rendering Provider NPI**[11]
  - Loop 2300 – Claim Information
  - Loop 2310B – Rendering Provider Name
    - NM1 – Rendering Provider Name
      - NM108 = XX (CMS NPI)
      - NM109 = Rendering Provider NPI
- **Billing Provider NPI**
  - Loop 2000A – Billing Provider Hierarchical Level
  - Loop 2010AA – Billing Provider Name
    - NM1 – Billing Provider Name
      - NM108 = XX (CMS NPI)
      - NM109 = Billing Provider NPI
- **Member ID**[12]
  - Loop 2000B – Subscriber Hierarchical Level
  - Loop 2010BA – Subscriber Name
    - NM1– Subscriber Name
      - NM108 = MI (Member Identification Number)
      - NM109 = <Alphanumeric Member Identification Number>
- **Dates of Service**[13]
  - Loop 2000C – Patient Hierarchical Level
  - Loop 2400 – Service Line Number
    - DTP – Date – Service Date
      - DTP03 = <Discreet service date or service date range>

X12 v5010 837 Institutional Submission Requirements

- **Rendering Provider NPI**[14]
  - Loop 2300 – Claim Information

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[10] Professional claim submissions using the X12 v5010 837 Claim transaction are limited to 12 diagnosis fields, necessitating prioritization by providers of what diagnoses to include on a claim. Providers can submit supplementary claims for a single encounter to add diagnoses, but data content requirements for this process differ between health plans. Though typically encountered for professional claims, this issue can also affect institutional claims.

[11] When applicable and it differs from Billing Provider NPI.

[12] Required for submission when claim is submitted for a person, rather than a non-person entity.

[13] Dates of service must match the date format specified in DTP02 as either a discreet or range of dates.

[14] When applicable and it differs from Billing Provider NPI.

  - Loop 2310D – Rendering Provider Name
    - NM1 – Rendering Provider Name
      - NM108 = XX (CMS NPI)
      - NM109 = Rendering Provider NPI
- **Billing Provider NPI**
  - Loop 2000A – Billing Provider Hierarchical Level
  - Loop 2010AA – Billing Provider Name
    - NM1 – Billing Provider Name
      - NM108 = XX (CMS NPI)
      - NM109 = Billing Provider NPI
- **Member ID**[15]
  - Loop 2000B – Subscriber Hierarchical Level
  - Loop 2010BA – Subscriber Name
    - NM1– Subscriber Name
      - NM108 = MI (Member Identification Number)
      - NM109 = <Alphanumeric Member Identification Number>
- **Dates of Service**[16]
  - Loop 2000C – Patient Hierarchical Level
  - Loop 2300 – Claim Information
    - DTP – Statement Dates
      - DTP03 = <Discreet service date or service date range>

4.2. Requirements for Health Plans

4.2.1. Remote Care Delivery Claims

When a claim is received with 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 to indicate telehealth services were rendered, a health plan and its agent may accept the following modifiers for qualifying service type codes covered for telemedicine per AMA's Appendix P CPT Code Set Note: acceptance of the POS and the modifier does not imply that such services are coverService rendered via interactive audio and video telecommunications systems,

Or

- AMA CPT Appendix A Modifier Code 93 – Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system,

Or

- AMA CPT Appendix A Modifier 95 – d Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system.

CORE-defined combinations of these codes in Table 6 describe each billing scenario and the corresponding POS + modifier code combination that must be used when billing a telehealth claim with POS 02 or 10.

4.2.2. Coordination of Benefits

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[15] Required for submission when claim is submitted for a person, rather than a non-person entity.

[16] Dates of service must match the date format specified in DTP02 as either a discreet or range of dates.

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General, health plan-specific requirements are outlined below. Please refer to health plan companion guides or X12 TR3s for the respective X12 v5010 837 Claim transaction for comprehensive requirements.

4.2.2.1. *Scenario 1: Provider to Health Plan COB Interaction Data Content Requirements*

Step 1: Primary Health Plan Requirements

Health plans and their agents must accept the following information from the provider in the X12 v5010 837 Claim transaction:

- In the Subscriber loop (Loop ID-2000B), the data for the subscriber holding the policy with the primary health plan.
- In Loop ID-2320, information pertaining to the secondary health plan and the subscriber associated with the secondary health plan.

Providers and their agents should expect to receive the data outlined in Table 3 and Table 4 of §3.5 as appropriate. They then must populate the secondary X12 v5010 837 Claim transaction with this information to submit to the secondary health plan.

Step 2: Secondary Health Plan Requirements

Health plans and their agents must accept the following information from the provider in the X12 v5010 837 transaction:

- In the Subscriber loop (Loop ID-2000B), the information for the subscriber holding the policy with the secondary health plan.
- In Loop ID-2320, the information for the subscriber related to the primary health plan.
- In Loop ID-2320, all total amounts paid by the primary health plan at the claim level in the AMT segment.
- Claim-level adjustment codes from the RA transaction (X12 v5010 835) provided by the primary health plan in the CAS (Claims Adjustment) segment within Loop ID-2320.
- Line level adjustment reason codes from the RA transaction (X12 v5010 835) and provided by the primary health plan in the CAS (Line Adjustment) segment within Loop ID-2430.

Providers and their agents should expect to receive the data outlined in Table 3 and Table 4 of §3.5 as appropriate. They then must populate the secondary X12 v5010 837 Claim transaction with this information to submit to the secondary health plan.

Step 3: Tertiary Health Plan Requirements

If there are additional health plans, health plans and their agents must:

- Repeat step 2, accepting the information for the subscriber holding the policy with the tertiary health plan in the Subscriber loop (Loop ID-2000B).
- Continue to accept COB information specific to the primary health plan in Loop ID-2320, specifying the health plan as primary.
- Accept Loop ID-2430 for line-level adjudications specific to the primary health plan, if applicable.
- Accept COB information for the secondary health plan by again accepting Loop ID-2320, specifying the health plan as secondary.
- Accept Loop ID-2430 for line-level adjudications related to the secondary health plan, if necessary.

Providers and their agents should expect to receive the data outlined in Table 3 and Table 4 of §3.5 as appropriate. They then must populate the secondary X12 v5010 837 Claim transaction with this information to submit to the secondary health plan.

4.2.2.2. *Scenario 2: Health Plan to Health Plan COB Interaction Data Content Requirements*

Step 1: Primary Health Plan Requirements

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Health Plans and their agents must submit the following information to the secondary health plan in the X12 v5010 837 Claim transaction:

- In the Subscriber loop (Loop ID-2000B), include the data for the subscriber holding the policy with the secondary health plan.
- In the Other Subscriber Information loop (Loop ID-2320), include the data for the subscriber holding the policy with the primary health plan.
- In the Other Subscriber Information loop (Loop ID-2320), include the claim level coordination of benefits (COB) data for the primary health plan.
- In the Line Adjudication Information loop (Loop ID-2430), include the line level coordination of benefits (COB) data for the primary health plan.

Providers and their agents should expect to receive the data outlined in Table 3 and Table 4 of §3.5 as appropriate. They then must populate the secondary X12 v5010 837 Claim transaction with this information to submit to the secondary health plan.

Step 2: Secondary Health Plan Requirements

Health plans and their agents must accept the following information from the primary health plan in the X12 v5010 837 transaction:

- In the Subscriber loop (Loop ID-2000B), the information for the subscriber holding the policy with the secondary health plan.
- In Loop ID-2320, the information for the subscriber related to the primary health plan.
- In Loop ID-2320, all total amounts paid at the claim level in the AMT segment.
- Claim-level adjustment codes provided by the primary health plan in the CAS (Claims Adjustment) segment within Loop ID-2320.
- Line level adjustment reason codes provided by the primary health plan in the CAS (Line Adjustment) segment within Loop ID-2430.

Providers and their agents should expect to receive the data outlined in Table 3 and Table 4 of §3.5 as appropriate. They then must populate the secondary X12 v5010 837 Claim transaction with this information to submit to the secondary health plan.

Step 3: Tertiary Health Plan Requirements

If there are additional health plans, health plans and their agents must:

- Repeat step 1, updating the information for the subscriber holding the policy with the tertiary health plan in the Subscriber loop (Loop ID-2000B).
- Continue to include COB information specific to the primary health plan in Loop ID-2320, specifying the health plan as primary.
- Include Loop ID-2430 for line-level adjudications specific to the primary health plan, if applicable.
- Include COB information for the secondary health plan by again populating Loop ID-2320 and specifying the health plan as secondary.
- Include Loop ID-2430 for line-level adjudications related to the secondary health plan, if necessary.

Providers and their agents should expect to receive the data outlined in Table 3 and Table 4 of §3.5 as appropriate. They then must populate the secondary X12 v5010 837 Claim transaction with this information to submit to the secondary health plan.

4.2.2.3. *Companion Guide Requirements for COB*

If a HIPAA-covered entity and its agent publishes a Companion Guide covering the X12 v5010 837 Claim transaction, the Companion Guide must follow the format/flow as defined in the *CAQH CORE Master Companion Guide Template* for X12 transactions available HERE. Minimum data content requirements shall be organized in section 10 of the *CAQH CORE Master Companion Guide Template* – "10. Transaction Specific Information."

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4.2.2.4. *Electronic Policy Access of Required Information*

A health plan and its agent must offer a readily accessible electronic method to be determined by the health plan and its agent for identifying the data needed to support a coordination of benefit claims request by any trading partner (e.g., a healthcare provider). Such information must be accurate and current and must clearly communicate to providers what information is needed. This rule DOES NOT establish which policy requirements a health plan and its agent must use for claims adjudication.

4.2.3. Matching Information Between an Initial and Supplementary Claim to Submit Additional Diagnoses for a Single Encounter

When a health plan or its agent accepts the submission of additional claims for a single encounter, they must require the following information to match between the initial claim and supplementary claim.

- Rendering Provider NPI
- Billing Provider NPI
- Member Identification Number
- Dates of Service

4.2.3.1. *Access of Required Information*

Health plans and their agents must make this data requirement easily accessible to submitters of an X12 v5010 837 Claim transaction, either on the plan website or in the transaction-specific companion guide. A health plan and its agent are not required to indicate the attendant loops and segments required by the X12 v5010 837 Professional and X12 v5010 837 Institutional to successfully submit the information indicated above.

4.3. Detection and Display of X12 v5010 837 Claim Transaction Data Elements

The receiver of an X12 v5010 837 Claim transaction (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.

The receiver must display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the X12 v5010 837 Claim transaction data content.

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,

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1 claims attachments, and referral certification and authorization.[17] The ACA requires HHS to adopt a set of
2 operating rules for these five transactions. In a letter dated 09/12/12 to the Chairperson of NCVHS,[18] the
3 Secretary of HHS designated CAQH CORE as the operating rule authoring entity for the remaining five
4 HIPAA-mandated electronic transactions.

5 *6.2. HIPAA Compliance Requirements*

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

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

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[17] 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.

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

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