CORE Health Care Claims (837) Data Content Rule

Version HC.1.0

October 2023

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1 **Revision History for 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 **1. Background Summary**

2 ***1.1. CORE Overview***

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

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

14 ***1.2. Industry Interest in Health Care Claims Data Content Operating Rules***

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

18 - Processing mode
19 - Connectivity
20 - System availability
21 - Real time processing mode response time
22 - Batch processing mode response time
23 - Real time acknowledgements
24 - Batch acknowledgements
25 - Companion guide

26 To complement the CORE Health Care Claim (837) Infrastructure Rule vHC.2.0, CORE undertook a
27 comprehensive environmental scan to identify industry challenges surrounding the submission and
28 adjudication of claims that could be addressed by specifying data requirements in a data content rule for
29 the health care claim transaction (hereafter referred to as X12 v5010 837 transaction). Initially identified
30 areas of focus ranged from data content gaps in widely used and accepted transactions to the exchange
31 of patient information using APIs (application programming interfaces).

32 The CORE Health Care Claims Focus Group convened in 2022 to prioritize operating rule opportunities.
33 Focus Group participants confirmed their support for the development of data content operating rules for
34 a refined list of claims-related opportunities including claim acknowledgement and error reporting,
35 telehealth, value-based payments (VBP), and clean claim requirements. Insights from the Focus Group
36 directly informed the launch agenda for the Health Care Claims Subgroup for data content operating rule
37 development.

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

[1] CAQH CORE (2022). 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 transactions).

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 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 CORE Health Care Claims (837) Data Content Rule requirements aim to strengthen the data content of the claim transactions to meet current and emerging industry needs.[5] The rule requirements ensure that healthcare providers, health plans, and clearinghouses 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 supports industry by:

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

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 are delivered and how.[6] Providers use the X12 v5010 837 transaction to indicate these data points, but minor differences in

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[2] CAQH Insights (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 Insights (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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reporting requirements between health plans necessitate costly, manual intervention to confirm what POS codes and any associated modifiers are required for a claim to be accepted.

CORE's environmental scan identified opportunities to align telehealth 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 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 high support. This guidance serves an industry preparing to contend with confusion around divergent 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 on both providers and health plans. Standardization of the X12 v5010 837 transaction can make COB workflows more streamlined, predicable, and expeditious, and reduce denials related to COB, timely filing, or other reasons. In the 2020 Revenue Cycle Denials Index, Change Healthcare found that one in four potentially avoidable denials are registration or eligibility related, and of these denials, over 40% are COB-related.[7]

CORE 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 VBP methodologies like risk adjustment and quality measurement and contribute to the documentation of SDOH through the inclusion of ICD-10 (International Classification of Diseases, Tenth Revision) 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 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 Participants 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

This Health Care Claims (837) Data Content Rule applies to the exchange of data content to support Health Care Claim Submissions sent via the X12 v5010 837 transaction and the X12 005010X221 835

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[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

Health Care Claim Payment/Advice transaction (hereafter referred to as the X12 v5010 835) and their associated errata.

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

Table 1 - In Scope X12 v5010 837 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

3.2. When the Rule Applies

3.2.1. Remote Care Delivery Claims

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

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

AND

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

3.2.2. Coordination of Benefits

This rule requirement applies when the primary health plan returns an X12 v5010 835,

AND

A provider or its agent submits an X12 v5010 837 transaction to a secondary health plan, to health plans providing coverage to members as a secondary insurer, or when a health plan sends a secondary claim to a secondary health plan for claims adjudication,[8]

AND

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

- Scenario 1: Provider to Health Plan COB Interaction
  - In this scenario, the provider submits the X12 v5010 837 transaction and sends the claim information to the primary health plan. The primary health plan adjudicates the claim and sends an X12 v5010 835 back to the provider, which contains any claim adjustment reason codes that apply to that specific claim. Upon receipt of the X12 v5010 835, the provider sends a second X12 v5010 837 transaction to the secondary health plan. The secondary health plan adjudicates the claim and sends the provider an X12 v5010 835.
- Scenario 2: Health Plan to Health Plan COB Interaction
  - In this scenario, the provider submits the X12 v5010 837 transaction and sends claim information to the primary health plan. The primary health plan adjudicates the claim and

[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 transaction.

sends an 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 X12 v5010 837 transaction and sends it to the secondary health plan. The secondary health plan receives the X12 v5010 837 transaction from the primary health plan and adjudicates the claim. The secondary health plan sends an 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 and the X12 v5010 835 transactions.

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 and X12 v5010 835 transactions 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 Transaction Loops and Segments for Remote Care Delivery Claims	
Data Element Name	**X12 v5010 837 Professional**
Place of Service	2300-CLM05-01
Procedure Modifier	2400-SV101-03
Procedure Modifier	2400-SV101-04
Procedure Modifier	2400-SV101-05
Procedure Modifier	2400-SV101-06
Place of Service	2400-SV105

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Table 3 – Applicable X12 v5010 837 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
Place of Service Code	2300-CLM05-01	Facility Type Code 2300-CLM05-01	2300-CLM05-01
Claim Frequency Code (Claim Frequency Type Code)	2300-CLM05-03	2300-CLM05-03	2300-CLM05-03
Admission Date and Hour	N/A	2300-DTP02	N/A
Tooth Number (Reference Identification)	N/A	N/A	2300-DN201
Tooth Status Code (Tooth Status Code)	N/A	N/A	2300-DN202
Payer Claim Control Number	2300-REF02	2300-REF02	2300-REF02
Assistant Surgeon NPI (Assistant Surgeon Primary Identifier)	N/A	N/A	2310D-NM109 or 2420B-NM109
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
Claim DRG Amount	N/A	2320-MIA04	N/A
Claim Payment Remark Code	N/A	2320-MIA05	N/A

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Table 3 – Applicable X12 v5010 837 Transaction Loops and Segments for COB			
Data Element Name	**X12 v5010 837 Professional**	**X12 v5010 837 Institutional**	**X12 v5010 837 Dental**
(Inpatient)			
HCPCS Payable Amount	2320-MOA02	2320-MOA02	2320-MOA02
Claim Payment Remark Code (Outpatient)	2320-MOA03	2320-MOA03	2320-MOA03
Other Payer Organization Name	2330B-NM103	Other Payer Last or Organization Name 2330B-NM103	Other Payer Last or Organization Name 2330B-NM103
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

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Table 4 – Applicable X12 v5010 835 Loops and Segments for COB	
Data Element Name	**X12 v5010 835**
Check Issue or EFT Effective Date	BPR16
Patient Control Number (Claim Submitter's Identifier)	2100-CLP01
Claim Payment Amount	2100-CLP04
Payer Claim Control Number	2100-CLP07
Claim Adjustment Group Code	2100-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	2100-CAS02
Adjustment Amount	2100-CAS03
Patient Last Name	2100-NM103
Patient First Name	2100-NM104
Subscriber Identifier	2100-NM109
Coordination of Benefits Carrier Name	2100-NM103
Coordination of Benefits Carrier Identifier	2100-NM109
Claim DRG Amount	2100-MIA04
Claim Payment Remark Code (Inpatient)	2100-MIA05
Claim HCPCS Payable Amount	2100-MOA02
Claim Payment Remark Code (Outpatient)	2100-MOA03
Other Claim Related Identifier	2100-REF02
Line Item Provider Payment Amount	2110-SVC03
Claim Adjustment Group Code	2110-CAS01
Adjustment Reason Code	2110-CAS02
Adjustment Amount	2110-CAS03
Line Item Control Number	2110-REF02
Remark Code (Line Level)	2110-LQ02

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Table 5 - Applicable X12 v5010 837 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 – 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	2010BA-NM109	2010BA-NM109

Table 5 - Applicable X12 v5010 837 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**
(Subscriber Primary Identifier)		
Identification Code Qualifier (Designation of CMS NPI – Rendering Provider)	2310B-NM108	2310D-NM108
Identification Code (CMS NPI – Rendering Provider)	2310B-NM109	2310D-NM109
Date Time Period	Service Date 2400-DTP03	Statement From and To Date 2300-DTP03

3.6. Code Sources Addressed

This rule addresses the following code sources:

3.6.1. Remote Care Delivery Claims

- AMA CPT Appendix A Modifier Codes
- AMA CPT Appendix P
- AMA CPT Appendix T
- Centers for Medicare and Medicaid Services External Place of Service Codes for Professional Claims[9]

3.6.2. Coordination of Benefits

- X12 External Code Source 974 Claim Adjustment Group Codes Data Element in the CAS segments of the X12 v5010 837 transactions identified in Table 3 above.
- X12 External Code Source 974 Claim Adjustment Group Codes Data Element in the CAS segments of the X12 v5010 835 in Table 4 above.
- X12 External Code Source 139 Claim Adjustment Reason Codes Data Element in the CAS segments of the X12 v5010 837 transactions identified in Table 3 above.
- X12 External Code Source 139 Claim Adjustment Reason Codes Data Element in the CAS segments of the X12 v5010 835 in Table 4 above.
- X12 External Code Source 411 Remittance Advice Remark Codes Data Element in the MOA segments of the X12 v5010 837 transactions identified in Table 3 and the MIA segments of the X12 v5010 837 Institutional identified in Table 3 above.
- X12 External Code Source 411 Remittance Advice Remark Codes Data Element in the MIA, MOA, and LQ segments of the X12 v5010 835 identified in Table 4 above.

3.7. Maintenance of This Rule

Any substantive updates to the rule (i.e., change to rule requirements) are determined based on industry need as supported by the CORE Participants per the CORE Change and Maintenance Process.

3.8. Assumptions

[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

Goals of this rule are 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 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 CORE Health Care Claims Operating Rules.[10]
- The 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 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 Transaction Technical Requirements

This section is organized into two main subsections – *Requirements for Providers* (§4.1) and *Requirements for Health Plans* (§4.2).

Each subsection contains three sets of unique requirements – *Remote Care Delivery Claims* (§4.1.1 and §4.2.1), *Coordination of Benefits* (§4.1.2 and §4.2.2), and *Matching Information Between an Initial and Supplementary Claim to Submit Additional Diagnoses for a Single Encounter* (§4.1.3 and §4.2.3).

Subsection 4.3 addresses detection and display X12 v5010 837 transaction data elements.

4.1. Requirements for Providers

4.1.1. Remote Care Delivery Claims

When a provider:

- Submits a claim for health care services delivered remotely.

AND

- Uses 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:

    - Healthcare Common Procedure Coding Systems (HCPCS) Modifier GT – Service rendered via interactive audio and video telecommunications systems,

OR

    - Current Procedural Terminology (CPT®) Modifier 93 – Synchronous telemedicine service rendered via a telephone or other real-time interactive audio-only telecommunications system (see CPT Appendix A and Appendix T for additional information),

OR

[10] The CORE Operating Rules are available at: https://www.caqh.org/core/operating-rules

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- CPT Modifier 95 – Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system (see CPT Appendix A and Appendix P for additional information).

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.

Table 6 – CORE-defined POS + Modifier Definitions

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

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4.1.2. Coordination of Benefits

General, provider-specific requirements are outlined below. Please refer to X12 TR3s for the respective X12 v5010 837 transaction requirements, along with health plan companion guides and billing manuals for any other information required by the health plan.

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 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

Providers and their agents must submit the following information to the primary health plans in the X12 v5010 837 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 transaction any information specified in Table 3 and Table 4 of §3.5, as appropriate.

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 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 group codes, claim-level adjustment codes and corresponding adjustment amounts from the X12 v5010 835 provided by the primary health plan and place them in the CAS (Claims Adjustment) segment within Loop ID-2320.
- Retrieve any line-level group codes, line-level adjustment codes and corresponding adjustment amounts from the X12 v5010 835 and insert them into the CAS (Line Adjustment) segment within Loop ID-2430.
- Retrieve any claim-level remark codes from the X12 v5010 835 provided by the primary health plan and place them in the MIA (Inpatient Adjudication Information) or MOA (Outpatient Adjudication Information) segments within Loop ID-2320 as appropriate.
- To ensure health plans and their agents can accurately coordinate benefits, providers and their agents must submit in the X12 v5010 837 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 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*

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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 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.
- To ensure health plans and their agents can accurately coordinate benefits, providers and their agents must submit in the X12 v5010 837 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[11]

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**[12]
  - 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**[13]
  - 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**[14]
  - Loop 2000C – Patient Hierarchical Level
  - Loop 2400 – Service Line Number

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[11] Professional claim submissions using the X12 v5010 837 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.

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

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

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

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        - DTP – Date – Service Date
            - DTP03 = <Discreet service date or service date range>

X12 v5010 837 Institutional Submission Requirements

- **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:

- Healthcare Common Procedure Coding Systems (HCPCS) Modifier GT - Service rendered via interactive audio and video telecommunications systems,

OR

- CPT Modifier 93 – Synchronous telemedicine service rendered via a telephone or other real-time interactive audio-only telecommunications system (see CPT Appendix A and Appendix T for additional information),

OR

- CPT Modifier 95 – Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system (see CPT Appendix A and Appendix P for additional information).

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.

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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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Note: acceptance of the POS and the modifier does not imply that such services are covered by a health plan.

4.2.2. Coordination of Benefits

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

NOTE: 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 with this information and other relevant adjudication data from the original claim and 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 group codes, adjustment codes and corresponding adjustment amounts from the X12 v5010 835 provided by the primary health plan in the CAS (Claims Adjustment) segment within Loop ID-2320.
- Line level group codes, adjustment codes and corresponding adjustment amounts from the X12 v5010 835 and provided by the primary health plan in the CAS (Line Adjustment) segment within Loop ID-2430.
- Retrieve any claim-level remark codes from the X12 v5010 835 provided by the primary health plan and place them in the MIA (Inpatient Adjudication Information) or MOA (Outpatient Adjudication Information) segments within Loop ID-2320 as appropriate.

NOTE: 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 X12 v5010 837 transaction with this information and other relevant adjudication data from the claim and submit to the tertiary health plan, if needed.

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.

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- Accept Loop ID-2430 for line-level adjudications related to the secondary health plan, if necessary.

NOTE: 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 X12 v5010 837 transaction with this information and other relevant adjudication data from the claim, submit the claim and repeat Step 3 as needed.

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

Step 1: Primary Health Plan Requirements

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

NOTE: Health plans and their agents should generate an X12 v5010 835 as a part of the adjudication process. Health plans 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 transaction with this information and other relevant adjudication data from the original claim and 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 group codes, adjustment codes and corresponding adjustment amounts provided by the primary health plan in the CAS (Claims Adjustment) segment within Loop ID-2320.
- Line level group codes, adjustment codes and corresponding adjustment amounts provided by the primary health plan in the CAS (Line Adjustment) segment within Loop ID-2430.

NOTE: Health plans and their agents should generate an X12 v5010 835 as a part of the adjudication process. Health plans 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 X12 v5010 837 transaction with this information and other relevant adjudication data from the claim and submit to the tertiary health plan, if needed.

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.

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NOTE: Health plans and their agents should generate an X12 v5010 835 as a part of the adjudication process. Health plans 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 X12 v5010 837 transaction with this information and other relevant adjudication data from the claim and repeat Step 3 as needed.

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 transaction, the Companion Guide must follow the format/flow as defined in the *CORE Master Companion Guide Template* for X12 transactions available HERE. Minimum data content requirements for COB must be organized in Section 10 of the *CORE Master Companion Guide Template* – "10. Transaction Specific Information."

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[17]
- 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 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 Transaction Data Elements

The receiver of an X12 v5010 837 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 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.

[17] Rendering Provider NPI for X12 v5010 837 Professional only.

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