Draft CORE Health Care Claims Operating Rules Package

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Draft CORE Claim Acknowledgement (X12 005010X214 277CA) Operating Rule

- NEW Draft CORE Claim Acknowledgment (277CA) Data Content Rule
- NEW Draft CORE-required Error Code Combinations for CORE-defined Claim Rejection Business Scenarios
- NEW Draft Claim Acknowledgment Certification Test Scenarios

	Draft CORE Health Care Claims (837) Data Content Rule	*Draft CORE Claim Acknowledgment (277CA) Data Content Rule*
In-scope	**X12 Submission Methods** ▪ X12 005010X222 837 Health Care Claim: Professional Transaction ▪ X12 005010X223 837 Health Care Claim: Institutional Transaction ▪ X12 005010X224 837 Health Care Claim: Dental Transaction	
		X12 Submission Methods ▪ X12 005010X214 277 Health Care Claim Acknowledgment Transaction
Data Content Requirements	**Aligned place of service (POS) and modifier reporting requirements across health plans for telehealth.** ▪ Modifier assignment for POS 10 and 02 is standardized to modifiers 93, 95, or GT. ▪ Definitions of POS + modifier combinations are established in an accessible reference resource. **Requirements for submitting a claim to a secondary health plan to support coordination of benefits (COB).** ▪ Standardized minimum required data elements for successful processing of COB. **Requirements for matching information between an initial and supplementary for a single encounter.** ▪ Standardized minimum required data elements to include on an 837 when submitting two claims related to a single encounter. **Specification for display of data content requirements.** ▪ Electronically accessible, transaction-specific companion guides set common expectations for where requirements are found.	**Specification of a minimum set of information to include on an X12 v5010 277CA response.** ▪ Standardized data used to associate the 277CA transaction with an 837 transaction. ▪ Standardized data used to associate a 277CA error code with an 837 service line item.
External Code Sets		**Requirements outlining uniform use of X12 CSCC + CSC combinations in the X12 v5010 277CA.** ▪ Descriptions of the categories for a rejection of a healthcare claim by a health plan's pre-adjudication system to which various combinations of claim status (CSC) and claim status category (CSCC) codes can be applied.

Punchline: *Simplifies claim submission by aligning data content expectations and ensuring error communication is clear and consistent. Rule requirements apply to common scenarios like telehealth coverage and emerging use cases like multiple claim submissions for a single encounter to support the administration of value-based payment models.*