CAQH CORE℠

Review Work Group Meeting #1

September 25, 2025

Reviewing Draft Claim Status Data Content Rule

CAQH CORE℠

CLAIM STATUS DATA CONTENT SUBGROUP MEETING #5

September 25th

- CORE Overview
- Participant Expectations
- Co-chair Introductions
- Overview of Draft Rule Requirements
- Preparing for Straw Poll #1
- Next Steps

CORE Overview

CORE facilitates an industry-driven, consensus-based process to advance interoperability

Operating Rule Definition: The "necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications"

Rule Set Contains Federally Mandated Operating Rules

CORE: Who We Are

Committee on Operating Rules for Information Exchange

ENSURING REPRESENTATION

100+

Multi-stakeholder Participating Organizations

From small provider organizations, to national health plans, CORE has the **unique ability to bring diverse industry stakeholders to the table** to tackle complex administrative problems together.

LEADING INDUSTRY

10

CORE Operating Rules Mandated Under HIPAA

CORE is a **trusted and independent operating rule author**. In addition to mandated operating rules, CORE offers operating rule sets for voluntary adoption.

REDUCING BURDEN

$46B

Annual Industry Cost Savings Attributed to CORE Operating Rules

Using CAQH Index® data, CAQH Insights identified annual savings of $26 billion for providers and $20 billion for health plans resulting from the implementation of the mandated **CORE Operating Rules**.

CORE Participating Organizations

Government

- Arizona Health Care Cost Containment System
- California Department of Health Care Services
- Centers for Medicare and Medicaid Services (CMS)
- Federal Reserve Bank of Atlanta
- Florida Agency for Health Care Administration
- Health Plan of San Joaquin
- Michigan Department of Community Health
- Minnesota Department of Health
- Minnesota Department of Human Services
- Missouri HealthNet Division
- North Dakota Medicaid
- Oregon Department of Human Services
- Oregon Health Authority
- Pennsylvania Department of Public Welfare
- TRICARE
- United States Department of Treasury Financial Management
- United States Department of Veterans Affairs

Health Plans

- Aetna
- Ameritas Life Insurance Corp.
- AultCare
- Blue Cross and Blue Shield Association (BCBSA)
- Blue Cross Blue Shield of Michigan
- Blue Cross Blue Shield of North Carolina
- Blue Cross Blue Shield of Tennessee
- CareFirst BlueCross BlueShield
- Centene Corporation
- CIGNA
- Elevance Health
- Health Care Service Corp
- Horizon Blue Cross Blue Shield of New Jersey
- Humana
- Medical Mutual of Ohio, Inc.
- Point32Health
- UnitedHealthGroup

Integrated Plan/Provider

- Highmark Health (Highmark, Inc.)
- Kaiser Permanente
- Marshfield Clinic/Security Health Plan of Wisconsin, Inc.

Account for 75% of Total American Covered Lives

Vendors & Clearinghouses

- AIM Specialty Health
- athenahealth
- Availity, LLC
- Cerner/Healthcare Data Exchange
- Change Healthcare
- ClaimMD
- Cloud Software Group
- Cognizant
- Conduent
- CSRA
- DentalXChange
- DXC Technology
- Edifecs
- Epic
- Experian
- Healthedge Software Inc
- HEALTHeNET
- HMS
- Infocrossing LLC
- InstaMed
- Lassie
- MCG Health
- NantHealth NaviNet
- NextGen Healthcare Information Systems, Inc.
- OptumInsight
- PaySpan
- PNC Bank
- PriorAuthNow
- SS&C Health
- Stedi, Inc.
- Surescripts
- The SSI Group, Inc.
- TriZetto Corporation, A Cognizant Company
- Utah Health Information Network (UHIN)
- Wells Fargo
- Zelis
- Zuub

Providers

- American Hospital Association (AHA)
- American Medical Association (AMA)
- Aspen Dental Management, Inc.
- Children's Healthcare of Atlanta Inc
- DaVita Kidney Care
- Greater New York Hospital Association (GNYHA)
- Healthcare Financial Management Association (HFMA)
- Laboratory Corporation of America
- Mayo Clinic
- Medical Group Management Association (MGMA)
- Montefiore Medical Center
- New Mexico Cancer Center
- OhioHealth
- Peace Health
- St. Joseph's Health
- University of Iowa College of Dentistry
- Virginia Mason Medical Center

Other

- American Dental Association
- ASC X12
- Cognosante
- Healthcare Business Management Association
- HL7
- NACHA The Electronic Payments Association
- National Association of Healthcare Access Management (NAHAM)
- National Association of Health Data Organizations (NAHDO)
- National Committee for Quality Assurance (NCQA)
- National Council for Prescription Drug Programs (NCPDP)
- National Dental EDI Council (NDEDIC)
- New England HealthCare Exchange Network (NEHEN)
- Preferra Insurance Company Risk Retention Group
- Sekhmet Advisors
- Tata Consultancy Services Ltd
- Utilization Review Accreditation Commission (URAC)
- Work Group for Electronic Data Interchange (WEDI)

Diverse representation among participants

CAQH

Participant Expectations

Review Work Group Charter

Purpose

The RWG will review and refine the draft **Claim Status Data Content Rule** that seeks to overcome current challenges, such as data misalignment and inconsistent coding

Scope

The draft rule requirements include:

1. **Standardizing Error Code Combinations**: Standardize Claim Status Codes (CSC) and Claim Status Category Codes (CSCC) through business scenarios
2. **Aligning Data**: Standardize the data exchanged within the Claim Status transaction and require additional specificity in certain error responses

Goals

1. **Reduce costs for providers and health plans**
   - Understand the status of a claim before receipt of the remittance advice to accelerate follow-up
   - Improve provider cash flows by moving claims rework to within days of submission rather than weeks
2. **Shorten processing times**
   - Providers can begin follow-up processes earlier, health plans can receive information needed to process claims, and patients experience improved billing processes
3. **Improve billing and claims accuracy**
   - Implementing error code standardization, data alignment, and real-time data exchange can significantly mitigate existing challenges

Operating Rule Development Process

We are here

Level 1: Claim Status Data Content Subgroup

Subgroups develop draft operating rule language

Formal vote is not required, but **consensus is assessed** via straw polls and must be achieved prior to moving to the next level of voting

Level 2: Review Work Group

Work Groups review and refine draft operating rule language

Work Groups **require for a quorum that 60% of organizational participants vote in the final ballot**. Simple majority vote (greater than 50%) by this quorum is needed to approve a rule

Level 3: Full Voting Membership

The Full CORE Vote allows for all Full CORE Voting organizations to vote on the draft operating rule

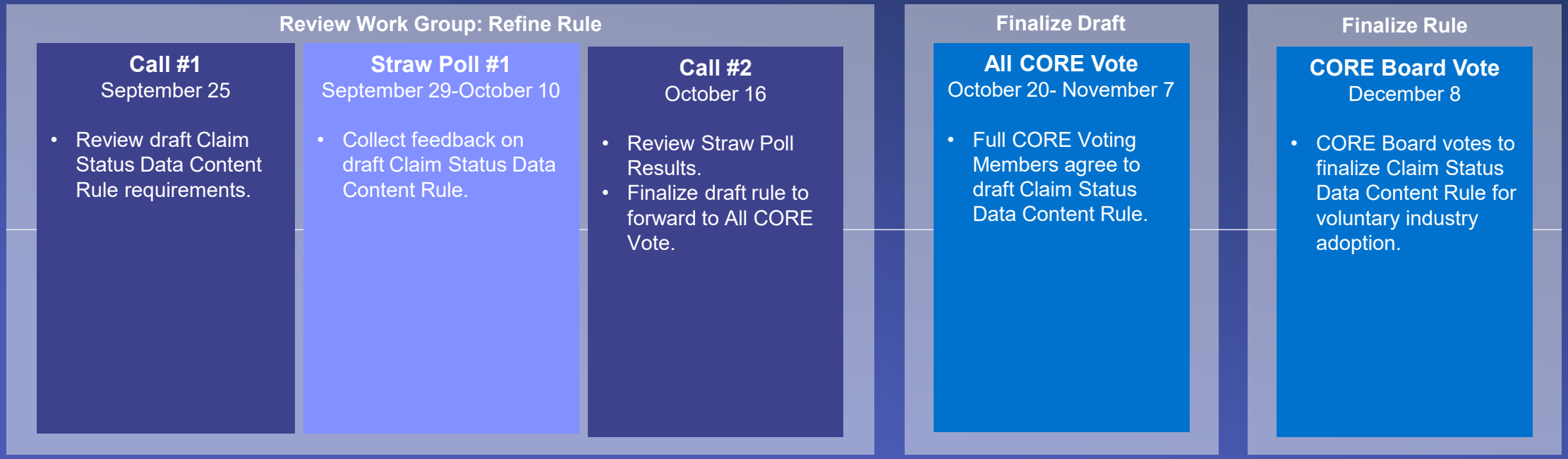
The Full CORE Vote **requires a quorum of 60% of all Full CORE Voting Member organizations** vote on the proposed rule at this stage. **With a quorum, 66.67%** support is needed to approve a rule

Level 4: CORE Board

The CORE Board reviews and votes through its **normal procedures on the draft rule**

If approved, the rule is formally published and available for industry adoption

Timeline



The timeline is subject to change based on the Work Group's needs.

Participant Expectations

Become familiar with CORE's processes

- Become familiar with CORE's operating rule structure and voting processes. Review the CORE Claim Status Infrastructure Rule, CORE Connectivity Rule, and CORE Code Combinations
- Read CORE's recently published issue brief on the claim status transaction

Attend and actively participate in calls

- CORE staff will email all call documents prior to each call and make all documents available on the Participant Dashboard.

Participate in Straw Polls

- All Participating Organizations are expected to complete all Straw Polls throughout the rule refinement process
- Note that organizations may have multiple participants in the Work Group, but only one submission is accepted per Participating Organization

Work with your organization's subject matter experts

- Work with your organization's subject matter experts to understand how the potential draft Claim Status Data Content Rule requirements would impact your organization and the industry, both in terms of feasibility to implement and value

Provide regular updates on Subgroup's progress to Executive Sponsors

- To gain greater support from your organization, keep your organization informed about the Review Work Group's progress
- If your organization has representation on the CORE Board, please keep your representative informed about the draft rule requirements

Co-chair Introductions

CORE Claim Status Data Content Subgroup Co-chairs

Kristin Thonsgaard

Manager, Industry Affairs
Optum

LinkedIn

Tyler Scheid

Lead Policy Analyst
American Medical Association
(AMA)

LinkedIn

Overview of Draft Rule Requirements

Why Standardization Matters

Fewer Claim Inquiries: Providers spend less time contacting payers for clarification inquiries and follow-ups

Better Data Accuracy: Standardized code combinations ensure all parties interpret claim statuses consistently

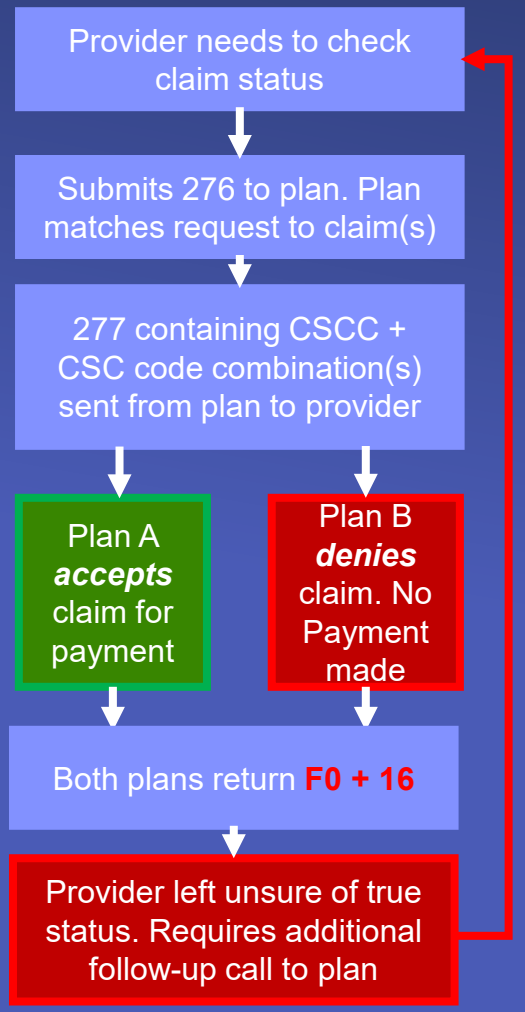
Faster Resolutions: Clear claim statuses allow for **immediate next steps**, reducing delays

Enhanced Automation: Systems can process claims efficiently without, or at least minimal, manual intervention

Reduced Administrative Costs: Less staff time required to manage claim inquiries and follow-ups

Industry Workflow Challenges

Claim Status Sample Workflows



1. *Inconsistent Use*

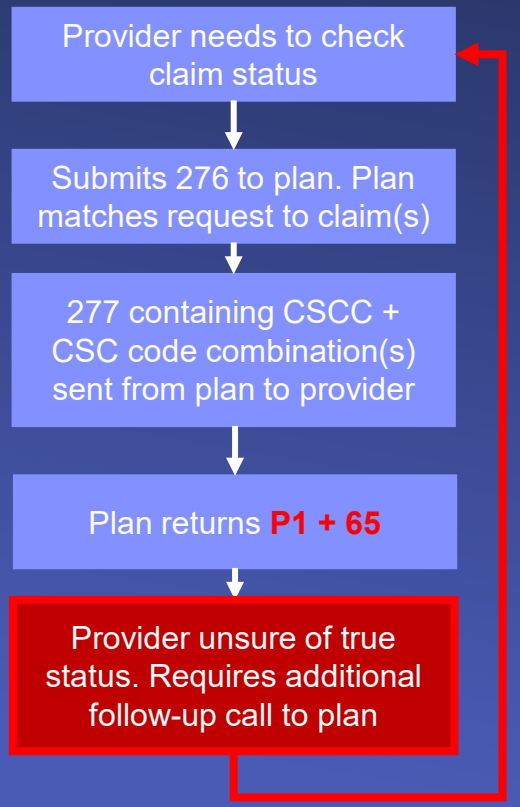
When the same code combination identifies different statuses across health plans, this leads to costly workaround and interruptions in workflow.

Providers are unsure of next steps to take to resolve

CSCC F0: Finalized – Completed Adjudication

+

CSC 16: Processed according to plan provisions



2. *Contradictory Combinations*

Illogical pairings create confusion

CSCC P1: Pending/in process– claim or encounter in adjudication system

+

CSC 65: Claim/line has been paid

3. *Variable adoption.*

Ranging from 6 to over 100 combinations in use, negatively impacts providers, forcing costly workarounds to find additional information due to limited implementations across health plans

Scope & Applicability

- **What the Rule Applies To**: The rule standardizes the use of Claim Status Category Code (CSCC) and Claim Status Code (CSC) combinations in the X12 005010X212 277 Health Care Claim Status Response to define ubiquitous business cases and establish actionable next steps for information sources and receivers

- **Applicable Code Sources:**
  - 507 Health Care Claim Status Category Codes
  - 508 Health Care Claim Status Codes

- **Applicable Loops, Segments, and Data Elements**:

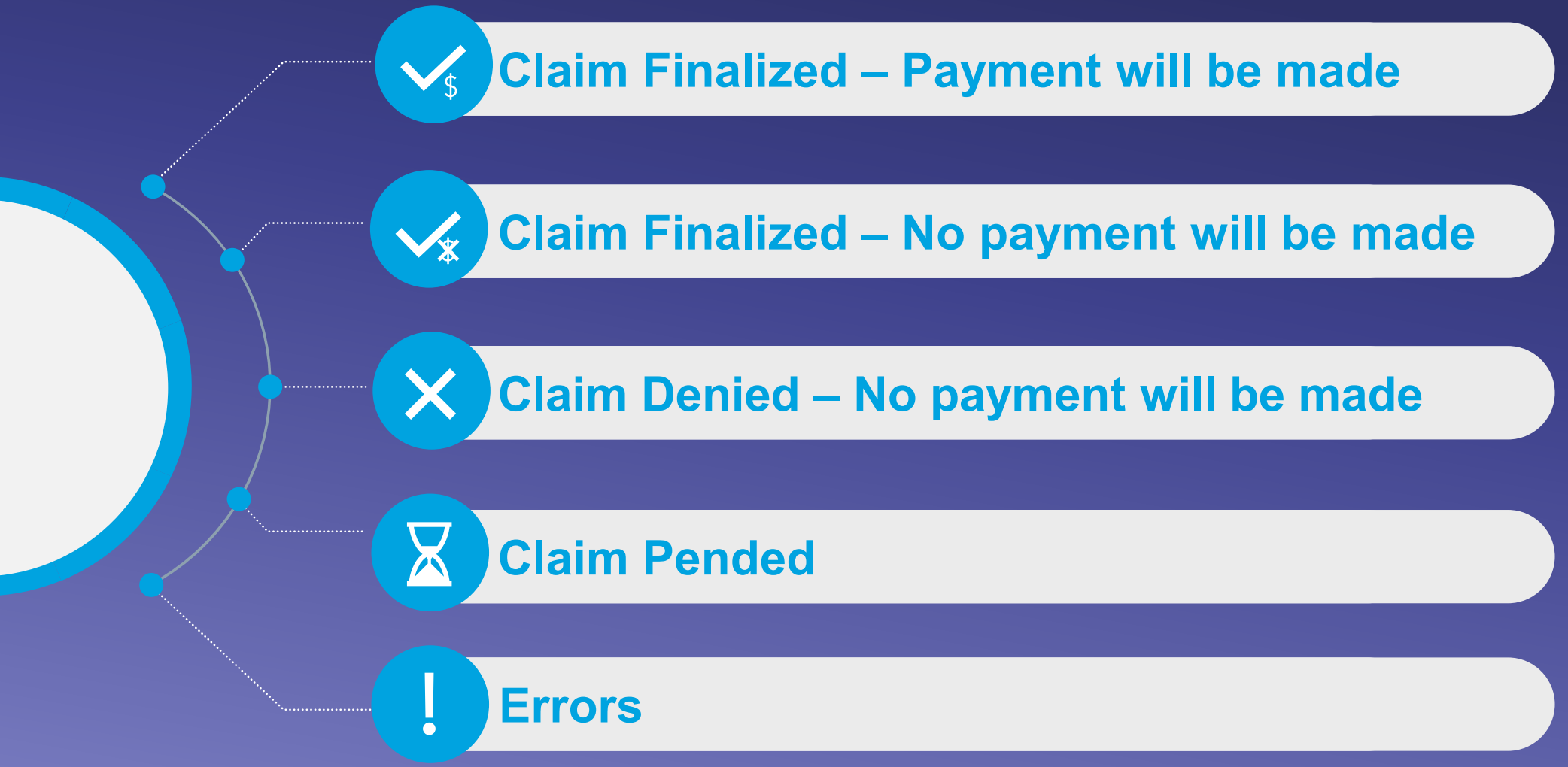
1. 2200B-STC01-01 and 2200B-STC01-02
2. 2200B-STC10-01 and 2200B-STC10-02
3. 2200B-STC11-01 and 2200B-STC11-02
4. 2200C-STC01-01 and 2200C-STC01-02
5. 2200C-STC10-01 and 2200C-STC10-02
6. 2200C-STC11-01 and 2200C-STC11-02
7. 2200D-STC01-01 and 2200D-STC01-02
8. 2200D-STC10-01 and 2200D-STC10-02
9. 2200D-STC11-01 and 2200D-STC11-02
10. 2220D-STC01-01 and 2220D-STC01-02
11. 2220D-STC10-01 and 2220D-STC10-02
12. 2220D-STC11-01 and 2220D-STC11-02
13. 2200E-STC01-01 and 2200E-STC01-02
14. 2200E-STC10-01 and 2200E-STC10-02
15. 2200E-STC11-01 and 2200E-STC11-02
16. 2220E-STC01-01 and 2220E-STC01-02
17. 2220E-STC10-01 and 2220E-STC10-02
18. 2220E-STC11-01 and 2220E-STC11-02

- **Who It Impacts**: Health plans, providers, clearinghouses, and vendors processing claim status transactions

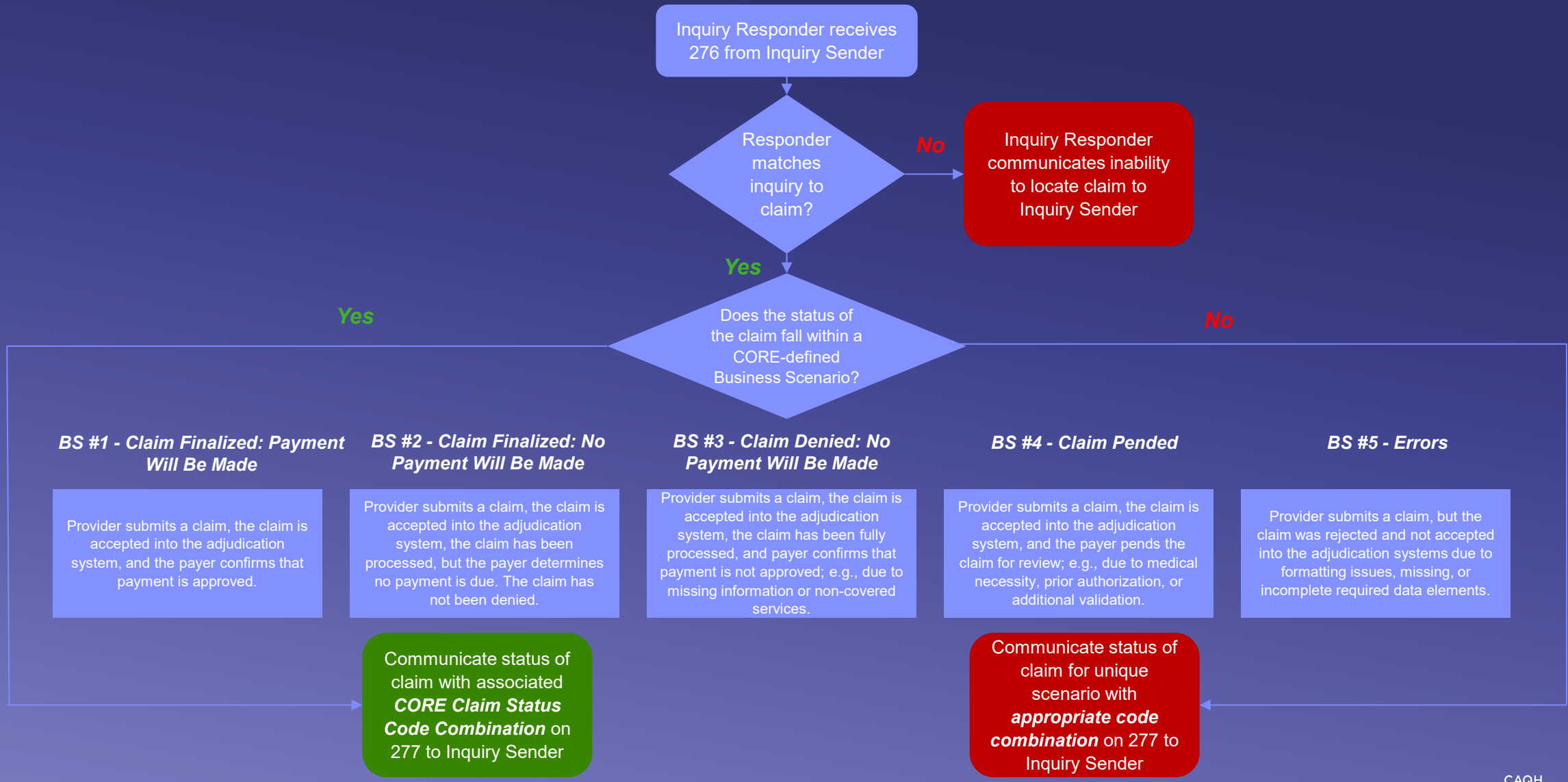
- **What It Does Not Apply to**: X12 005010X214 277 Health Care Claim Acknowledgment, X12 005010X213 277 Health Care Claim Request for Additional Information, and X12 005010X364 277 Data Reporting Acknowledgment

CLAIM STATUS CODE COMBINATIONS

CORE-Defined Claim Status Business Scenarios



Business Scenario Usage



CLAIM STATUS CODE COMBINATIONS

Business Scenarios Development

The first step in developing Claim Status Category Code (CSCC) + Claim Status Code (CSC) combinations was identifying the appropriate "business scenarios" to prioritize for industry alignment. Based on industry research and previous CORE code standardization work, ***CORE is recommending using the X12 CSCCs returned on the X12 277 to outline common business scenarios for claim status communication.***

Draft CORE-defined Claim Status Business Scenario	Alignment to X12 Claim Status Category Codes
1. Claim Finalized: Payment will be made	**Finalized (F Codes)** • F0: Finalized – Completed Adjudication • F1: Finalized/Payment – Claim Paid
2. Claim Finalized: No payment will be made	**Finalized (F Codes)** • F3: Finalized/Revised – Adjudication Information has Changed
3. Claim Denied: No payment will be made	**Finalized (F Codes)** • F2: Finalized/Denial – Claim Denied
4. Claim Pended	**Pended (P Codes)** • P1: Pending/In Process • P2: Pending/Payer Review • P3: Pending/Provider Requested Information • P4: Pending/Patient Request Information
5. Errors	**Error (E Codes) + Searches (D Codes)** • DO: Data Search Unsuccessful • EO: Response Not Possible – Error On Submitted Request • E1: Response Not Possible – System Status

Code Set Usage & Maintenance Process

Minimum Required Set:
The Claim Status Category Code (CSCC) and Claim Status Code (CSC) combinations specified in this rule represent the **minimum required data set** for industry use. These combinations are established as **best practice** to promote consistency and improve clarity in claim status responses across trading partners. Entities are required to use these code combinations when they report the status of a claim that falls within one of the CORE-defined business scenarios; however, entities may use **additional CSCC+CSC combinations** beyond those specified, as needed, to meet specific business or workflow requirements, provided such usage remains compliant with the applicable implementation guides and trading partner agreements.

Code Maintenance:
To ensure consistency, sustainability, and responsiveness to industry needs, CORE will maintain the standardized **CSCC + CSC code combinations** through its existing **CORE Code Combinations Maintenance Process**. This process is modeled after the well-established maintenance of the CORE-required CARC + RARC combinations and is designed to:

- Incorporate updates to external code lists (e.g., X12 Code Source 507 and 508)
- Review draft combinations in the context of CORE-defined business scenarios
- Address changes in payer or provider workflows, policy updates, or regulatory shifts
- Support a transparent, consensus-based approach to updates

This process will maintain CSCC + CSC combinations associated with the Claim Status Data Content Rule, ensuring they remain current and aligned with evolving business needs.

DATA ALIGNMENT

Why Data Alignment Matters

The Problem

Data misalignment leads to:

- “Claim Not Found” errors
- Delayed or incomplete follow-up
- Workflow disruptions

The Solution

A Data Content rule can:

- Standardize required and recommended fields to improve automation and consistency
- Align 267 inputs and 277 outputs to ensure better transaction matching
- Add critical response elements like check numbers and normalized names to support faster, actionable follow-up

The Impact

Fully automating claim status workflows will result in:

- $2.8 B in savings
  - $2.4 B for the medical industry
  - $421 M for the dental industry
- 18 minutes saved per transaction by eliminating manual workarounds

DATA ALIGNMENT

Industry Workflow Challenges

Claim Status Request Workflow

Information Receiver submits claim status request

Plan A requires:
- Patient DOB
- Subscriber Last Name
- Transaction Trace Number
- Monetary Amount
- Date of Service
- Subscriber First Name
- Gender Code
- Rendering Provider

Plan B requires:
- Patient DOB
- Subscriber Last Name
- Transaction Trace Number
- Monetary Amount
- Date of Service
- Billing Provider

Claim found! 277 generated by plan and returned to provider

Claim Not Found! Requires additional follow-up call to plan

Variation in required data of the inquiry reduces the utility of the claim status transaction and can result in unnecessary **claim not found** responses

Claim Status Response Workflow

Information Source returns claim status response

Plan A returns:
- Transaction Trace Number
- Payer Claim Number
- Date(s) of Service
- Check Number
- Check Date

Plan B returns:
- Transaction Trace Number
- Payer Claim Number
- Date(s) of Service

Response with additional information related to the payment **enhances follow-up workflows**

Follow-up workflows for pended or denied claims paused until 835 generated. **May required additional follow-up**

Additional data for paid, denied and pended claims can enhance provider follow-up workflows and result in **faster claim rework and AR clearance**

Scope & Applicability

- **What the Rule Applies To**: The data alignment section of the rule standardizes the data exchanged within the Claim Status transaction across three matching use cases:
  - Patient Search & Match Criteria
  - Claim Matching
  - Remittance Advice & Check/Payment Information

- **Applicable Loops, Segments, and Data Elements**:
  - *See the Data Alignment Use Cases & Matching Criteria Hierarchy slide.*

- **Who It Impacts**: Health plans, providers, clearinghouses, and vendors processing claim status transactions.

- **What It Does Not Apply to**: X12 005010X214 277 Health Care Claim Acknowledgment, X12 005010X213 277 Health Care Claim Request for Additional Information, and X12 005010X364 277 Data Reporting Acknowledgment

Proposed Draft Requirements

Data	276 & 277 Loop/Segment	276 Level of Requirement	277 Level of Requirement
Use Case: Patient Search & Match Criteria			
Patient Name	2100D-NM103/04 (Subscriber), 2100E-NM103/04 (Dependent)	**Requirement**	**Requirement**
Name Normalization	2100D-NM103 (Subscriber), 2100E-NM103 (Dependent)	**Requirement**	**Requirement**
Subscriber ID	2100D-NM109 (Subscriber)	**Requirement**	**Requirement**
Patient Date of Birth*	2000D-DMG02 (Subscriber), 2000E-DMG03 (Dependent)	**Requirement**	N/A
Patient Gender Code*	2000D-DMG02 (Subscriber), 2000E-DMG03 (Dependent)	Recommendation	N/A
Use Case: Claim Matching			
Date of Service	2200D-DTP03 (Subscriber), 2200E-DTP03 (Dependent)	**Requirement**	**Requirement**
Billing Provider Information (Provider Name and ID Code)	2100C-NM103/09	Recommendation	Recommendation
Claim Submitter Identifier	2200D-REF02 (Patient Control Number, Subscriber) 2200E-REF02 (Patient Control Number, Dependent)	**Requirement**	**Requirement**
Payer Claim Control Number	2200D-REF02 (Payer Claim Control Number, Subscriber) 2200E-REF02 (Payer Claim Control Number, Dependent)	Recommendation	Recommendation
Claim Identification for Clearinghouses and Other Transmission Intermediaries	2200D-REF02 (Claim ID for Clearinghouse, Subscriber) 2200E-REF02 (Claim ID for Clearinghouse, Dependent)	Recommendation	Recommendation
Use Case: Remittance Advice & Check/Payment Information Matching			
Billing Provider Information (Provider Name and ID Code)	2100C-NM103/09	Recommendation	Recommendation
Payer Claim Control Number	2200D-REF02 (Payer Claim Control Number, Subscriber) 2200E-REF02 (Payer Claim Control Number, Dependent)	**Requirement**	**Requirement**
Check Number**	2200D-STC09 (Subscriber) 2200E-STC09 (Dependent)	N/A	**Requirement**
Check Date**	2200D-STC08 (Subscriber) 2200E-STC08 (Dependent)	N/A	**Requirement**
Claim Submitted Charges	2200D-AMT02 (Subscriber, 276), 2200E-AMT02 (Dependent, 276) 2200D-STC04 (Subscriber, 277), 2200E-STC04 (Dependent, 277)	Recommendation	Recommendation
Claim Payment Amount**	2200D-STC05 (Subscriber) 2200E-STC05 (Dependent)	Recommendation	Recommendation

*Data element is only found in the 276.
**Data element is only found in the 277

Data Alignment Use Cases & Matching Criteria Hierarchy

Patient Search & Match Criteria

The RWG will develop recommendations to make health plan search and match criteria as effective as possible.

Proposed Data Element Hierarchy:

1. **Subscriber ID***
   - Requirement
2. **Patient/Subscriber/Dependent First and Last Name***
   - Requirement
3. **Name Normalization***
   - Requirement
4. **Patient/Subscriber/Dependent Date of Birth****
   - Requirement
5. **Patient/Subscriber/Dependent Gender Code****
   - Recommendation

*Data element is found in both the 276 and 277.
**Data element is only found in the 276.
***Data element is only found in the 277.

Claim Matching

The RWG will develop recommendations to make claim matching between the claim status inquiry and response transactions as effective as possible.

Proposed Data Element Hierarchy:

1. **Claim Submitter Identifier***
   - Requirement
2. **Payer Claim Control Number***
   - Strong Recommendation
3. **Date of Service***
   - Requirement
4. **Billing Provider Information***
   - Recommendation
5. **Claim Identification for Clearinghouses and Other Transmission Intermediaries***
   - Recommendation

RA & Check/Payment Information

The RWG will develop recommendations to make remittance advice (RA) and check/payment information matching between the RA and claim status response transactions as effective as possible.

Proposed Data Element Hierarchy:

1. **Payer Claim Control Number***
   - Requirement
2. **Check Number*****
   - Requirement
3. **Check Date*****
   - Requirement
4. **Billing Provider Information***
   - Recommendation
5. **Claim Payment Amount*****
   - Recommendation
6. **Claim Charge Amount***
   - Recommendation

Next Steps

Next Steps

Complete Straw Poll #1
September 29-October 10

- Indicate your organization's level of support for the draft rule language

- All call documents from today's call are available on the Participant Dashboard.
- Reach out to core@caqh.org with any questions.

Review Work Group Roster

Name	Organization
Rose Hodges	Aetna
Mark Rabuffo	Aetna
Rebekah Fiehn	American Dental Association
Andrea Preisler	American Hospital Association
Emma Andelson	American Medical Association
Celine Lefebvre	American Medical Association
Heather McComas	American Medical Association
Rob Otten	American Medical Association
Tyler Scheid	American Medical Association
Muhamed Cesko	athenahealth
Caitlin Daniels	athenahealth
Jason Ellsworth	athenahealth
Melissa Fiore	athenahealth
Daniel Kilpatrick	athenahealth
Evi Russo	athenahealth
Vijayaganesh Sampathkumar	athenahealth
Chelsea Smith	athenaHealth
Leah Barber	Availity
Gail Kocher	Blue Cross Blue Shield Association
Amy King	Blue Cross Blue Shield of Michigan
Amy Turney	Blue Cross Blue Shield of Michigan
Sal Zarate	Blue Cross Blue Shield of North Carolina
Susan Langford	Blue Cross Blue Shield of Tennessee
Jamie Osborne	Children's Healthcare of Atlanta
Annette Kemplin	Cigna
Sadaf Ali-Simpon	CMS
Paul Anderson	CMS
lakisha brown	CMS
Joi Campbell	CMS
Michael Cimmino	CMS
Felicia Fernandez	CMS
Clay Gorton	CMS

Name	Organization
Shaheen Halim	CMS
Jennifer Lindstrom	CMS
Jami Lookabill	CMS
Angelo Pardo	CMS
Charlene Parks	CMS
Barbara Pecoraro	CMS
Kevin Stewart	CMS
christopher wilson	CMS
Rob Sikorski	DaVita
Robin Strange	DaVita
Kevin Day	Edifecs
Julia Sakhnov	Edifecs
leslie allanson	Elevance Health
James Habermann	Epic
Matt McCandless	Epic
Geoff Palka	Epic
Donna Campbell	Health Care Service Corporation
Shannon Loupe	Health Care Service Corporation
CK Pillay	Health Care Service Corporation
Jaishree Nair	HEALTHEDGE
Christopher Gracon	Healthenet
Cari Adams	Humana
Patricia Edmondson	Humana
Emil Del Rosario	Kaiser
William Barba	Kaiser Permanente
Franz Cordero	Kaiser Permanente
David Tran	Kaiser Permanente
Gheisha-Ly Rosario Diaz	Labcorp
Betsy Dunlap	Mayo Clinic
Rebecca Fortek	Mayo Clinic
Christan Hegland	Mayo Clinic

Name	Organization
Michael Herman	Mayo Clinic
Travis Nixa	Mayo Clinic
Kelsey Rolling	Mayo Clinic
Joel Banazek	NAHAM
Juliet Sullivan	NAHAM
Tonia Bateman	New Mexico Oncology Hematology Consultants
Holly Arlofski	Optum
Odianosen Ayewoh	Optum
Evert Ford	Optum
Alka Mukker	Optum
Tara Rose	Optum
Kristin Thonsgaard	Optum
Anna Tymczak	Optum
Marie Becan	PeaceHealth
Shannon Kennedy	Sekhmet Advisors
Diana Fuller	State of Michigan Medicaid
George Hurgeton	Stedi, Inc.
Sean Li	Stedi, Inc.
Nick Radov	Stedi, Inc.
Jamie Schwartz	Stedi, Inc.
Nick Caddell	The SSI Group, LLC.
Jack Pregeant	The SSI Group, LLC.
Tracey Tillman	The SSI Group, LLC.
Terri Cook	UnitedHealthcare
Holly Gilligan	UnitedHealthcare
Kiran Kalluri	UnitedHealthcare
Lynn Conway	University of Iowa College of Dentistry
Nancy Spector	WEDI
Robert Tennant	WEDI
Filip Bortkiewicz	Wells Fargo
Robert Kim	Zuub
Luka Sklizovic	Zuub