



CAQH CØRESM

Review Work Group
Meeting #2

October 23, 2025

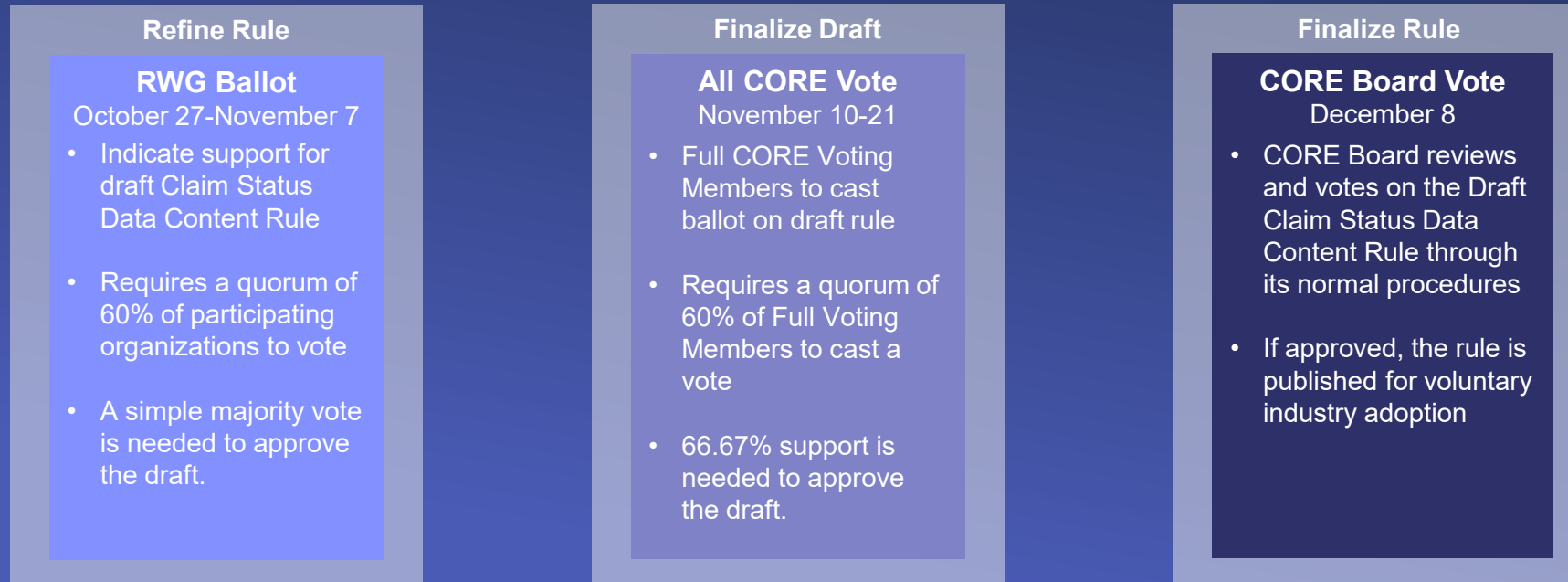
Reviewing Straw Poll #1

October 23rd

- Level Set
- Overview of Straw Poll #1
- Straw Poll #1 Results
- Preparing for RWG Ballot
- Next Steps

Level Set

Next Steps in the Process



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

Overview of Straw Poll #1

Purpose of Straw Poll #1

Straw Poll #1 gathered RWG participating organizations' support level and feedback on the draft rule language sections and companion document:

1. Background Summary
2. Issues to Be Addressed & Business Requirement Justification
3. Scope
4. Technical Requirements
5. CORE-required Claim Status Code Combinations for CORE-defined Claim Status Business Scenarios



OVERVIEW OF STRAW POLL #1

Work Group Submissions

Total Number of Organizational Responses	25 (68%)
Provider/Provider Association Responses	28%
Vendor/Clearinghouse Responses	28%
Health Plan/Health Plan Association Responses	24%
Other Stakeholder Type Responses (includes SDOs)	12%
Government Responses	8%

*Number of CSSG Participating Organizations: 37

Straw Poll #1 Results

STRAW POLL #1 RESULTS

Comment Categorizations

All comments received on Straw Poll #1 were sorted into three categories:

1. **Substantive Comments:** May impact rule requirements; some comments require Work Group discussion on potential adjustments to the draft requirements.
2. **Points of Clarification:** Pertain to areas where more explanation for the Work Group is required; may require adjustments to the rule which do not change rule requirements.
3. **Non-substantive Comments:** Pertain to typographical/grammatical errors, wordsmithing, clarifying language, addition of references; do not impact rule requirements.

All comments are available for offline review in Document #2.

Overall Results

Section	Support	Do Not Support
1: Background Summary	100%	0%
2: Issues to Be Addressed and Business Requirement Justification	91%	9%
3: Scope	83%	17%
4.1: Uniform Use of CORE-Claim Status Business Scenarios with Claim Status Category Codes & Claim Status Codes	85%	15%
4.2: Technical Requirements	82%	18%
4.3: Data Alignment Requirements	64%	36%
4.4: Requirements of Receivers of X12 v5010 277	95%	5%
5: Conformance Requirements	100%	0%
CORE-Required Claim Status Code Combinations for CORE-defined Claim Status Business Scenarios	85%	15%

Section 2: Issues to Be Addressed and Business Requirement Justification

Support	Do Not Support
91%	9%

Substantive Comments

#	Summary of Comment	RWG Co-Chairs & Staff Response
1	One organization stated that there should be no requirement to return code combinations, as this would affect businesses' current adjudication practices. They recommended reviewing the actual reasons during the claim adjudication cycle that led to non-payment, denial, and error scenarios first, as this is where much of the 'inconsistency' in the industry stems.	Do Not Adjust. Feedback from the Claim Status Subgroup and the success of CORE's CARC/RARC combinations highlight the need for better alignment. It is expected that health plans and their agents already review reasons for denied, non-payment, and erroneous claims during their adjudication cycles. The CSCC + CSC combinations help eliminate guesswork regarding the appropriate combination. Additionally, the rule does not require health plans and their agents to use a CORE-defined code combination if the claim does not fit within a Business Scenario, or if the available code combinations within those scenarios do not accurately reflect the claim status.

Point of Clarification

#	Summary of Comment	RWG Co-Chairs & Staff Response
2	One organization commented that Claim Status Category Codes (CSCC) and Claim Status Codes (CSC) are under the purview of X12, not CORE, and their uses are a business decision. The commenter does not agree that they should be included in the operating rule.	While X12 maintains ownership of the CSCC and CSC code sets, it does not prescribe how these codes used are implemented operationally. CORE Operating Rules are designed to complement the X12 standard by offering additional guidance and use-case context that support uniform and consistent implementation across the industry.

Section 3: Scope

Support	Do Not Support
83%	17%

Substantive Comments

#	Summary of Comment	RWG Co-Chairs & Staff Response
1	Two organizations clarified that Loop NM109 does not exist in Loop 2100E.	Adjust. The X12 v5010 276 and 277 transactions do not use the 2100-NM109 and these references will be removed from the draft rule. <i>Note: this applies to all sections of the rule.</i>
2	One organization noted their disagreement for naming the existing CORE Code Combinations Maintenance Process modeled after the maintenance of CARCs and RARCs, stating it does not readily align with the X12 code maintenance process, because some claim status category codes or status codes may cause an issue with codes being added or deactivated.	Do Not Adjust. The maintenance process referenced in the draft rule is not the X12 process for the code sets themselves. CORE's maintenance process for CSCCs and CSCs with the CORE-defined Business Scenarios will mirror the existing process for CARC/RARC combinations and business scenarios. The maintenance process will adapt to accommodate CSCC and CSC combination needs via Compliance-based Adjustments and Market-based Adjustments due to industry changes or adjustments to the code sets. CORE does not have the authority to add or deactivate CSCCs or CSCs. However, CORE works closely with X12 to contribute to the code set maintenance process.

Section 3: Scope

Support	Do Not Support
83%	17%

Points of Clarification

#	Summary of Comment	RWG Co-Chairs & Staff Response
1	One organization asked for clarification for why the Billing Provider is listed instead of the Rendering Provider.	The Claim Status Subgroup identified the Billing Provider as a key matching criterion, whereas the Service Provider may not be as directly relevant for this purpose. The distinction between the types of Billing Providers—whether an individual, an organization, or the same as the Rendering Provider—is not material, as matching is based on the provider's identifying information. Claims can be processed using either provider. CORE will revise the statement to "health plans and their agents should send the provider, rendering or billing, as specified in the claim file."
3	One organization noted that many payers do not perform three-part matches and that enforcing a strict search-and-match hierarchy could lead to performance lags, particularly due to differences between paper and electronic claims.	There is no implied hierarchy across the matching use cases. The rule is written so the use cases are independent of each other.

Section 4.1: Uniform Use of CORE-Claim Status Business Scenarios

Support	Do Not Support
85%	15%

Points of Clarification

#	Summary of Comment	RWG Co-Chairs & Staff Response
1	One organization asked what actions a provider would take in BS #1 vs. BS #2.	BS #1 (approved/will pay): no corrective action; post the 835/EFT when received. BS #2 (approved/adjusted/not denied): typically, no corrective action at status time; post the 835 when received.
2	One organization stated that there is an overlap between BS #3 and BS #5 since they both cover missing information.	Although the language is similar, there is no overlap between the scenarios. The missing information in BS #3 concerns specific claim details rather than adjudication criteria (i.e., the data content). The missing/invalid data in BS #5 refers to data that is simply missing, which prevents the intake of the claim into an adjudication application (i.e., issues with the infrastructure, syntax, format, etc.).
3	One organization asked for clarification between BS #3 and BS #4.	BS #3 outlines denied claims, while BS #4 outlines pended claims. The pended/denied status is communicated via the CSCCs, and the CSCs add further details to specify the status.
4	One organization asked whether BS #4 requires provider action.	BS #4 will require provider action depending on the reason for the pended status. The returned CSCC+CSC will guide whether to supply documentation, verify COB/other payer information, await medical review, etc.
5	Three organizations provided comments on BS #5. • One commented that it is confusing because it refers to claim rejections. • One asked to clarify if errors can be corrected and resubmitted. • One noted that organizations may use different applications for 276/277 and 837, limiting the utility of the scenario.	BS #5 covers two distinct error paths returned via the 277: claim errors and claim-status inquiry (276) errors. It already separates these with two code-combination sets—claim errors maintained by the CORE Code Combinations Task Group and inquiry errors developed by the Claim Status Subgroup. While applications vary in how they handle acknowledgments, the mandated 277 applies across systems and is used to respond to both error types.

Section 4.2: Association and Alignment of Returned Status to Claim and Line

Support	Do Not Support
82%	18%

Substantive Comments

#	Summary of Comment	RWG Co-Chairs & Staff Response
1	One organization recommended amending Section 4.2.4: All entities shall maintain consistency of persistent identifiers across subsequent X12 v5010 277 to “all entities shall give a good faith effort to maintain consistency of persistent identifiers across subsequent X12 v5010 277 responses for the same claim, including, at a minimum, the patient control number and the payer claim control number, to preserve a stable association over time.”	Adjust. CORE will update the language from <i>shall</i> to <i>should</i> .

Point of Clarification

#	Summary of Comment	RWG Co-Chairs & Staff Response
2	Three organizations asked for clarity around “claim-level” and “line-level.” - Two asked if and how an entity can return line-level detail in addition to a claim-level status. - Another suggested information specifying how downstream systems should display statuses when one claim line is finalized and another is pended.	Per section 1.4.3.2 of the TR3, “When service lines within a claim have various statuses (example both pending and finalized), a single status must be reflected at the claim level and the service specific statuses must be reported at the service level (2220D or 2220E).” Display requirements are up to the health plan and its agent to properly display claim and/or line-level statuses and make them clear to the provider/end user.

STRAW POLL #1 RESULTS

Section 4.3: Data Alignment Requirements

Support	Do Not Support
64%	36%

Substantive Comments

#	Summary of Comment	RWG Co-Chairs & Staff Response
1	Four organizations provided comments on the Payer Claim Control Number. Two noted challenges of requiring the Payer Claim Control Number for RA and payment matching are that it would require formatting the 276 transaction differently when payment information is available. They suggested relying solely on the Patient Control Number, which is listed under claim-matching details.	For RWG Discussion. The RWG should consider the following options: 1. Update the Payer Claim Control Number from a required to a recommended data element. 2. Add Patient Control Number as a required data element. 3. Make both data elements recommended and allow organizations to choose the most appropriate one, with at least one being required.
2	Three organizations noted reasoning for not supporting Patient Name and Name Normalization requirements. One noted that the 276/277 has other data elements that hold more value. Another noted that the name has already been accepted early in the revenue cycle and changing it to meet the Name Normalization requirements may result in missing a match.	Agree. Patient Name will be a <u>recommended</u> data element, and Name Normalization will be <u>removed</u> from the draft rule.

STRAW POLL #1 RESULTS

Section 4.3: Data Alignment Requirements

Support	Do Not Support
64%	36%

Points of Clarification

#	Summary of Comment	RWG Co-Chairs & Staff Response
1	Four organizations recommended more clarity around the “required” versus “recommendation” designation of Data Elements for each use case.	Agree. The purpose of the “required” versus “recommended” designation refers to the Data Element’s use as matching criteria in each scenario and does not override or contradict the X12 TR3. Clarifying language will be added to the draft rule.
2	One organization asked whether a segment/element is required in the X12 276/277 Implementation Guide and whether it should be exempt from the CORE operating rule. Another organization asked how Data Elements should be used when matches occur without all Data Elements.	An inquiry match should be considered successful even if not all matching criteria Data Elements are used. Once a match is achieved, health plans and their agents are not required to continue matching against additional Data Elements, and they should not fail an inquiry simply because some matching criteria are missing. It is important to note that this clarification does not override or contradict the X12 TR3 regarding the required or situational Data Elements in the transaction. In this context, “Required” and “Recommended” refer to the use of Data Elements as matching criteria in each scenario.

Next Steps

Next Steps

Complete RWG Ballot

October 27-November 7

- Indicate your organization's level of support for the draft rule language
 - Requires a quorum of **60%** of participating organizations to vote
 - A simple majority vote is needed to approve the draft

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

Appendix

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
Muhammed 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
Iakisha 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	Healthnet
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
Odianos 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

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