Claim Status Data Content Operating Rule FAQs

General

1. **What is the value to industry of the CORE Claim Status (276/277) Data Content Rule?**

   The CORE Claim Status (276/277) Data Content Operating Rule provides consistent, actionable claim status data, allowing health plans, providers, and vendors to automate more of the revenue cycle and spend less time interpreting vague responses. Specifically, it standardizes the use of Claim Status Category Code (CSCC) and Claim Status Code (CSC) combinations through CORE-defined Claim Status Business Scenarios, thereby reducing variability and discouraging the use of proprietary codes. It also defines minimum request and response data to improve patient and claim matching—resulting in fewer "claim not found" outcomes and single, clearly identifiable matches—and adds payment-linkage elements to expedite accounts receivable (AR) reconciliation when a paid status is received. The result is lower administrative costs, fewer provider inquiries, faster issue resolution, improved cash flow, and more accurate, timely billing, which benefits health plans, providers, vendors, and patients.

2. **Can proprietary codes be used in addition to CSCC+CSC combinations? Presumably, the proprietary code will provide more detail as to the claim's status and more specific next steps for Information Receivers.**

   As currently written, proprietary codes returned to Information Receivers would not conflict with the operating rule. The operating rule discourages the use of proprietary codes but does not prohibit them if the CSCC + CSC combinations are still used in the appropriate Business Scenarios (i.e., used in addition to).

   Section 2.2 - "This rule discourages the use of proprietary claim status codes. Any codes used must not conflict with or override the CSCC and CSC sets defined by X12 and Business Scenarios defined by CORE."

3. **What date should organizations use when implementing the operating rule (date of implementation/go-live, date of federal mandate, CORE certification date, etc.)?**

   The implementation date should align with the date on which an organization goes-lives with the operating rule (i.e., voluntarily adopts it) or the date the operating rule is required (i.e., the date it becomes federally mandated).

CORE-required Claim Status Code Combinations for the CORE-defined Claim Status Business Scenarios

4. How were the CORE-defined Claim Status Business Scenarios created?

The CORE-defined Claim Status Business Scenarios are grounded in industry standards, mirroring the messaging currently communicated by the Claim Status Category Codes (CSCC) returned in the X12 277, to allow for consistent and clear claim status communication across the industry. Each of the five CORE-defined Claim Status Business Scenarios are mapped to the corresponding CSCCs. This approach ensures that any CORE-defined Business Scenarios align with standardized codes, providing clarity to health plans, providers, and vendors while reducing ambiguity and supporting automation.

CORE-defined Claim Status Business Scenario	Alignment to Claim Status Category Codes
Claim Finalized: Payment will be made	• **Finalized (F Codes)** • F0: Finalized – Completed Adjudication • F1: Finalized/Payment – Claim Paid
Claim Finalized: No payment will be made	• **Finalized (F Codes)** • F3: Finalized/Revised – Adjudication Information has Changed
Claim Denied: No payment will be made	• **Finalized (F Codes)** • F2: Finalized/Denial – Claim Denied
Claim Pended	• **Pended (P Codes)** • P1: Pending/In Process • P2: Pending/Payer Review • P3: Pending/Provider Requested Information • P4: Pending/Patient Request Information
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

5. Can an organization use code combinations outside of the CORE-required Claim Status Code Combinations for the CORE-defined Claim Status Business Scenarios?

Yes. Organizations can use Claim Status Category Codes (CSCC) and Claim Status Codes (CSC) that are not in the CORE-required Claim Status Code Combinations for the CORE-defined Claim Status Business Scenarios. For example, if the status of a claim does not fall into one of the five CORE-defined Claim Status Business

Scenarios, organizations may return a unique combination. The CSCC and CSC combinations of the CORE-defined Claim Status Business Scenarios are a minimum set.

6. **Do organizations need to use all CORE-required Claim Status Code Combinations for the CORE-defined Claim Status Business Scenarios listed?**

   No. Organizations are not required to use all CORE-required Claim Status Code Combinations. Organizations should select the code combinations that clearly articulate the claim status and pertain to them.

   How will the CORE-required Claim Status Code Combinations for the CORE-defined Claim Status Business Scenarios be updated?

   CORE's maintenance process for Claim Status Category Codes (CSCC) and Claim Status Codes (CSC) with the CORE-defined Claim Status Business Scenarios will mirror the existing process for Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (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, driven by industry changes or updates to the code sets.

   CORE does not have the authority to add, edit, or deactivate CSCCs or CSCs. However, CORE works closely with X12 to support the maintenance of these code sets.

7. **Can an organization use more than one Claim Status Code (CSC) with a Claim Status Category Code (CSCC) within a CORE-defined Claim Status Business Scenario?**

   Organizations are encouraged to use multiple CSCs to provide more detail about a claim's status. Multi-CSC combinations (e.g., more than one CSC in STC01, STC10, or STC11) are permissible per the X12 TR3 §1.4.3.1.

   For example, CSCC P3 and CSC 297 can be supplemented with CSC 345.

   - P3 - Pending/Provider Requested Information - The claim or encounter is waiting for information that has already been requested from the provider. (Usage: A Claim Status Code identifying the type of information requested, must be reported)
   - 297 - Medical notes/report.
   - 345 - Treatment plan for service/diagnosis

8. **Can an organization use multi-segment combinations within a CORE-defined Claim Status Business Scenario?**

   Yes. Multi-STC segment combinations (e.g., use of STC01, STC10, and STC11) are permissible per the X12 TR3 §1.4.3.1.

9. **What Entity Code should an organization use?**

   Organizations should select the most appropriate Entity Code from the X12 v5010 276/277 TR3 internal code sets; CORE will not prescribe the entity (payer, provider, patient, etc.) for a given claim. CORE encourages the use of Entity Codes even when the CSC does not require it.

10. **What is a pended claim?**

    Pended claims encompass a range of scenarios. Based on the definitions of the P-type Claim Status Category Codes (CSCC), a pended claim is one without a remittance advice, partially paid, suspended for review, undergoing adjudication, or under a system or administrative hold.

11. **Do organizations need to back-date their configuration when implementing the CORE-defined Business Scenarios or align with any type of date (date of service, date of claim, date claim received, calendar date, etc.)?**

    Organizations do not need to back-date configuration changes. The effective date of system changes should align with the date on which an organization goes-lives with the operating rule (i.e., voluntarily adopts it) or the date the operating rule is required (i.e., the date it becomes federally mandated).

<u>Matching Use Cases/Data Alignment</u>

12. **Do organizations need to perform three-part matches on Patient Search & Match Criteria, Claim Matching, and Remittance Advice & Check/Payment Matching?**

    Organizations must follow the data element guidance (requirement or recommendation) for each use case. There is no implied hierarchy across the matching use cases. The rule is written so the use cases operate independently of each other or in any combination with another.

13. **What Provider Identifier should be used for matching if multiple are available?**

    Organizations should select the same provider (billing or rendering) that was transmitted in the claim file.

14. **When performing claim matching, should a match "fail" if all Data Elements are not present?**

    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.

15. **Why are Check Number and Check Data included in the X12 277?**

    The purpose of including remittance advice (RA) information in the X12 277 is to communicate it as quickly as possible to providers and their agents. CORE research has shown that organizations want as much information regarding claim adjudication as soon as possible.

16. **How should organizations display claim statuses?**

    Display requirements are up to the health plan and its agent to properly display claim statuses and make them clear to the provider/end user.

17. **What is meant by "requirement" and "recommendation" in the context of the matching use cases? Do "requirement" and "recommendation" contradict or override the Data Element's usage in the X12 v5010 276/277 TR3?**

    The purpose of the "requirement" versus "recommended" designation refers to the Data Element's use as matching criteria in each use case and does not override or contradict the X12 v5010 276/277 TR3. All implementation instructions of the X12 v5010 276/277 TR3 must be followed.