Draft CORE Claim Status Data Content Operating Rule

Contents at-a-glance

Draft CORE Health Claim Status Data Content Operating Rule

- NEW Draft CORE Claim Status Data Content Rule vCS1.0
- NEW Draft CORE-required Claim Status Code Combinations for CORE-defined Claim Status Business Scenarios

X12 Submission Methods

- X12 005010 276: Health Care Claim Status Request
- X12 005010 277: Health Care Claim Status Response

Draft CORE Claim Status (276/277) Data Content Rule	
Scope	This rule applies when any HIPAA-covered entity or its agent uses, conducts, or processes the X12 v5010 276/277 claim status transaction to report a rejection, payment, denial, or pending status of a claim or a claim status request by a health plan or its agent from a pre-adjudication or adjudication system.
CORE-defined Business Scenarios	Standardizes the use of Claim Status Category Code (CSCC) and Claim Status Code (CSC) combinations in the X12 277 Health Care Claim Status Response through five CORE-defined Business Scenarios to establish actionable next steps for health plans and providers. **CORE-defined Claim Status Business Scenarios:** 1. Claim Finalized – Payment Will Be Made 2. Claim Finalized – No Payment Will Be Made 3. Claim Denied – Not Payment Will Be Made 4. Claim Pended 5. Errors
Data Alignment Requirements	Minimum Set of data elements to improve match rates, reduce "claim not found" responses, and enable earlier, actionable follow-up across three use cases: Patient Search & Match Criteria, Claim Matching, and Remittance Advice & Check/Payment Matching. ▪ **Patient Search & Match Criteria** – 276 Data Elements: 1. Patient Date of Birth (requirement) 2. Patient Gender Code (recommendation) 3. Patient Last Name (recommendation) 4. Patient First Name (recommendation) 5. Subscriber ID (requirement) – 277 Data Elements: 1. Patient Last Name (recommendation) 2. Patient First Name (recommendation) 3. Subscriber ID (requirement) ▪ **Claim Matching** – 276 Data Elements: 1. Provider Name/ID Code (recommendation) 2. Payer Claim Control Number (requirement*) 3. Patient Control Number (requirement*) 4. Claim Identification for Clearinghouses and Other Transmission Intermediaries (recommendation) 5. Claim Service Date (recommendation) – 277 Data Elements: 1. Provider Name/ID Code (recommendation) 2. Payer Claim Control Number (requirement*) 3. Patient Control Number (requirement*) 4. Claim Identification for Clearinghouses and Other Transmission Intermediaries (recommendation) 5. Claim Service Date (recommendation) ▪ **Remittance Advice & Check/Payment Matching** – 276 Data Elements: 1. Provider Name/ID Code (recommendation) 2. Payer Claim Control Number (requirement*) 3. Patient Control Number (requirement*) 4. Total Claim Charge Amount (recommendation) – 277 Data Elements: 1. Provider Name/ID Code (recommendation) 2. Payer Claim Control Number (requirement*) 3. Claim Payment Amount (recommendation) 4. Check Date (requirement**) 5. Check Number (requirement**) 6. Payer Control Number (requirement*) 7. Patient Control Number (requirement*) * Requirement: must use either the Payer Claim Control Number, Patient Claim Control Number, or Both. ** Requirement: must be returned if known at the time of the request.

Provides greater clarity in claim status requests and responses to streamline administrative processes, reduce interpretation burden, minimize avoidable outreach, address rework earlier in the adjudication process, and accelerate cash flow.