

**CAQH Committee on Operating Rules for Information Exchange (CORE)
Review Work Group (RWG)
Straw Poll #1: Reviewing and Refining the Draft Claim Status Data Content Operating
Rule**

Non-Substantive Comments Received on RWG Straw Poll #1

I. Overview & Purpose

The Review Work Group (RWG) launched in September 2024 to review and refine the draft Claim Status Data Content Operating Rule requirements developed by the CORE Claim Status Subgroup (CSSG) earlier in the year. The RWG's review of the draft rule is a critical step in the CORE Voting Process. It requires a formal ballot with a quorum of 60% of participating organizations and a simple majority approval.

This Straw Poll gathers RWG participants' support level and feedback on the draft rule language. It also offers an opportunity for RWG participants to suggest edits to the draft Claim Status Data Content Rule requirements before the RWG Ballot, which will seek approval for the operating rule.

II. Non-Substantive Comments Received on Straw Poll #1

Section	Summary of Comment	RWG Co-Chairs & CORE Staff Response
1: Background Summary	One organization commented that status return messages should include additional information regarding whether a claim is denied and/or pended.	Denied and Pended status is communicated from the Information Source to the Information Receiver via the Claim Status Category Codes (CSCCs). The Claim Status Codes (CSCs) provide additional details for pended or denied status.
	One organization recommended including language in the background summary that clearly states the current X12 277 response codes are often inadequate for guiding provider workflow decisions. This is a key reason stakeholders support standardizing more detailed, context-specific code combinations.	Agree. CORE will add this language to Section 3: Scope.
2: Issues to Be Addressed and Business Requirement Justification	One organization noted that spaces were missing.	Agree. CORE will add the spaces.
	One organization commented that internal business rules define the claim adjudication reason codes that organizations chose to use.	Unique business rules create confusion among providers. The intent of the Claim Status Data Content Operating Rule is to standardize code combinations to create a common foundation for organizations to work from.
	One organization recommended adding language to the rule to distinguish CARC+RARC and CSCC+CSC combinations more clearly.	Clarification will be provided in an FAQ.
	One organization commented that references to the 835 transaction cause confusion.	No references to the 835 transaction exist in the draft rule.
	One organization recommended restating the benefits of aligning 276 and 277 transactions with consistent business scenarios and minimum code combinations to reinforce industry support for reducing ambiguity and improving the automation of follow-up actions.	Disagree. The benefits are already stated in Sections 2.2. and 3.1 of the draft rule.

**CAQH Committee on Operating Rules for Information Exchange (CORE)
Review Work Group (RWG)
Straw Poll #1: Reviewing and Refining the Draft Claim Status Data Content Operating Rule**

Section	Summary of Comment	RWG Co-Chairs & CORE Staff Response
	One organization commented that they do not support requiring Patient Name or Name Normalization.	Patient Name will be recommended and Name Normalization will be removed from the draft rule.
3: Scope	One organization noted that Provider Name would be in NM103, NM104, NM105 & NM107, not just NM103.	Agree. However, the operating rule reflects the required Data Element for the provider's name, regardless if that provider is an individual or an organization. The TR3 contains the specific situational rules for NM104, NM105, and NM107.
	One organization asked for clarification regarding the reference to "and after v3070."	"And after v3070" refers to X12 standard version 7030 and subsequent versions.
	One organization asked for examples of each use case scenario.	Examples will be provided as part of FAQs that accompany the operating rule.
	One organization asked to consolidate the loops and segments tables.	The table formatting mirrors CORE operating rules.
	One organization recommended several edits and clarifications: - Clarification that the rule does not govern claims attachments or appeals processes. - Strengthening language to confirm that the rule does not require specific proprietary codes and any codes used must not conflict or override the standardized code sets defined by X12 and CORE. - Adding a link to the CARCs, RARCs, CSCCs, and CSCs. - Adding a reference to entity code usage guidance for code combinations that require an entity qualifier.	Agree. Clarifying language will be added. Agree. Clarifying language will be provided as part of FAQs that accompany the operating rule. Links are provided in footnotes of the draft rule. Agree. Clarifying language will be provided as part of FAQs that accompany the operating rule.
	One organization clarified that "Claim Submitted Amount" is "Total Claim Charge Amount" in the X12 TR3 and the rule should match.	Agree. Language will be updated in the draft rule.
	One organization noted that Section 3.7 Abbreviations and Definitions does not include abbreviations.	N/A
	One organization recommended adding that compliance is only necessary if the transaction is mandated.	While compliance with all CORE operating rules is only necessary for those mandated by HHS, this rule builds upon other CORE operating rules, and it is assumed the implementers are using all CORE operating rules as a unified ecosystem.
4.1: Uniform Use of CORE-Claim Status Business Scenarios with Claim Status Category Codes &	One organization asked for clarification on a clearinghouse if a payer does not comply with the rule requirements.	Until the operating rule is federally mandated, organizations are not required to comply with the rule. Only organizations that wish to be CORE Certified will need to comply.
	One organization said the scenarios don't specify the next steps providers/plans should take, even though Sections 2.1 and 3.1 state that the CSCC+CSC combinations "clearly direct" next steps.	Agree. The CSCC + CSC combinations decided upon by the subgroup are more detailed and actionable compared to other CSCs. The CSCs contain information on the action the provider or health plan should take. That action may vary across entities due to a

**CAQH Committee on Operating Rules for Information Exchange (CORE)
Review Work Group (RWG)
Straw Poll #1: Reviewing and Refining the Draft Claim Status Data Content Operating
Rule**

Section	Summary of Comment	RWG Co-Chairs & CORE Staff Response
Claim Status Codes		multitude of factors (including, but not limited to, service types provided, payer mix, internal adjudication processes, internal AR/denial management processes, etc.).
	One organization recommended adding clarifying language on how additional CSCC+CSC will be used beyond the required CORE-required code combinations. They also suggested adding language that additional combinations should remain consistent with the definitions outlined in the Business Scenarios.	Agree. Language is already present in Section 4.1.2.
4.2: Technical Requirements	Two organizations noted a spelling error with an extra 's' on line 234.	Agree.
	One organization commented that there is a reference to 4.2.5 but that section is not in the draft rule.	There is no Section 4.2.5 nor any reference to it in the draft rule.
	One organization recommended adding the payer address or another applicable identifier since some provider offices used a shared tax ID.	The Data Elements have been agreed upon by the Subgroup as the best set to use.
4.3: Data Alignment Requirements	One organization noted their non-support for gender.	Gender is a recommended data element and is not required.
	One organization commented that check matching is a business decision.	If a health plan or their agent knows the check data and check number when a claim status inquiry is received, they should communicate both on the 277.
	One organization noted that 4.3.2.3.4.1 should be 4.3.2.3.4.2.	Agree.
	One organization asked for clarity on which use case is for Patient Search & Match Criteria and how it differs from Claim Matching.	Patient Search & Match refers to a health plan or their agent locating a patient in their database for claim status inquiries. More details will be added to define this use case. Claim Matching refers to matching the claim.
	One organization noted that a v5017 reference should be v5010.	Agree.
	One organization asked for clarification on how recurring data-mismatch issues should be flagged for resolution, and recommended language that encourages health plans and their agents to provide tooling or automated reconciliation reports for high-volume submitters to reduce friction in downstream claim edits proactively.	It is up to the health plan and their agents to determine how to best flag mismatches.
	Two organizations commented on Check Date and Check Number. One noted that they are situationally known, depending on whether the claim was completed in the revenue cycle. Another commented that Check Matching is a business decision.	If a health plan or their agent knows the check date and check number when a claim status inquiry is received, they should communicate both on the 277.
4.4: Requirements for Receivers of X12 v5010	One organization asked what "appropriately available" means	"Appropriately available" refers to the display of the 277 response data to Information Receiver end users. To make the 277 response data useful and accessible to end users, the

**CAQH Committee on Operating Rules for Information Exchange (CORE)
Review Work Group (RWG)
Straw Poll #1: Reviewing and Refining the Draft Claim Status Data Content Operating
Rule**

Section	Summary of Comment	RWG Co-Chairs & CORE Staff Response
277 Responses		Information Receiver must determine the appropriate method to display the data (dashboard, widget, or report vs the natural 277 file for example).
	One organization noted that line 348 should refer to a 277 response rather than a 276.	Agree.
	One organization recommended stronger wording to encourage receivers to acknowledge and normalize CSCC+CSC in a manner consistent with the CORE-defined Business Scenarios.	Sections 2.1 and 4.1 provide context and justification for CSCC+CSC and their associated Business Scenarios.
	One organization asked for clarity on whether receivers are responsible for passing forward additional payer-specific	