CAQH CORE℠

Claim Status Data Content Subgroup Meeting #2

April 3, 2025

Standardizing Code Combinations Through Business Scenarios

CAQH CORE SM

CLAIM STATUS DATA CONTENT SUBGROUP MEETING #2

April 3

- Level Set
- Co-chair Introductions
- Scope
- Industry Challenges: Current Claim Status Reporting
- Business Scenarios & Examples of Code Combinations
- Overview of Code Combinations Maintenance Process
- Preparing for Straw Poll #1
- Next Steps

Level Set

Claim Status Subgroup Charter

Purpose

The CSSG will develop a **Claim Status Data Content Rule** by the end of 2025 that overcome current challenges, such as data misalignment and inconsistent coding.

Scope

Initial opportunities for rule development include:

1. **Standardize Code Combinations**: Standardize Claim Status Codes (CSC) and Claim Status Category Codes (CSCC) combinations through business scenarios.
2. **Data alignment**: Standardize the data exchanged within the Claim Status transaction and require additional specificity in certain error responses.
3. **Real-time claim status processing**: Align on a set of best practices that provide a real-time claim status response.

The Subgroup may consider additional opportunities as they arise.

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.

Timeline

Introduction

Call #1
March 6

- Summary of CORE work on Claim Status.
- Review CCSG workplan and participant expectations.

Opportunity Area 1: Code Combinations

Call #2
April 3

- Discuss potential rule requirements for code combinations.
- Orient CSSG to Straw Poll #1.

Straw Poll #1
April 7-25

- Collect feedback on draft CORE-defined Business Scenarios and corresponding CORE Code Combinations.

Call #3
May 22

- Review Straw Poll results.
- Finalize draft language for code combinations.

Opportunity Area 2: Data Alignment

Call #4
July 10

- Discuss potential data alignment rule requirements.
- Orient CSSG to Straw Poll #2.

Straw Poll #2
July 14-25

- Collect feedback on draft data alignment rule requirements.

Call #5
August 7

- Review Straw Poll results.
- Finalize draft data alignment rule requirements.

Opportunity Area 3: Real-time Claim Status Processing

Call #6
September 4

- Discuss potential rule requirements for real-time claim status processing.
- Orient CSSG to Straw Poll #3.

Straw Poll #3
September 15-26

- Collect feedback on draft real-time claim status processing rule requirements.

Call #7
October 9

- Review Straw Poll results.
- Finalize draft language for real-time claim status processing.

Finalize Draft

Ballot
September 22-October 3

- Approve draft Claim Status Data Content Rule to forward to CORE Review Work Group.

Claim Status Data Content Rule Review & Finalization

Review Work Group & Ballot
TBD

- Review and agree to draft Claim Status Data Content Rule requirements.

Final CORE VOTE
TBD

- Full CORE Voting Members agree to draft Claim Status Data Content Rule.

CORE Board Vote
TBD

- CORE Board votes to finalize Claim Status Data Content Rule for voluntary industry adoption.

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

Co-chair Introductions

CORE Claim Status Data Content Subgroup Co-chairs

Tyler Scheid

Lead Policy Analyst
American Medical Association (AMA)

LinkedIn

Kristin Thonsgaard

Manager, Industry Affairs
Optum

LinkedIn

Scope

SCOPE

Issues to be Addressed

- **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

- **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

Industry Challenges

Current Claim Status Reporting

Challenges with Current Claim Status Reporting

The results of CORE's environmental scan showed challenges with claim status for all parties involved.

- **Confusing & Contradictory Responses:** The same claim scenario may be coded differently by different payers, leading to provider uncertainty and increasing vendor system complexity.
- **Increased Administrative Burden:** Providers must manually interpret claim responses, leading to phone calls and manual follow-ups, which create high volumes of inquiries to payers.
- **Lack of Standardization:** Different health plans use varying combinations of claim status category code and claim status code combinations, making automation and interoperability difficult for providers, vendors, and payers.
- **Delayed Claim Processing & Payments:** Errors in claim status reporting slow down resolution, delay provider reimbursement, increase payer inefficiencies, and adds complexity for clearinghouses.
- **Lack of Clear Mapping to Business Scenarios:** Providers struggle to determine whether a claim is finalized, pended, denied, or contains an error – or even what the error is.
- **Duplicate Claim Submissions:** Without a clear response, providers may resubmit claims unnecessarily, increasing workload for both payers and providers.

INDUSTRY CHALLENGES

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.

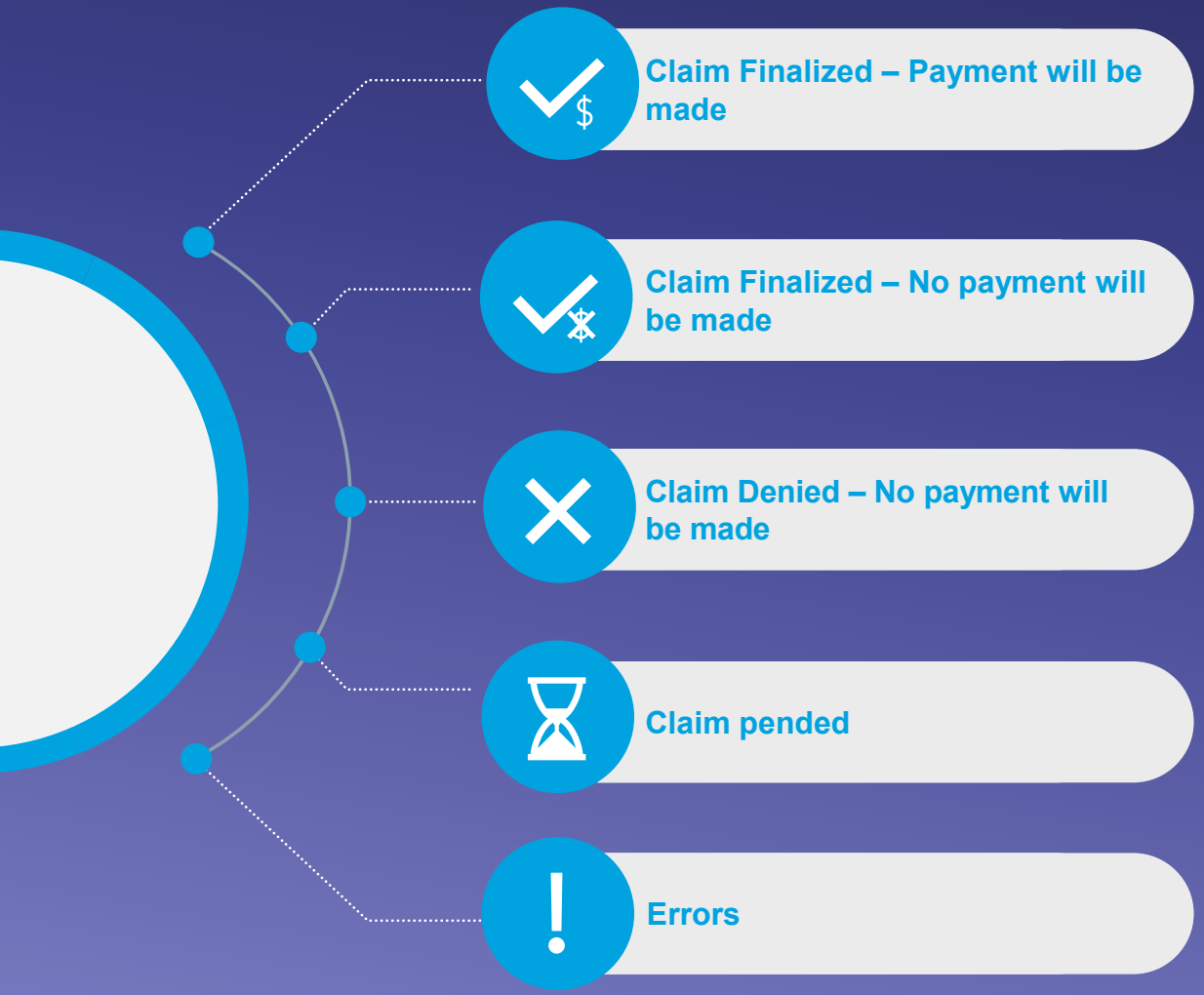
Faster Resolutions: Clear claim statuses allow for **immediate next steps**, reducing delays.

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.

Business Scenarios & Examples of Code Combinations

CORE-Defined Business Scenarios



- CORE identified five primary business scenarios that capture the most common claim status outcomes.
- Each scenario maps to a set of claim status category codes and claim status codes.
- These mappings help providers easily interpret claim statuses across multiple health plans without, or with minimal, manual intervention.
- *CSCC + CSC combinations already present in CORE Claim Acknowledgement (277CA) Data Content Rule*

BUSINESS SCENARIOS

5 CORE-Defined Business Scenarios

Business Scenario	Description	Example Code Combination
1. Claim Finalized: Payment will be made	Provider submits a claim, the claim is accepted into the adjudication system, and the payer confirms that payment is approved.	**F0** – Finalized. The claim/encounter has completed the adjudication cycle and no more action will be taken. **3** – Claim has been adjudicated and is awaiting payment cycle.
2. Claim Finalized: No payment will be made	Provider submits a claim, the claim is accepted into the adjudication system, the claim has been processed, but the payer determines no payment is due.	**F3F** – Finalized/Forwarded. The claim/encounter processing has been completed. Any applicable payment has been made and the claim/encounter has been forwarded to a subsequent entity as identified on the original claim or in this payer's records. **16** – Claim/encounter has been forwarded to entity. Usage: This code requires use of an Entity Code.
3. Claim Denied: No payment will be made	Provider submits a claim, the claim is accepted into the adjudication system, and payer confirms that payment is not approved; e.g., due to missing information or non-covered services.	**F2** – Finalized/Denial. The claim/line has been denied. **84** – Service not authorized.
4. Claim Pended	Provider submits a claim, the claim is accepted into the adjudication system, and the payer pends the claim for review; e.g., due to medical necessity, prior authorization, or additional validation.	**P0** – Pending: Adjudication/Details. This is a generic message about a pended claim. A pended claim is one for which no remittance advice has been issued, or only part of the claim has been paid. **37** – Predetermination is on file, awaiting completion of services.
5. Errors	Provider submits a claim, but the claim was rejected and not accepted into the adjudication systems due to formatting issues, missing, or incomplete required data elements.	**A3** – Acknowledgement/Returned as unprocessable claim. The claim/encounter has been rejected and has not been entered into the adjudication system. **0** – Cannot provide further status electronically.

Example

This combination by itself is helpful, but does not provide sufficient detail to understand the issue:

- CSCC F2 – Finalized/Denial. The claim/line has been denied.
- CSC 297 – Medical notes/report.

This combination is limiting:

- Are the medical notes missing in their entirety, i.e., the health plan did not receive them?
- Is there a portion of the medical notes missing, i.e., the health plan received the notes, but the relevant, needed portion or information is not included?
- Were the medical notes submitted by the provider, but the health plan cannot open the attachment, associate them with the claim in question, etc.?
- Does the health plan need a specific type of medical notes or report? If so, which one, or type?

However, the addition of another CSC can provide more specificity to make the information actionable:

- CSC 287 – Medical necessity for service.
  In this scenario, the provider can better understand the reasoning behind the determination of the denial; e.g., the medical notes did not substantiate medical necessity.

Discussion:

Which of these business scenarios do you encounter most frequently, and how do inconsistencies in claim status codes impact your workflow?

What improvements do you think standardization could bring to your organization?

Overview of Code Combinations Maintenance Process

Industry Collaboration

36 organizations collaborate in the CORE Code Combinations Task Group to facilitate **essential uniformity** in how healthcare payment adjustments are communicated, **reducing abrasion** between health plans and providers by avoiding **time-consuming and costly follow-up**. This effort allows focus to be maintained where it belongs – **on the patient**.

Member Impact

18 leading health plans representing 79% of covered lives, including national plans, regional Blues, state Medicaid agencies, and federal healthcare programs

Provider Engagement

5 provider organizations, including associations representing over 270,000 providers

Vendor Support

10 technology vendors from electronic health records, clearinghouses, integration platforms, and revenue cycle solutions

SDO Coordination

3 standards development organizations and advisory bodies provided critical guidance to align rule development with industry standards to maximize chance of adoption

CORE Participants have convened since **2011** to engage in the maintenance of the mandated CORE Operating Rule.

June 2011

v3.0.0 of *CORE Code Combos published*

January 2014

Industry stakeholders required to comply with mandated CORE ERA & EFT Operating Rules

October 2024

V3.8.3 of *CORE Code Combos* published containing 1,905 required CARC and CARC and RARC code combinations

March 2025

Expansion of duties to the maintenance of *CORE Error Code Combinations* for the X12 277CA

CORE Code Combinations Task Group

The CORE Code Combinations Task Group (CCTG) meets a minimum of 3 times per year to consider the impacts of updates to relevant published code lists.

CORE Code Combinations (835)

- Maintained since the publishing of the mandated, CORE Uniform Use of CARCs and RARCs Operating Rule in 2011
- Considers updates to the CARC and RARC lists
- Standardizes combinations of CARC + RARC + CAGC codes for uniform use within CORE-defined Business Scenarios

CORE Error Code Combinations (277CA)

- Maintenance began March 2025 after the publishing of the voluntary CORE Claim Acknowledgement Data Content Rule in 2024.
- Considers updates to the Claim Status Category Code and Claim Status Code lists
- Standardizes combinations of CSCC + CSC codes for uniform use within CORE-defined Claim Rejection Business Scenarios.

Potential CORE Claim Status Code Combinations (277)

Industry Impact

Empowers the Patient

Enhanced patient experience by reducing billing errors, allowing for **accurate statements through timely account balancing**.

Enables the Focus on Care

Clinicians spend more time on patient care and less on administrative tasks, thanks to fewer, more **predictable claim denials along with clear payment and remittance**.

Improves Workflow Automation

Code standardization enhances workflow automation by ensuring consistency, reducing errors, and improving interoperability. This predictability enables accurate, actionable follow-ups.

Strengthens Trust in the Healthcare System

CORE Code Combinations provide consistent, reliable transparency improving billing **processes**, **reducing manual claim inquiries**, **and minimizing claim rework.**

If you are interested in joining the CORE Code Combinations Task Group, reach out to Tanner Fuchs, Senior Associate at tfuchs@caqh.org

Preparing for Straw Poll #1

Overview

Purpose:

Gather input on the five CORE-defined Business Scenarios and proposed Claim Status Category Codes (CSCC) and Claim Status Codes (CSC) combinations

Format:

This straw poll consists of five sections:

1. Scope & Applicability
2. CORE-defined Business Scenarios
3. Code Combinations & Maintenance Process
4. Value & Feasibility
5. Future Rule Development Opportunities

Please submit your organization's response via the online submission link by **the end of the day on Friday, April 25th**

Next Steps

Next Steps

Complete Straw Poll #1
April 7-25

- Indicate your organization's level of support for the five CORE-defined Business Scenarios & Code Combinations.
- Submit your organization's Straw Poll by the end of the day, Friday April 25th.

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

Claim Status Subgroup Roster

Name	Organization
Mark Rabuffo	Aetna
Rose Hodges	Aetna
Rebekah Fiehn	American Dental Association
Andrea Preisler	American Hospital Association
Celine Lefebvre	American Medical Association
Emma Andelson	American Medical Association
Heather McComas	American Medical Association
Rob Otten	American Medical Association
Tyler Scheid	American Medical Association
Muhamed Cesko	athenahealth
Leah Barber	Availity
Gail Kocher	Blue Cross Blue Shield Association
Sal Zarate	Blue Cross Blue Shield of North Carolina
Jamie Osborne	Children's Healthcare of Atlanta
Rob Sikorski	DaVita
Robin Strange	DaVita
Leslie Allanson	Elevance Health
Geoff Palka	Epic
James Habermann	Epic
Matt McCandless	Epic
Christopher Gracon	Healthenet
Cari Adams	Humana
Patricia Edmondson	Humana
Gheisha-Ly Rosario Diaz	Labcorp

Name	Organization
Betsy Dunlap	Mayo Clinic
Christan Hegland	Mayo Clinic
Kelsey Rolling	Mayo Clinic
Rebecca Fortek	Mayo Clinic
Travis Nixa	Mayo Clinic
Alka Mukker	Optum
Anna Tymczak	Optum
Holly Arlofski	Optum
Kristin Thonsgaard	Optum
Odianosen Ayewoh	Optum
Tara Rose	Optum
Marie Becan	PeaceHealth
Shannon Kennedy	Sekhmet Advisors
Diana Fuller	State of Michigan Medicaid
George Hurgeton	Stedi, Inc.
Nick Radov	Stedi, Inc.
Jack Pregeant	The SSI Group
Tracey Tillman	The SSI Group
Nick Caddell	The SSI Group
Holly Gilligan	UnitedHealthcare
Kiran Kalluri	UnitedHealthcare
Sonya May	UnitedHealthcare
Terri Cook	UnitedHealthcare
Robert Tennant	WEDI

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. Please review these ahead of time, whenever possible. Reach out to CORE for any questions or clarification.

Participate in Straw Polls

All Participating Organizations are expected to complete all Straw Polls throughout the rule development process. Note that organizations may have multiple participants in the Subgroup, 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 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 Executive Sponsor informed about the Subgroup's progress. If your organization has representation on the CORE Board, please keep your representative informed about the draft rule requirements.

CORE Code Combinations Task Group

The CORE Code Combinations Task Group (CCTG) meets a minimum of 3 times per year to consider the impacts of updates to relevant published code lists.

Activity	Timeframe
March Compliance-based Review Cycle	March 1st – June 1st
July Compliance-based Review Cycle	July 1st – October 1st
Annual Market-based Review Cycle	Q3
November Compliance-based Review Cycle	November 1st – February 1st

Task Group Co-chaired by:

AMA AMERICAN MEDICAL ASSOCIATION

CVS Health | aetna

United Healthcare

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