CAQH CORE℠

Claim Status Data Content Subgroup Meeting #3

May 22, 2025

Standardizing Code Combinations Through Business Scenarios

CAQH CORE℠

CLAIM STATUS DATA CONTENT SUBGROUP MEETING #3

May 22

- Level Set
- Overview of Straw Poll #1
- Review Straw Poll Results & Proposed Updates to Draft Rule Language
- Preparing for Straw Poll #2
- 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

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.

Straw Poll #2
June 9-27

- Collect feedback on draft CORE-defined Business Scenarios and corresponding CORE 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 #3
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 #4
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.

Overview of Straw Poll #1

Standardizing Code Combinations through Business Scenarios

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.

Purpose of Straw Poll

Straw Poll #1 gathered CSSG participants' input on the five draft **CORE-defined Claim Status Business Scenarios** and **proposed Claim Status Category Codes (CSCC) + Claim Status Codes (CSC) Claim Status Code Combinations** that would form the foundation of standardized claim status communications across the X12 v5010 277 transaction.

Straw Poll #1 consisted of five sections:

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

Subgroup Submissions

Total Number of Organizational Responses	20 (74%)
Provider/Provider Association Responses	**35%**
Vendor/Clearinghouse Responses	**25%**
Health Plan/Health Plan Association Responses	**20%**
Other Stakeholder Type Responses (includes SDOs)	**15%**
Government Responses	**5%**
*Number of CSSG Participating Organizations: 27	

Review Straw Poll #1 Results

Summary of substantive comments and points of clarification received and proposed updated draft language

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.

Section 1: Scope & Applicability

Rule Section Scope and Issues to be Addressed

Does your organization agree with the proposed scope and applicability of the rule?

Yes, fully agree	Yes, with minor suggestions	Neutral/Need more information	No, significant objections or concerns
63%	28%	5%	5%

Substantive Comments

#	Comment	CORE CSSG Co-chair & Staff Response
1	Three organizations recommended adding the following as Applicable Loops, Segments, and Data Elements: • 2200E-STC01-01 and 2200E-STC01-02 • 2200E-STC10-01 and 2200E-STC10-02 • 2200E-STC11-01 and 2200E-STC11-02 • 2220E-STC01-01 and 2220E-STC01-02 • 2220E-STC10-01 and 2220E-STC10-02 • 2220E-STC11-01 and 2220E-STC11-02	**Agree**. STC segments in the 2200E and 2220E loops will be added to the Applicable Loops, Segments, and Data Elements in the Scope of the rule.
2	One entity made three recommendations: clarify multi-segment combinations in the X12 277 (e.g., dual CSCs in STC 01/10/11), include options for JSON/FHIR-rendered formats, and encourage the use of secondary CSCs to resolve ambiguity.	**Agree**. CORE will undertake industry education on multi-segment combinations and use of secondary CSCs as outlined in the X12 TR3 Section 1.4.3.1. Rendering the 276/277 in other formats will also be considered.

*Support level percentages may not add up exactly to 100 due to rounding.

Rule Section Scope and Issues to be Addressed

Does your organization agree with the proposed scope and applicability of the rule?

Yes, fully agree	Yes, with minor suggestions	Neutral/Need more information	No, significant objections or concerns
63%	28%	5%	5%

Points of Clarification

#	Comment	CORE CSSG Co-chair & Staff Response
3	One organization asked for more specificity in instances where terminology is vague.	**Agree**. CORE will revise language for clarity.

*Support level percentages may not add up exactly to 100 due to rounding.

Proposed Updates to Draft Rule Language

- **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
13. 2200E-STC01-01 and 2200E-STC01-02
14. 2200E-STC10-01 and 2200E-STC10-02
15. 2200E-STC11-01 and 2200E-STC11-02
16. 2220E-STC01-01 and 2220E-STC01-02
17. 2220E-STC10-01 and 2220E-STC10-02
18. 2220E-STC11-01 and 2220E-STC11-02

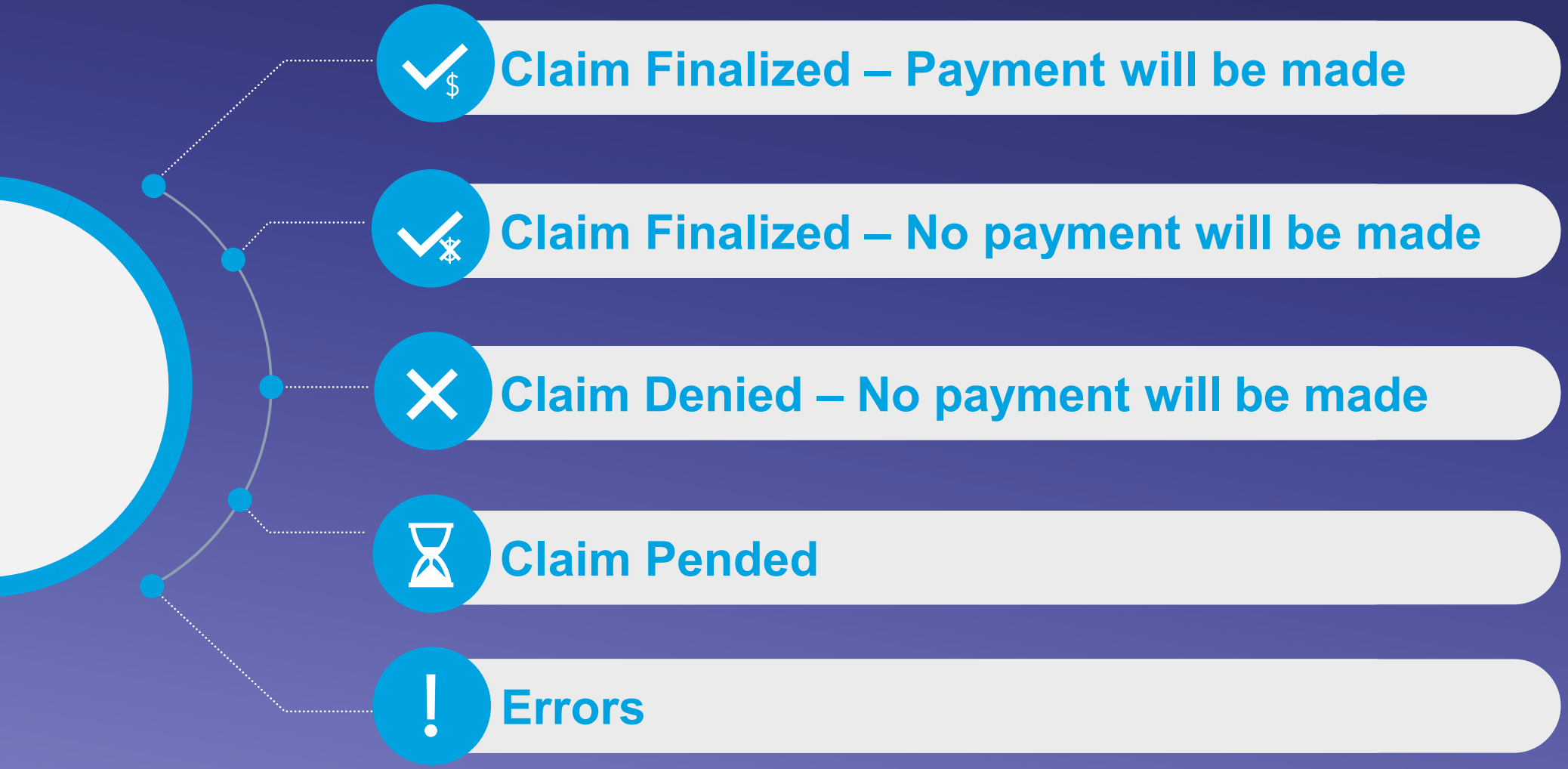
- **Who It Impacts**: Health plans, providers, clearinghouses, and vendors processing claim status transactions.

- **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

CORE will also undertake industry education on key elements in the X12 TR3 and issue FAQs on elements that need additional clarification.

Section 2: CORE-defined Claim Status Business Scenarios

CORE-Defined Claim Status Business Scenarios

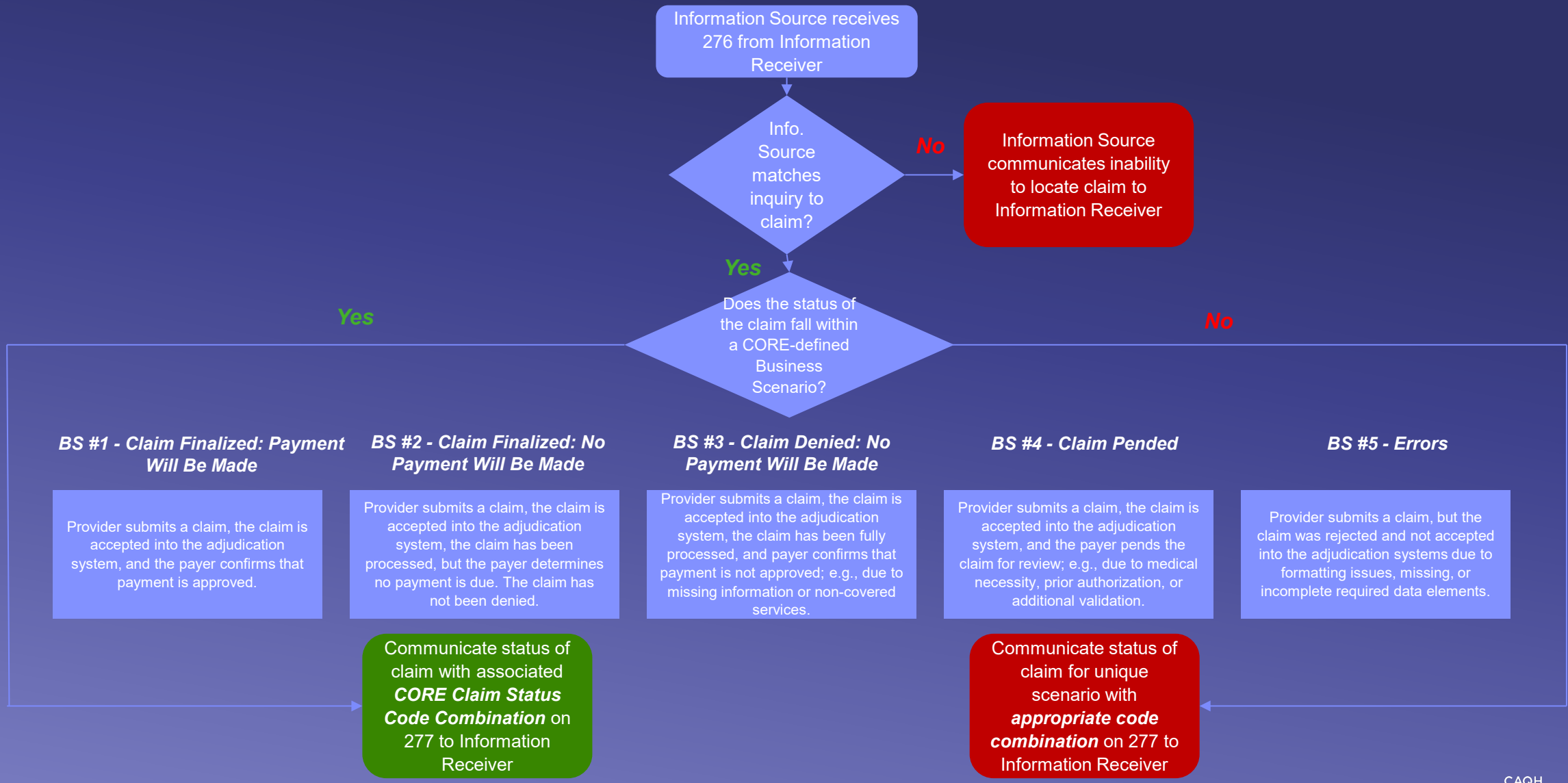


Business Scenarios Development

The first step in developing Claim Status Category Code (CSCC) + Claim Status Code (CSC) combinations was identifying the appropriate "business scenarios" to prioritize for industry alignment. Based on industry research and previous CORE code standardization work, ***CORE is recommending using the X12 CSCCs returned on the X12 277 to outline common business scenarios for claim status communication.***

Draft CORE-defined Claim Status Business Scenario	Alignment to X12 Claim Status Category Codes
1. Claim Finalized: Payment will be made	**Finalized (F Codes)** • F0: Finalized – Completed Adjudication • F1: Finalized/Payment – Claim Paid
2. Claim Finalized: No payment will be made	**Finalized (F Codes)** • F3: Finalized/Revised – Adjudication Information has Changed
3. Claim Denied: No payment will be made	**Finalized (F Codes)** • F2: Finalized/Denial – Claim Denied
4. Claim Pended	**Pended (P Codes)** • P1: Pending/In Process • P2: Pending/Payer Review • P3: Pending/Provider Requested Information • P4: Pending/Patient Request Information
5. 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

Business Scenario Usage



Business Scenario 1: Claim Finalized – Payment Will Be Made

Does your organization support this business scenario?

Support	Neutral	Do Not Support
84%	11%	5%

Substantive Comments

#	Comment	CORE CSSG Co-chair & Staff Response
1	One entity recommended updating the description to specify that payment may be for only some portion of the claim with other claim lines denied.	**Do not agree**. Partial payments are covered as pended claims, as defined by the P type CSCs. This will be clarified as part of guidance.
2	Two entities suggested replacing “paid” with “approved” or “allowed” to account for scenarios where no actual payment is issued (e.g., amounts applied to deductibles or covered by PLBs).	**Do not agree.** Business Scenario 1 aligns with the F CSCCs. If no direct payment is issued, payers should use appropriate CSCs (e.g., CSC 98 or CSC 101) to indicate payment application or adjustment. This will be clarified as part of guidance.

Business Scenario 2: Claim Finalized – No Payment Will Be Made

Does your organization support this business scenario?

Support	Neutral	Do Not Support
58%	16%	26%

Substantive Comments

#	Comment	CORE CSSG Co-chair & Staff Response
1	One entity suggested that this Business Scenario is not needed.	**Do not agree**. This Business Scenario is necessary as it reflects a full claim adjustment, such as for non-covered charges, payer determinations, or penalties.
2	One entity suggested greater clarification around non-payment scenarios that are not denials, such as capitated services where payment responsibility was met outside of the claim and claims that were fully forwarded to another payer without current payment liability.	**Agree**. Greater clarity will be included in an updated description of the Business Scenario.

Point of Clarification

#	Comment	CORE CSSG Co-chair & Staff Response
3	Three entities questioned whether this Business Scenario is distinct enough from #1: Claim Finalized-Payment will be made and #3: Claim Denied-No payment will be made.	Business Scenario #1 is for claim that were *fully paid* while Business Scenario #2 is the result of an *adjustment*, and Business scenario 3 is a result of a *denial*. Any claims that were *partially paid* are covered in Business Scenario #4: Claim Pended, as defined by the P type CSCs. This will be clarified as part of guidance and revised business scenario descriptions.

Business Scenario 3: Claim Denied – No Payment Will Be Made

Does your organization support this business scenario?

Support	Neutral	Do Not Support
74%	21%	5%

Substantive Comments

#	Comment	CORE CSSG Co-chair & Staff Response
1	Two entities suggested updating the description to state that the claim was accepted, processed, and finalized, but no payment is approved, implying that the current Business Scenario may be too rigid to communicate nuanced claim outcomes.	**Agree**. Greater clarity will be included in an updated description of the Business Scenario.

Point of Clarification

#	Comment	CORE CSSG Co-chair & Staff Response
2	Three entities asked for greater clarity regarding missing information: one entity asked if the response will appropriately identify the missing information and two entities asked if this reflects a pended claim required submitter action or a finalized denial due to insufficient information.	In this Business Scenario, the missing or invalid information results in a finalized *denied* claim, not a pended one. CSC 21 is used in combination with another CSC to specify the missing or invalid information. If the claim were pended while awaiting additional information, it would be represented under Business Scenario #4: Claim Pended. This will be clarified as part of guidance.

Business Scenario 4: Claim Pended

Does your organization support this business scenario?

Support	Neutral	Do Not Support
89%	0%	11%

Substantive Comments

#	Comment	CORE CSSG Co-chair & Staff Response
1	Two entities recommended breaking this Business Scenario into two subtypes, such as clinical and administrative, or based on whether provider action is required. Differentiating claims that require provider follow up (e.g., documentation requests) from those under internal payer review (e.g., audits) may help reduce unnecessary outreach and clarify next steps for providers.	**Do Not Adjust**. This Business Scenario could be broken into two distinct subtypes but may present additional challenges as a single CSCC+CSC combination can be applied to multiple clinical or administrative actions and may not uniquely identify whether the action is on the payer or provider. As permitted in Section 1.4.3.1 in the X12 TR3, payers should respond using multiple CSCs and clearly indicate the appropriate entity in the STC segment. CORE will continue to liaise with X12 to support more consistent and meaningful use of existing codes.

Business Scenario 5: Errors

Does your organization support this business scenario?

Support	Neutral	Do Not Support
68%	5%	26%

Substantive Comments

#	Comment	CORE CSSG Co-chair & Staff Response
1	Two entities suggested updating this Business Scenario to reflect when the claim status request has been rejected, rather than the claim.	This will be clarified as part of guidance and revised descriptions.
2	Three entities noted that their expectation that information would be returned on the 277CA: one entity noted they would expect the A3 message to be returned on the 277CA for claim rejections and that if a claim status request is submitted for a claim that was rejected, they would expect an A4 (not found) response. Another entity commented that the current scenarios do not account for up-front rejections that occur before a claim enters the adjudication system, which would typically be communicated via a 277CA. One entity noted that claim rejections are generally sent via the 277CA.	**Agree.** The CSCC and CSC combinations are also used in the 277CA – CAQH CORE has published an operating rule for specific business scenarios for this transaction. Those under consideration for this draft rule for the 276/277, Business Scenario #5, allow for those organizations using the 276/277 to communicate these types of errors, too. The 277CA is not a HIPAA mandated transaction, using these combinations in the 276/277 supports provider needs to better understand the reason for when the claim was received but may not make it to the full adjudication cycle. Through periodic Compliance and Market Based Reviews, industry will have the opportunity to revise the code combinations to meet evolving business needs through time.
3	One entity noted that the scenario appropriately addresses hard rejections, but recommended enhancements for claim re-entry workflows, such as asking payers to specify the exact field or segment triggering the rejection, mapping CSCs to a remediation checklist or field path, and issuing guidance or a flag to indicate whether a claim can be resubmitted as-is.	**Agree**. CORE will provide industry guidance and work with industry to identify best practices and workflow improvements to reduce administrative burden due to the lack of clarity in claim rejection detail and resubmission processes.

*Support level percentages may not add up exactly to 100 due to rounding.

Additional Business Scenarios

#	Proposed Business Scenario	CORE CSSG Co-chair & Staff Response
1	**Claim in Progress**: provider submits a claim, the claim is accepted into the adjudication system, and the claim is in progress. • This scenario would help differentiate between claims that are “stuck” from claims that are progressing as normal • Examples: P1 + 40 for claim in progress, P3 + 297 for claim pended for provider action, and P2 + 46 for claim pended for payer action	**Do Not Adjust**. Business Scenario #4: Claim Pended could be broken into distinct subtypes but may present additional challenges as a single CSCC+CSC combination can be applied to multiple scenarios. The description of Business Scenario #4 can be updated to clarify that pended claims include claims that are suspended awaiting review.
2	**Loopback Request**: claim requires additional clarification before adjudication can proceed. • This scenario captures claims that were received by the payer but cannot progress through adjudication due to non-terminal issues that require clarification or corrected documentation from the provider. • Examples: A3 + 192 for Claim un-processable due to missing attachment control number, A3 + 27 for claim not found—likely due to incorrect ID or formatting issues, F2 + 297 for medical notes received but not linked or usable, A7 + 125 for submission incomplete; payer awaits clarification or corrected data	**Do Not Adjust**. Business Scenario #4: Claim Pended could be broken into distinct subtypes but may present additional challenges as a single CSCC+CSC combination can be applied to multiple scenarios. The description of Business Scenario #4 can be updated to clarify that pended claims include claims that are suspended awaiting further documentation.
3	**Claim Not Accepted**: claim not accepted into adjudication system. • This scenario encompasses situations where a claim has not been accepted into the adjudication system, but not due to errors covered by Business Scenario 5: Errors.	**Do Not Adjust**. Business Scenario #5: Errors could be broken into distinct subtypes but may present additional challenges as a single CSCC+CSC combination can be applied to multiple scenarios. The description of Business Scenario #5 includes claims that were not accepted into the adjudication system. Claim Acknowledgement scenarios currently address these situations.

Proposed Updates to Draft Rule Language

Business Scenario	Description
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.
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. The claim has not been denied.
3. Claim Denied: No payment will be made	Provider submits a claim, the claim is accepted into the adjudication system, the claim has been fully processed, and payer confirms that payment is not approved; e.g., due to missing information or non-covered services.
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. No remittance advice has been issued or only part of the claim has been paid. Pended claims can also include claims suspended and awaiting review.
5. Errors	Provider submits a claim, but the claim was rejected and not accepted into the adjudication system due to formatting issues, missing, or incomplete required data elements.

CORE will also undertake industry education on key elements in the X12 TR3 and issue FAQs on elements that need additional clarification.

Section 3: Code Combinations & Maintenance Process

Claim Status Code Combinations

Does your organization support the draft CSCC + CSC code combinations listed for this scenario?

Business Scenario	Support Level	Polling %
1. Claim Finalized—Payment will be made	Support	53%
	Partially	5%
	Do Not Support	42%
2. Claim Finalized—No payment will be made	Support	42%
	Partially	11%
	Do Not Support	47%
3. Claim Denied—No payment will be made	Support	47%
	Partially	11%
	Do Not Support	42%
4. Claim Pended	Support	53%
	Partially	11%
	Do Not Support	37%
5. Errors	Support	53%
	Partially	16%
	Do Not Support	32%

All code combination level feedback received on the CSSC + CSC combinations will be included on Straw Poll #2

*Support level percentages may not add up exactly to 100 due to rounding.

Claim Status Code Combinations

Does your organization support the draft CSCC + CSC code combinations listed for this scenario?

Summary of Comments

#	Summary of Comments	CORE CSSG Co-chair & Staff Response
1	**Code Usage** • Questions about the appropriateness of certain CSCC+CSC code combinations • Concerns over exhaustiveness and specificity of codes • Requests for changes to support more clarity and accuracy.	• CSSG Co-chairs and staff will provide an updated list of code combinations on Straw Poll #2 that includes suggested edits. • The CSSG will consider making the code sets a set of best practices to use rather than a rigid set – the floor not the ceiling for use. • CORE will undertake industry education on use of code sets and work with X12 on potential edits to codes for greater clarity and accuracy.
2	**Claim Status Workflows** • Confusion around which status messages apply at different claim lifecycle stages • Requests for clearer differentiation between full versus partial claims, rejections versus denials, and provider versus health plan action • Request for workflows or diagrams to visually map out expected responses	• CORE will undertake industry education on key elements of the X12 TR3, specifically noting that multiple CSCs can be used to communicate layered status information. • The CSSG will consider adding field-level detail (e.g., segment/loop references) to indicate who must act. • The CSSG will consider developing workflows or diagrams to map out expected responses.
3	**Guidance** • Request for example use cases or field-level specificity • Suggestion to link CSCs to detailed data paths (e.g., Loop/Segment references) • Greater clarity of terms used	• CORE will undertake industry guidance and define all terms used in the operating rule.

Defining Role of Claim Status Code Combinations

Should the sets of code combinations be defined set or a set of best practices?

Require implementers to use **only** the combinations listed in the rule for these specific business scenarios; other proprietary business scenarios are out of scope for the rule. (i.e., a defined set)	Treat the listed combinations as best practices, allowing implementers to use additional combinations if needed (i.e., a floor, not a ceiling)	Not Sure/Need More Discussion
32%	53%	16%

Substantive Comments

#	Comment	CORE CSSG Co-chair & Staff Response
1	One entity recommended a “required floor, optional ceiling” hybrid approach where a minimum core set of code combinations will be required for use, but implementers may go beyond the minimum set to support flexibility, innovation, and complex or unique situations.	**For Subgroup Discussion**. Should the code set be a “required floor, optional ceiling” approach?
2	Three entities expressed concerns over making the list the only allowable combinations to use because it would be too rigid and unrealistic to accommodate real-life scenarios.	**Agree**.
3	One entity encouraged CORE to work with X12 on the codes before making the code sets mandatory.	CORE will continue to liaise with X12 to support more consistent and meaningful use of existing codes.

*Support level percentages may not add up exactly to 100 due to rounding.

Benefits of Hybrid “Required Floor, Optional Ceiling” Approach

- ✓ Balances structure with flexibility by allowing multiple combinations per scenario
- ✓ Supports diverse stakeholder needs through a mix of standardized and optional codes
- ✓ Addresses concerns about rigidity by clarifying that lists are **not exclusive**
- ✓ Enables the inclusion of new and revised code combinations as industry needs evolve
- ✓ Allows refinement of scenarios (e.g., splitting or combining as appropriate)
- ✓ Accommodates overlapping workflows between 276/277 and 277CA transactions
- ✓ Supports the use of **multiple CSCs** for clearer, more actionable responses

For Subgroup Discussion: Does this approach meet your organization’s operational and system needs?

Claim Status Code Combinations Maintenance

Does your organization support using the CORE Code Combinations Maintenance process?

Results

Support Level	Polling %
Yes, this is an appropriate and effective approach	63%
Yes, but we have suggestions for improvement	32%
No, we recommend a different approach	0%
Neutral/Need More Information	5%

Suggestions Provided in Comments

1. **Strengthen Collaboration**
   - Recommend closer coordination with X12 to ensure appropriate use of codes and to avoid incomplete combinations
   - Include claim status experts in the CORE Code Combinations Task Group
   - Add specialty-specific (e.g., dental) discussions in the CORE Code Combinations Task Group to address unique use cases

2. **Evolve and Expand Code Maintenance Process**
   - Create a baseline review cycle beyond X12 updates to reflect real-world operations
   - Include field-level and loop/segment mapping to enhance automation
   - Publish industry usage metrics for transparency and refinement
   - Strengthen provider representation, especially among small/medium-sized organizations
   - Offer FHIR/JSON mapping prototypes to support modern standards and interoperability.

Proposed Updated to Draft Rule Language

Minimum Required Set:
The Claim Status Category Code (CSCC) and Claim Status Code (CSC) combinations specified in this rule represent the **minimum required data set** for industry use. These combinations are established as **best practice** to promote consistency and improve clarity in claim status responses across trading partners. Entities are required to use these code combinations when they report the status of a claim that falls within one of the CORE-defined business scenarios; however, entities may use **additional CSCC+CSC combinations** beyond those specified, as needed, to meet specific **business or workflow requirements**, provided such usage remains compliant with the applicable implementation guides and trading partner agreements.

Code Maintenance:
To ensure consistency, sustainability, and responsiveness to industry needs, CORE will maintain the standardized **CSCC + CSC code combinations** through its existing **CORE Code Combinations Maintenance Process**. This process is modeled after the well-established maintenance of the CORE-required CARC + RARC combinations and is designed to:

- Incorporate updates to external code lists (e.g., X12 Code Source 507 and 508)
- Review draft combinations in the context of CORE-defined business scenarios
- Address changes in payer or provider workflows, policy updates, or regulatory shifts
- Support a transparent, consensus-based approach to updates

This process will maintain CSCC + CSC combinations associated with the Claim Status Data Content Rule, ensuring they remain current and aligned with evolving business needs.

CORE will also undertake industry education on key elements in the X12 TR3 and issue FAQs on elements that need additional clarification.

Preparing for Straw Poll #2

Overview

Purpose:

Review updates and provide level of support 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 three sections:

1. CORE-defined Claim Status Business Scenarios & Additional Scenarios
2. Claim Status Code Combinations
3. Future Rule Development Opportunities

Please submit your organization's response via the online submission link by **the end of the day on Friday, June 27th**

Next Steps

Next Steps

Complete Straw Poll #2
June 9-27

- Indicate your organization's level of support for the updated draft language for the CORE-defined Business Scenarios & Code Combinations.
- Submit your organization's Straw Poll by the end of the day, Friday June 27th.

- 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.