# Claim Status Data Content Subgroup

# Meeting #1

March 6, 2025

**March 6**

- CORE Overview
- Subgroup Expectations
- Co-chair Introductions
- Environmental Scan & 2024 CAQH Index Report Findings
- Overview of Opportunity Areas
  - 1: Error Code Standardization
  - 2: Transaction Data Alignment
  - 3: Real-time Data Exchange
- Next Steps


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# CORE Overview


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# CORE facilitates an industry-driven, consensus-based process to advance interoperability

**Operating Rule Definition:** The "necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications."

| Patient Encounter is Scheduled | Patient Encounter Occurs | Provider Submits Claim | Health Plan Adjudicates Claim | Provider is Paid by Health Plan | Management of Health Plan Membership |
|---|---|---|---|---|---|
| **Eligibility & Benefits*** <br> **Attributed Patient Roster** | **Prior Authorization & Referrals** | **Health Care Claims** | **Claim Status*** | **Payment & Remittance*** | **Benefit Enrollment** <br> **Premium Payment** |

**Rule Set Contains Federally Mandated Operating Rules*


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# CORE: Who We Are

## Committee on Operating Rules for Information Exchange

### ENSURING REPRESENTATION

**100+**

**Multi-stakeholder Participating Organizations**

From small provider organizations, to national health plans, CORE has the **unique ability to bring diverse industry stakeholders to the table** to tackle complex administrative problems together.

### LEADING INDUSTRY

**10**

**CORE Operating Rules Mandated Under HIPAA**

CORE is a **trusted and independent operating rule author**. In addition to mandated operating rules, CORE offers operating rule sets for voluntary adoption.

### REDUCING BURDEN

**$46B**

**Annual Industry Cost Savings Attributed to CORE Operating Rules**

Using CAQH Index® data, CAQH Insights identified annual savings of $26 billion for providers and $20 billion for health plans resulting from the implementation of the mandated **CORE Operating Rules**.


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# CORE Participating Organizations

## Government

- Arizona Health Care Cost Containment System
- California Department of Health Care Services
- Centers for Medicare and Medicaid Services (CMS)
- Federal Reserve Bank of Atlanta
- Florida Agency for Health Care Administration
- Health Plan of San Joaquin
- Michigan Department of Community Health
- Minnesota Department of Health
- Minnesota Department of Human Services
- Missouri HealthNet Division
- North Dakota Medicaid
- Oregon Department of Human Services
- Oregon Health Authority
- Pennsylvania Department of Public Welfare
- TRICARE
- United States Department of Treasury Financial Management
- United States Department of Veterans Affairs

## Health Plans

- Aetna
- Ameritas Life Insurance Corp.
- AultCare
- Blue Cross and Blue Shield Association (BCBSA)
- Blue Cross Blue Shield of Michigan
- Blue Cross Blue Shield of North Carolina
- Blue Cross Blue Shield of Tennessee
- CareFirst BlueCross BlueShield
- Centene Corporation
- CIGNA
- Elevance Health
- Health Care Service Corp
- Horizon Blue Cross Blue Shield of New Jersey
- Humana
- Medical Mutual of Ohio, Inc.
- Point32Health
- UnitedHealthGroup

## Integrated Plan/Provider

- Highmark Health (Highmark, Inc.)
- Kaiser Permanente
- Marshfield Clinic/Security Health Plan of Wisconsin, Inc.

**Account for 75% of Total American Covered Lives**

## Vendors & Clearinghouses

- AIM Specialty Health
- athenahealth
- Availity, LLC
- Cerner/Healthcare Data Exchange
- Change Healthcare
- ClaimMD
- Cloud Software Group
- Cognizant
- Conduent
- CSRA
- DentalXChange
- DXC Technology
- Edifecs
- Epic
- Experian
- Healthedge Software Inc
- HEALTHeNET
- HMS
- Infocrossing LLC
- InstaMed
- Lassie
- MCG Health
- NantHealth NaviNet
- NextGen Healthcare Information Systems, Inc.
- OptumInsight
- PaySpan
- PNC Bank
- PriorAuthNow
- SS&C Health
- Stedi, Inc.
- Surescripts
- The SSI Group, Inc.
- TriZetto Corporation, A Cognizant Company
- Utah Health Information Network (UHIN)
- Wells Fargo
- Zelis

## Providers

- American Hospital Association (AHA)
- American Medical Association (AMA)
- Aspen Dental Management, Inc.
- Children's Healthcare of Atlanta Inc
- DaVita Kidney Care
- Greater New York Hospital Association (GNYHA)
- Healthcare Financial Management Association (HFMA)
- Laboratory Corporation of America
- Mayo Clinic
- Medical Group Management Association (MGMA)
- Montefiore Medical Center
- New Mexico Cancer Center
- OhioHealth
- Peace Health
- St. Joseph's Health
- Virginia Mason Medical Center

## Other

- American Dental Association
- ASC X12
- Cognosante
- Healthcare Business Management Association
- HL7
- NACHA The Electronic Payments Association
- National Association of Healthcare Access Management (NAHAM)
- National Association of Health Data Organizations (NAHDO)
- National Committee for Quality Assurance (NCQA)
- National Council for Prescription Drug Programs (NCPDP)
- National Dental EDI Council (NDEDIC)
- New England HealthCare Exchange Network (NEHEN)
- Preferra Insurance Company Risk Retention Group
- Sekhmet Advisors
- Tata Consultancy Services Ltd
- Utilization Review Accreditation Commission (URAC)
- Work Group for Electronic Data Interchange (WEDI)


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# Diverse representation among participants













BlueCross BlueShield
of North Carolina







BlueCross®
BlueShield®






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CAQH

# Subgroup Expectations


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# 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 Error Code Combinations**: Standardize Claim Status Codes (CSC) and Claim Status Category Codes (CSCC) 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.


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# Operating Rule Development Process

*We are here*

## Level 1:
Claim Status Data Content Subgroup

Subgroups develop draft operating rule language.

Formal vote is not required, but **consensus is assessed** via straw polls and must be achieved prior to moving to the next level of voting.

## Level 2:
Review Work Group

Work Groups review and refine draft operating rule language.

Work Groups **require for a quorum that 60% of organizational participants vote in the final ballot**. Simple majority vote (greater than 50%) by this quorum is needed to approve a rule.

## Level 3:
Full Voting Membership

The Full CORE Vote allows for all Full CORE Voting organizations to vote on the draft operating rule.

The Full CORE Vote **requires a quorum of 60% of all Full CORE Voting Member organizations** vote on the proposed rule at this stage. **With a quorum, 66.67%** support is needed to approve a rule.

## Level 4:
CORE Board

The CORE Board reviews and votes through its **normal procedures on the draft rule.**

If approved, the rule is formally published and available for industry adoption.


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# 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 11

- 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.*


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# 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.


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# Co-chair Introductions


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# CORE Claim Status Data Content Subgroup Co-chairs

**Emma Andelson**
Lead Policy Analyst
*American Medical Association (AMA)*
*(Filling in for Tyler Scheid)*

**Kristen Thonsgaard**
Manager, Industry Affairs
*Optum*


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# Environmental Scan & 2024 CAQH Index Report Findings


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# Claim Status Environmental Scan Methodology

## Detailed Literature Review:

- ✓ Companion guides
- ✓ Best practices
- ✓ Transaction standards
- ✓ Thought leadership

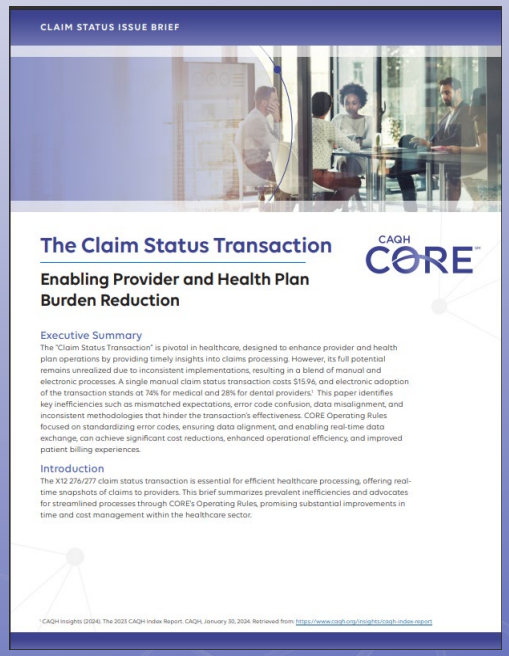
## 20+ Interviews:

- ✓ Commercial health plans
- ✓ Government health plans
- ✓ Providers
- ✓ Clearinghouses
- ✓ Practice Management Systems

## Quantitative Analysis:

- ✓ Claim Status Data, including:
  - ➢ X12 276/277
  - ➢ X12 277CA
  - ➢ X12 277RFAI

*"Historical inefficiencies in claim status transactions highlight the urgent need for standardization and automation to alleviate the administrative burden on the healthcare system."*


CLAIM STATUS ISSUE BRIEF

The Claim Status Transaction

CAQH CORE

Enabling Provider and Health Plan Burden Reduction

Executive Summary

The "Claim Status Transaction" is pivotal in healthcare, designed to enhance provider and health plan operations by providing timely insights into claims processing. However, its full potential remains unrealized due to inconsistent implementations, resulting in a blend of manual and electronic processes. A single manual claim status transaction costs $15.96, and electronic adoption of the transaction stands at 74% for medical and 28% for dental providers.[1] This paper identifies key inefficiencies such as mismatched expectations, error code confusion, data misalignment, and inconsistent methodologies that hinder the transaction's effectiveness. CORE Operating Rules focused on standardizing error codes, ensuring data alignment, and enabling real-time data exchange, can achieve significant cost reductions, enhanced operational efficiency, and improved patient billing experiences.

Introduction

The X12 276/277 claim status transaction is essential for efficient healthcare processing, offering real-time snapshots of claims to providers. This brief summarizes prevalent inefficiencies and advocates for streamlined processes through CORE's Operating Rules, promising substantial improvements in time and cost management within the healthcare sector.

[1] CAQH Insights (2024). The 2023 CAQH Index Report. CAQH, January 30, 2024. Retrieved from https://www.caqh.org/insights/caqh-index-report

CORE recently published an issue brief highlighting current challenges, opportunities, and potential solutions; calling the industry to action.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# 2024 CAQH Index Report Findings

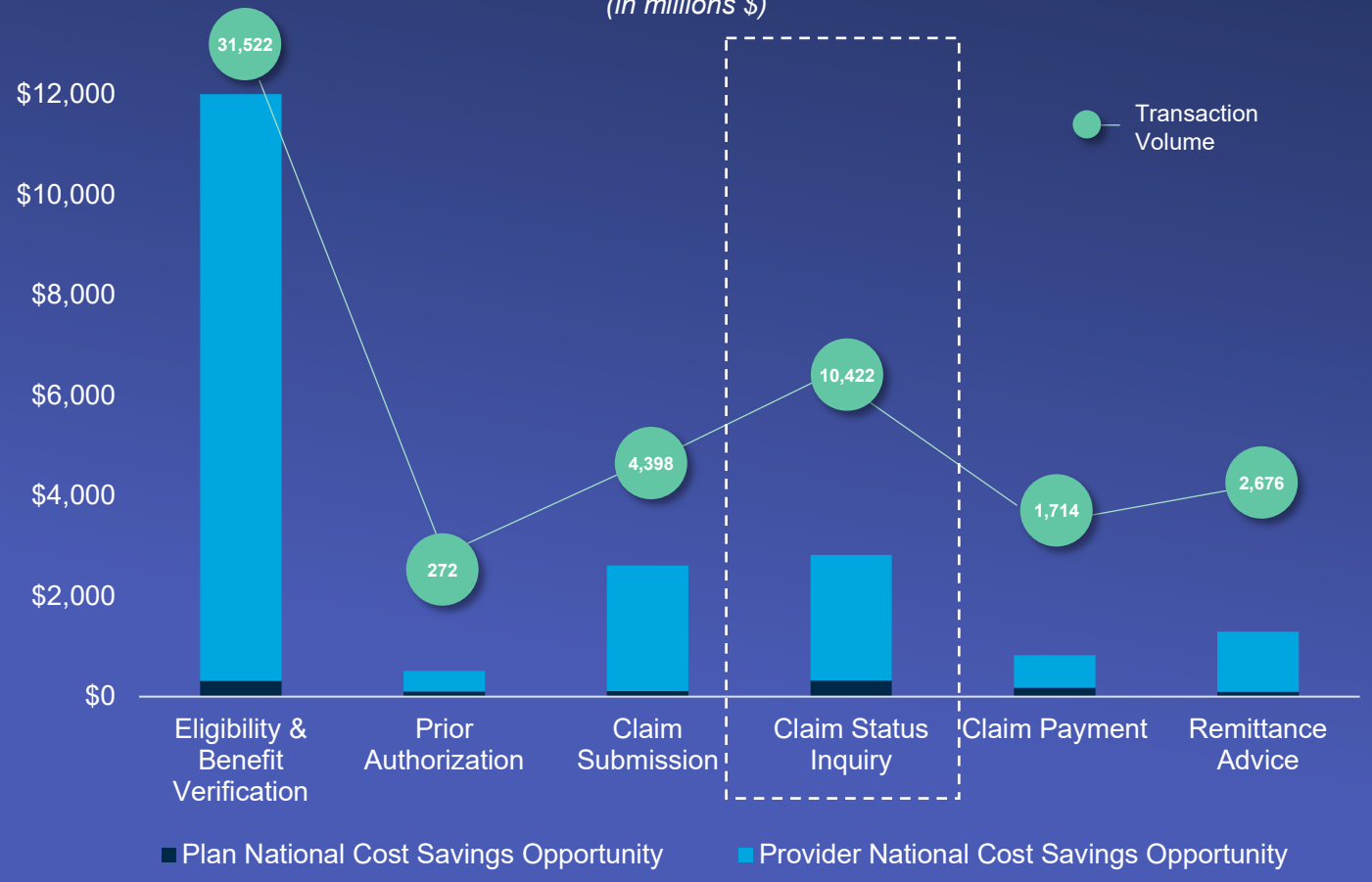
## The medical industry:

**Spent**
**$11 billion**
conducting claim status inquires

**Can save**
**18 minutes**
per transaction using fully automated workflows

**Can save**
**$2.4 billion**
annually using fully automated workflows

**Estimated National Cost Savings Opportunities and Volumes by Transaction**
*Medical and Dental Industries*
*(in millions $)*





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# Overview of Opportunity Areas


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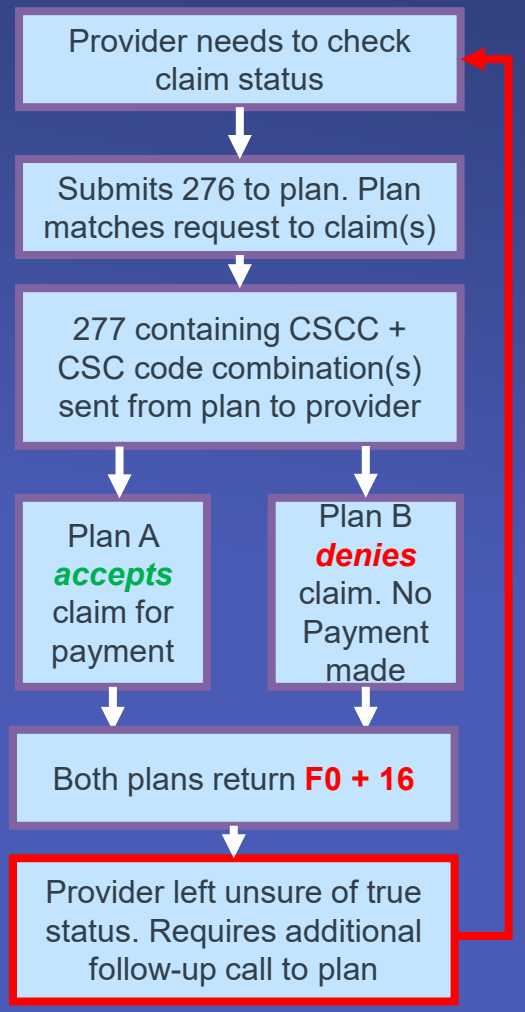
# Opportunity #1 – Error Code Standardization

Enhancing the claim status response transaction allows for more accurate and timely claims processing

*Claim Status Sample Workflows*



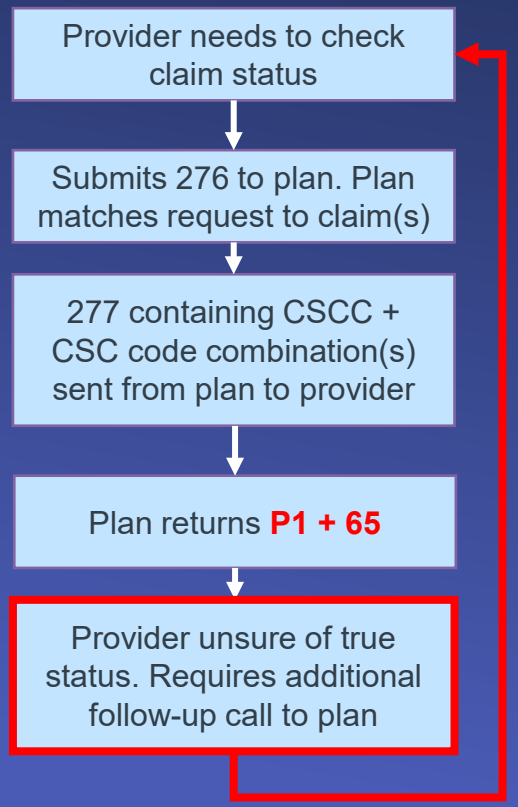

***Inconsistent Use***

1. When the same code combination signals different statuses across health plans, leads to costly workaround and interruptions in workflow. Providers are unsure what next steps to take to resolve.

**CSCC F0**: Finalized – Completed Adjudication

+

**CSC 16**: Processed according to plan provisions




***Contradictory Combinations***

2. Illogical pairings create confusion

**CSCC P1**: Pending/in process–claim or encounter in adjudication system

+

**CSC 65**: Claim/line has been paid

3. ***Variable adoption.*** Ranging from 6 to over 100 combinations in use, negatively impacts providers, forcing costly workarounds to find additional information due to limited implementations across health plans.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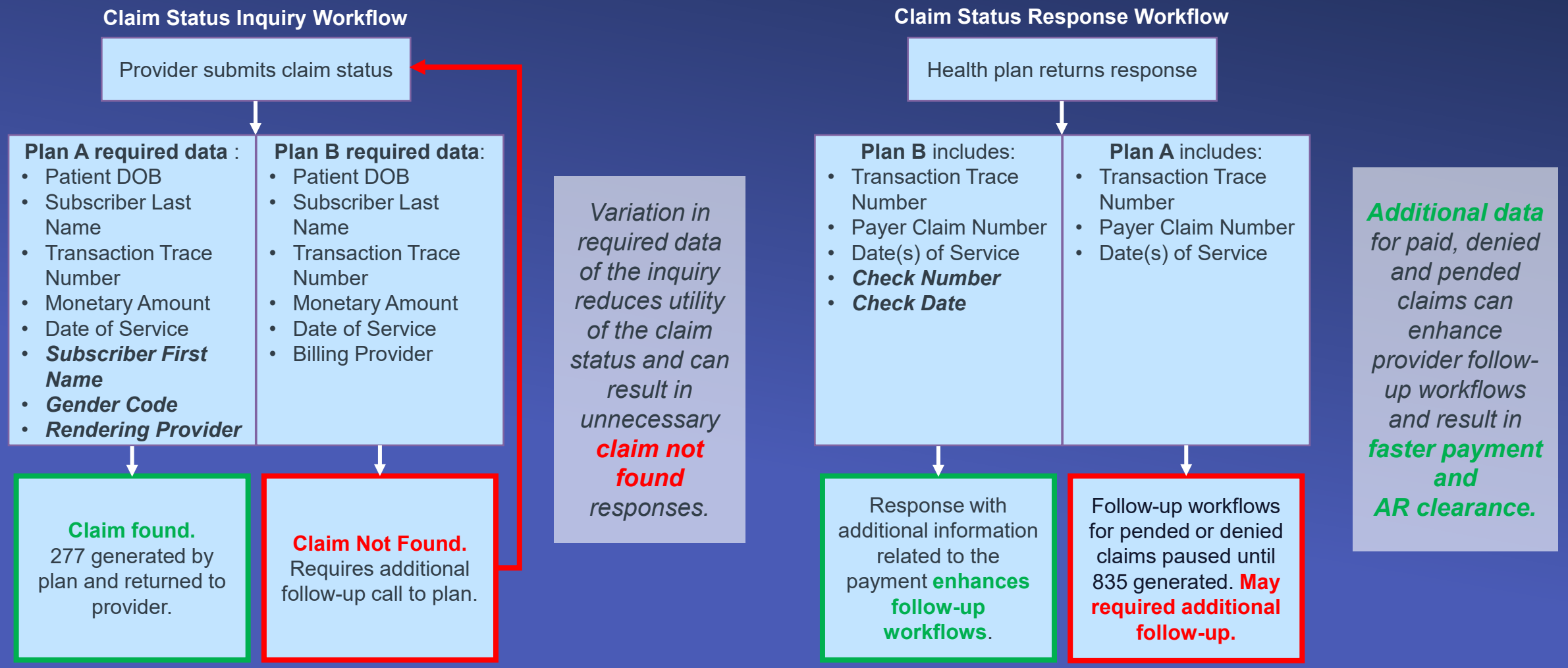
# Opportunity #2 – Data Alignment

A CORE operating rule would bring predictability to the stakeholders involved in the transactions and support simplification and automation.




***BOLD** indicates that a data element is NOT required by the associated X12 TR3.*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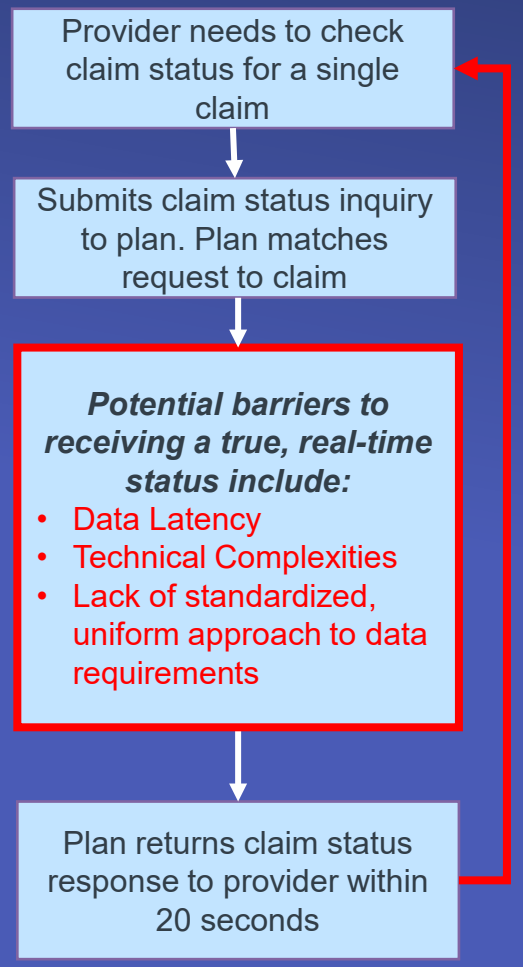
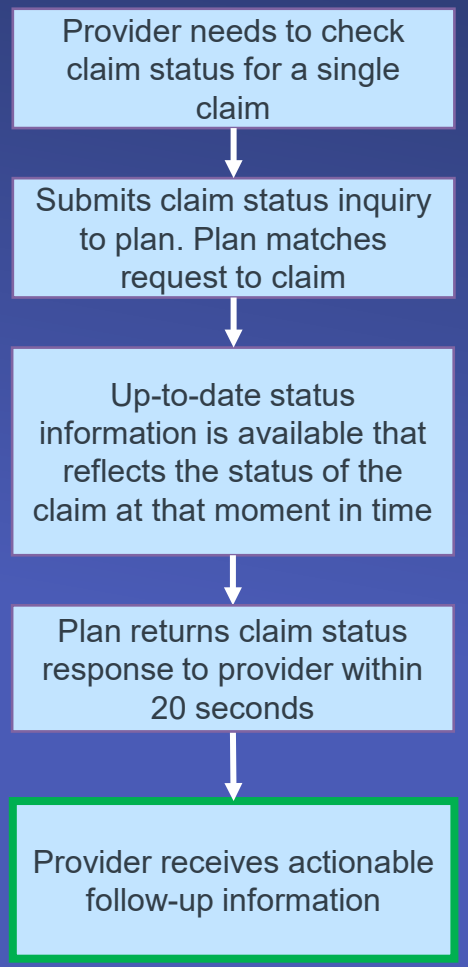
# Opportunity #3 – Real Time Claim Status Processing

*Aligning industry stakeholders to a set of best practices that, when followed, simplify the build for, connection of, and data available in a real time claim status response.*

### *Current Real Time Workflow*




### *Ideal Real Time Workflow*




Instant, detailed data benefits all parties in the care continuum – providers can begin their follow up processes earlier than otherwise, health plans receive information needed to process claims, and, thanks to timely and accurate claims processing, the patient billing experience improves.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SUBGROUP DISCUSSION

# Are there additional challenges within the claim status transaction that the Subgroup should consider for rule development?


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# Next Steps


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# Next Steps

**Attend Call #2**

April 3 from 3:00-3:45 pm ET

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

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


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# 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 | BCBSA |
| Sal Zarate | Blue Cross NC |
| 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 |


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