# Committee on Operating Rules for Information Exchange (CORE™)

Phase III CORE Real Time 276/277 Claim History Availability Rule

Certification/Testing Subgroup Draft – March 23, 2010

## DOCUMENT CHANGE HISTORY

| Description of Change | Name of Author | Date Published |
|---|---|---|
| First Review Draft | CAQH Staff | June 04, 2009 |
| Second Review Draft | Claim Status Subgroup | June 18, 2009 |
| Third Review Draft<br>(Revisions based on Subgroup feedback and discussion) | Claim Status Subgroup | July 02, 2009 |
| Subgroup Straw Poll Version<br>(Version to be distributed for Claim Status Subgroup Straw Poll) | Claim Status Subgroup | July 16, 2009 |
| Subgroup Version approved for Rules Work Group Review | Claim Status Subgroup | July 31, 2009 |
| Rules Work Group version as of Straw Poll Results | Claim Status Subgroup | November 05, 2009 |
| Rules Work Group Draft | Rules Work Group | March 23, 2010 |
| Certification/Testing Subgroup Draft | N/A | March 23, 2010 |

# Table of Contents

## 1 Background Summary

In Phase II, CORE built on the Phase I foundation by adding the application of the Phase I CORE infrastructure rules to the conduct of the HIPAA-adopted ASC X12 v4010A1 276/277 claim status transactions. CORE Phase II Claim Status Rules focused on improving the real time conduct and exchange of electronic claim status query and response transaction as these transactions can have a direct impact on a provider's revenue cycle management process. Thus, if providers can determine the status of a claim once it's been accepted into a health plan's adjudication system, all the transactions that follow will be more effective and efficient. Building on this, CAQH determined that CORE Phase III should be extended to include rules for specifying the time period for the real time availability of claim history using the 276/277 claim status transactions to allow providers to check the status of a claim electronically, without manual intervention, or confirm claims receipt. CORE Phase III rules will focus on the v5010 of the HIPAA-adopted administrative transactions. Benefits to electronic claims status inquiry and response will provide for:

- Less staff time spent on phone calls and websites;
- Increased ability to conduct targeted follow-up;
- More accurate and efficient processing and payment of claims.

The inclusion of this CORE Phase III rule for establishing requirements around the time period that claim status information is available for real time query and reporting using the 276/277 will facilitate the industry's transition to the v5010 administrative transactions, increase access to the claim status transaction, and will encourage CORE-certified entities to build on and extend the infrastructure they have for v4010A1 eligibility (270/271) and claims status (276/277) to the v5010 transactions.

## 2 Issue to be Addressed and Business Requirement Justification

In order to electronically process a claim status inquiry, providers not only need to have a robust 277 claim status response that includes the status of the claim, but to have access to such claim status information in real time for a sufficient time period such that the providers can efficiently and effectively manage their revenue cycle.

HIPAA provides a foundation for the electronic exchange of claim status information, but does not go far enough to ensure that today's paper-based system can be replaced by an electronic, interoperable system. HIPAA's mandated data scope does not address such things as connectivity, system availability, the use of standard acknowledgments, nor the length of time critical administrative information must be available for electronic access using the HIPAA-adopted administrative transactions.

The CORE Phase II #250 Claim Status Rule defines the specific infrastructure requirements that health plans must implement and which vendors, clearinghouses and providers should use if they want to be CORE-certified. As with all CORE rules, these requirements are intended as a base or minimum set of requirements and it is expected many CORE-certified entities will add to these requirements as they work towards the goal of administrative interoperability. The Phase II Claim Status Rule requires that health plans respond to an inquiry in real time (within 20 seconds), make appropriate use of the standard acknowledgements when conducting the 276/277, support the CORE "safe harbor" connectivity requirement, and ensure that the system components required to process claim status inquiries are available 86% of the time.

Requiring a health plan to make claim history available in real time for a specified time period via the existing v4010A1 and v5010 276/277 HIPAA standards, this CORE Phase III Real Time Claim History Rule helps provide the information necessary to electronically process a claim status inquiry and thus reduce the current cost of today's manual transaction process.

# 3 Scope

## *3.1 What the Rule Applies To*

Since this CORE rule does not address any data content requirements for the 276/277, it is reasonable to apply this rule to both version 4010A1 and v5010 of the HIPAA-adopted 276/277 Health Care Claim Status Request and Response transactions. Therefore, this CORE rule builds upon and extends the CORE Phase II Claim Status Infrastructure rules to specify the time period for which claim history will be available from a CORE-certified health plan or information source in response to either a real time v4010A1 or a real time v5010 276 Claim Status Request transaction.

## *3.2 When the Rule Applies*

This rule applies when a Phase III CORE-certified entity uses, conducts, or processes the HIPAA-adopted v4010A1 276/277 Claim Status Query and Response transactions or 005010X212 Health Care Claim Status and Response (276/277) transactions, or both, in real time. CORE-certified entities may also elect to apply this rule to the HIPAA-adopted v4010A1 276/277 Claim Status Query and Response transactions and/or 005010X212 Health Care Claim Status and Response (276/277) transactions conducting these transaction in batch.

This rule applies only to a claim that has been accepted by the health plan's adjudication system.

*Notes:*

*§1.4 of the 005010X212 276/277 TR3 states that "The 276 is used to transmit request(s) to obtain the status of specific health care claim(s) within a payer's adjudication process. The payer uses the 277 to transmit the current system status of those requested claims."*

*§1.4 of the 005010X214 277 TR3 states that "This 277 transaction is the only notification of pre-adjudication claim status." And "Claims failing the pre-adjudication editing process are not forwarded to the claims adjudication system . . . " and "Claims passing the pre-adjudication editing process are forwarded to the claims adjudication system . . ."*

## *3.3 What the Rule Does Not Require*

This rule does not require any entity to:

- Apply the Phase II CORE #270 Connectivity Rule to the conduct of the claims status transactions. However, if any entity wishes to apply the Phase II CORE #270 Connectivity Rule to the conduct of the claim status transactions, it may do so at its own discretion.
- Integrate its current claim status processing system components into its current eligibility processing system if they are not currently integrated.

## *3.4 Outside the Scope of This Rule*

This rule does not address the data content of the 276 claim status inquiry or the data content of the health plan's response using the 277 claim status response transaction.

This rule does not apply to the use of the 276/277 claim status request and response transactions for a claim that has not been accepted into a health plan's adjudication system.

## *3.5 How the Rule Relates to CORE Phase II*

This rule builds on the Phase II CORE 250 Claim Status infrastructure rules (e.g., Connectivity, Response Time, System Availability, Acknowledgements, and Companion Guide) by adding requirements specifying a minimum time period during which claim history will be available for real time claim status inquiry using the 276/277 claim status transactions.

As with other Phase I and Phase II rules, general CORE policies also apply to Phase III rules and will be outlined in the CORE Phase III rule set. The CORE policies include:

- Certification testing for each stakeholder wishing to be awarded a CORE-certified Seal
- Entities seeking CORE-certification may use a contracted party to meet CORE rules, e.g. some providers meet CORE connectivity requirements via their vendor products
- A health plan system exemption policy for system migration
- Entities need to test for and meet batch rule requirements only if they currently offer batch for claim status transactions. A CORE guiding principle is to move to real time; thus, CORE rules do not require entities to build batch capabilities.

### *3.6 Assumptions*

The following assumptions apply to this rule:

- Real time response time of 20 seconds or less as specified in §4.4 of the CORE 250 Phase II Claim Status Rule;
- This rule is a component of the larger set of CORE Phase III rules; as such, all the CORE Guiding Principles apply to this rule and all other rules;
- All entities seeking Phase III certification must be Phase I and Phase II certified as CORE Phase I and CORE Phase II provide a foundation for CORE Phase III;
- This rule is not a comprehensive companion document addressing any content requirements of either the 276 Claim Status Request or 277 Claim Status Response transaction sets.
- Compliance with all CORE rules is a minimum requirement; a CORE-certified entity is free to offer more than what is required in the rule.
- Providers, vendors, clearinghouses and health plans all need to meet appropriate aspects of the rule and all will be tested via CORE certification testing.

Consistent with §1.3.2.1 of 005010X212 276/277 TR3, a real time 276 claim status request must contain only one status request, whether or not the 276 submitted is based on v4010A1 or v5010 of the HIPAA-mandated transactions.

## 4 Draft Rule Requirements

### *4.1 Real Time Availability of Claim History*

Many healthcare providers have a need to determine the status of a claim that has been submitted for adjudication outside of the typical business day and business hours and for a sufficient period of time. In addition to allocating staff resources to performing administrative and financial back-office activities on weekends and evenings, providers have a business need to be able to obtain claim history for a reasonable time period. This rule addresses the need for a standard and consistent time period during which claim history is available for real time inquiry.

#### 4.1.1 Requirements for Real Time Availability of Claim History

A CORE Certified health plan or information source must provide real time access to claim history a minimum of 24 months from the date that a claim is accepted into the health plan's adjudication system as indicated by the acceptance date specified in the 005010X214 Health Care Claim Acknowledgment (277). The date of submission of a claim is not used to determine the beginning date of the 24-month availability time period.

# 5 Conformance Requirements

Conformance with this rule is considered achieved when all of the required detailed step-by-step test scripts specified in the CORE Phase III Certification Test Suite are successfully passed.

The detailed requirements for the certification test scripts and CORE Phase III Certification Test Suite will be developed by the CORE Phase III Testing Subgroup and Technical Work Group.

For Phase III, the certification testing approach is similar to the Phase I and Phase II testing approach. In Phase I and Phase II, entities were not tested for their compliance with all sections of a rule, rather just certain sections as testing is not exhaustive and is paired with the CORE Enforcement policy. CORE certification requires entities to be compliant with all aspects of the rule when working with all trading partners, unless the CORE-certified entity has an exemption. Refer to the CORE Phase III Certification Test Suite for details.

# 6 Appendix

## *6.1 Appendix 1: Abbreviations and Definitions Used in this Rule*

## *6.2 Appendix 2: References*

- ASC X12 v4010A1 Claim Status and Response (276/277) Implementation Guide
- ASC X12 005010X212 Health Care Claim Status and Response (276/277) Technical Report Type 3
- ASC X12 005010X214 Health Care Claim Acknowledgment (277) Technical Report Type 3