Committee on Operating Rules for Information Exchange (CORE™)

Phase III CORE Uniform Use of Claim Status Category & Claim Status Codes (276/277) Rule

Certification/Testing Subgroup Draft – April 27, 2010

DOCUMENT CHANGE HISTORY

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Claim Status Subgroup Draft	Claim Status Subgroup	April 26, 2010
Rules Work Group Draft	Rules Work Group	April 27, 2010

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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.

This rule builds upon and extends the Phase II CORE 250 Claim Status Rule Version 2.0.0 (and any revised versions[1]), and also complements the Phase III CORE Acknowledgements Rule for v5010 837 Claims, and the Phase III CORE Real Time 276/277 Claim History Availability Rule. Specifically, CORE determined that Phase III should include rules for specifying the consistent and uniform use of the claim status category and claim status codes when conducting the HIPAA-adopted ASC X12 005010X212 Health Care Claim Status Request and Response (276/277) hereafter referred to as v5010 276/277. 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 consistent and uniform use of the claim status category and claim status codes 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

The HIPAA-adopted ASC X12 005010X212 Health Care Claim Status Request and Response (276/277) transactions (hereafter referred to as v5010 276/277) provide a range of information to the provider regarding the status of a claim within a health plan's system. The status is currently identified by the health plan using three code sets that, when used in combination, should supply the provider with necessary detail regarding the status of the claim. These code sets are:

- Health Care Claim Status Category Code (Required/external code list)
- Health Care Claim Status Code (Required/external code list)
- Entity Identifier Code (Situational/internal X12 code list)

***Note**: The first 2 code lists above (Claim Status Category and Claim Status Codes) identify the category, e.g., pended, finalized, etc., and the specific status of the claim, e.g., the reason the claim is pended. The purpose for pursuing this rule area for Phase III is further defined in §2.1 and centers around requirements for the consistent use of discrete combinations of Category and Status codes (Data elements STC01-1 and STC01-2 in the 277 Health Care Claim Status Response transaction.) See Figure 1 in 2.1 below.*

2.1 Problem Space

[1] *All CORE rules do not repeat Federal requirements but rather go above and beyond the Federal requirements in order to advance the industry. When Federal requirements on which CORE rules are based change, relevant CORE rules are reviewed and updated as appropriate.*

Variation in responses to providers occurs when health plans differ on the use, meaning or intent of the claim status category and claim status codes they send. Due to the frequency of these types of transaction variations, additional provider interpretation is required to make sense of confusing and often contradictory responses. Often, these issues can only be resolved with an increase in non-value added workflow such as follow-up phone calls and additional Web inquiries. The v5010 276/277 Technical Report Type 3 (TR3) in §1.4.4 identifies that a claim may be:

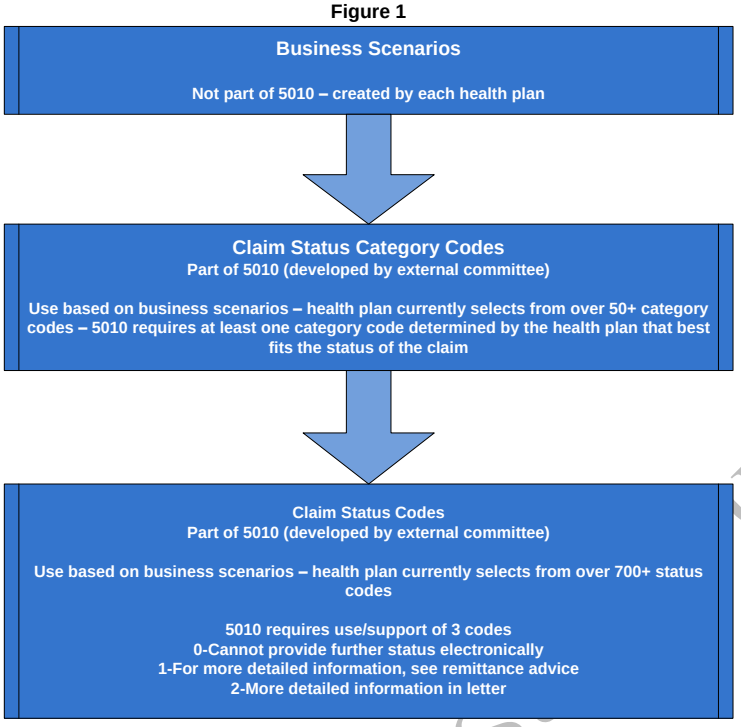
- Finalized — a claim that has completed the adjudication process and/or remittance cycle. A finalized claim may be rejected, denied, approved for payment and paid.
- Pended — a claim that has been placed in a pended or suspended status while the payer performs various functions, such as validation editing, medical reviews, determining contractual requirements, etc. A claim generally remains in a pended' state until the payer resolves or completes validation and the claim is finalized.

The v5010 277 claim status response to a v5010 276 status request can contain a range of information. Most important to the provider is the status of the claim in the health plan's system. Health plans currently use claim status category codes and claim status code combinations to convey the essential information providers need to know:

1. **Has the Claim been paid, denied, pended, or rejected?**
   A claim that has not been paid may not have been posted correctly. With relevant claim status information the provider can do additional research and get it posted correctly.
2. **Does the health plan have the claim?**
   A claim can be lost or unaccounted for due to any number of reasons, e.g., a lost daily batch of claims, or the claim did not get through the provider's patient accounting or practice management system and released for submission to the health plan. Confirmation that a claim has been received will eliminate duplicative efforts to get a claim resubmitted and processed correctly. [**Note:** *This need for confirmation of receipt for a claim is addressed by the draft Phase III CORE Acknowledgements Rule for 5010 837 Claims with the use of the 277CA Claims Acknowledgement transaction.*]

Figure 1 below provides an overview of the industry's current approach to using claim status category and claim status codes. It also illustrates the number of total codes that are available for use under v5010 277. Among the 700+ claim status codes, v5010 277 only requires three status codes to be used that best fits the status of the claim. The corresponding category code is determined by the health plan while the business scenarios are individual to each health plan.

Figure 1



2.2 CORE Process in Addressing the Problem Space

CORE researched other industry efforts that have taken on the issue of implementing more consistent claim status category codes, claim status codes and entity codes in the claim status transaction. Aspects of these approaches have been included in the current scope of this rule, including:

- UHIN: provides a general guideline recommending health plans use a combination of STC segments and elements in order to create simple and clear messages – i.e., a "one status concept per STC segment" and that payers NOT crosswalk codes based simply on the content or wording of a status but should know the action that results from the codes
- Linxus: identified several provider action work flows and associated them to several health plan business scenarios along with minimum code set pairings for each business scenario and the provider action work lists as a "best practice" for each business scenario-an approach which is very complex

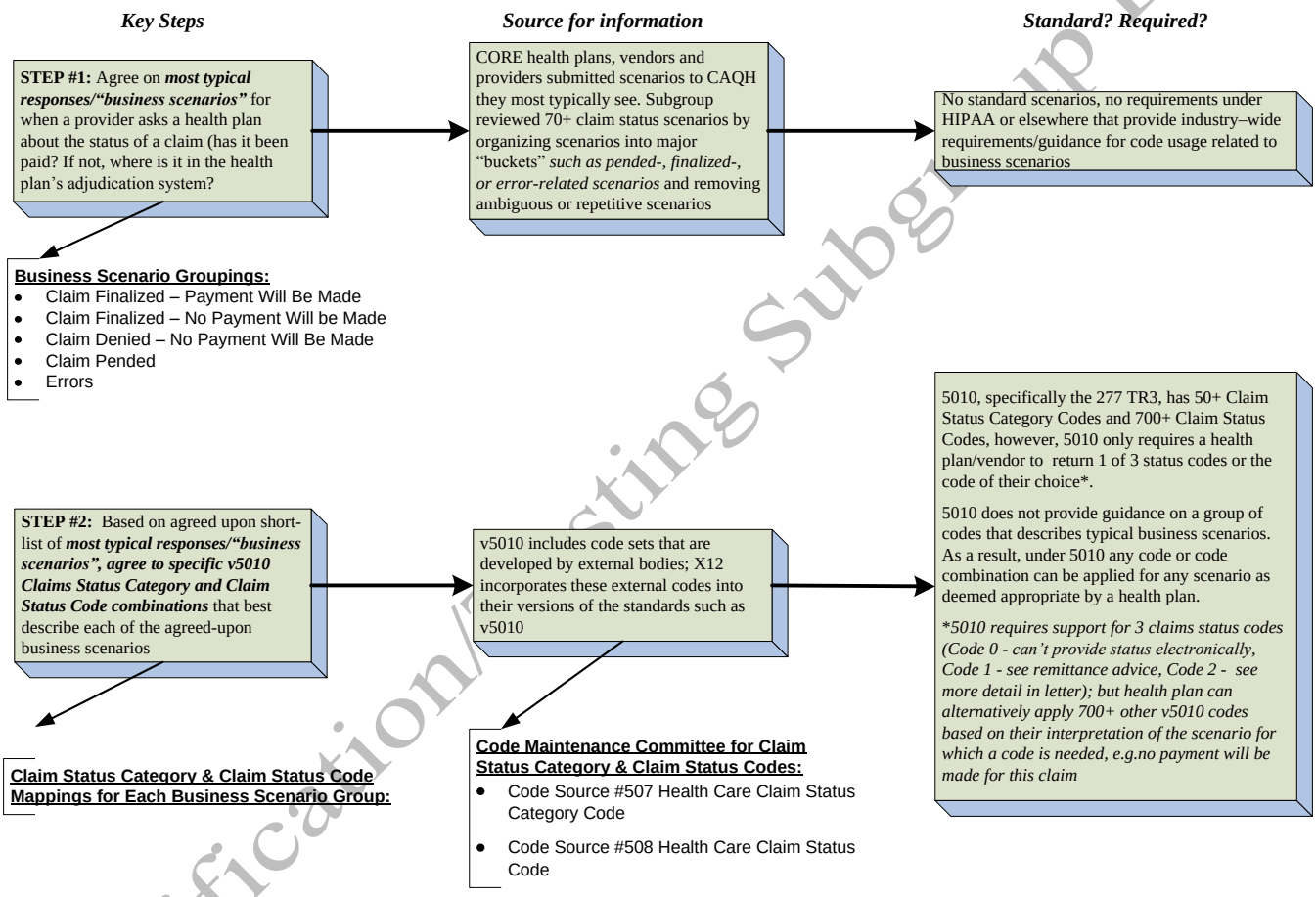
To address this Problem Space associated with the v5010 277 response transaction, CORE participants participating in the development of this rule achieved substantial consensus that a Phase III CORE Claim Status Category and Claim Status Codes Uniform Use Rule should map specific "business scenarios" (representing what a health plan wishes to convey to providers regarding the status of a claim) to specific v5010 277 category and status code combinations currently in use by CORE health plan participants.

CORE participants agreed to "Identify a subset of claim status category and claim status codes for inclusion in a Phase III CORE rule that must be supported for corresponding business scenarios defined in the rule." A comprehensive analysis of the existing claim status category code and claim status code lists was done Since these code lists undergo maintenance three times a year, a volatility analysis was also conducted to determine the number of codes in each list that are modified, added, or deleted. This volatility analysis confirmed a high level of stability in both the category and status code lists to support including appropriate code combinations in a Phase III rule as requirements.

CORE health plan participants were requested to submit their commonly used business scenarios along with the claim status category codes and claim status codes use. This feedback was collected, analyzed, and grouped into five most commonly used business scenarios along with claim status category codes and claim status codes. CORE participants agreed to five business scenarios and the corresponding claim status category and claim status code combinations. This Phase III CORE rule addresses the consistent use of these claim status category code and claim status code combinations mapped to CORE-defined business scenarios for reporting claim status in the 277 claim status response.

The figure below depicts a high level process and key steps that CORE used to complete its work.

Overview: Process for Phase III Rule on Claim Status Category Codes



3 Scope

3.1 What the Rule Applies To

This CORE rule conforms with and builds upon the HIPAA-adopted ASC X12 005010X212 Health Care Claim Status Request and Response (276/277)Technical Report Type 3 implementation guide (hereafter referred to as v5010 276/277 request/response).

This rule builds upon and extends the Phase II CORE 250 Claim Status Rule Version 2.0.0 (and any revised versions[2]), the Phase III CORE Acknowledgements Rule for v5010 837 Claims, and the Phase III CORE Real Time 276/277 Claim History Availability Rule by requiring the v5010 277 response to use a uniform set of claim status category and claim status codes for specified CORE Claim Status Business Scenarios.

3.2 Applicable Loops, Data Elements & Code Sources

This rule covers the following data element and loops in the v5010 277 response transaction. The scope of this rule is limited to the overall claim level status and does not explicitly include any claim service line loops and data elements. This rule represents a floor of minimum requirements for CORE-certified entity and does not prohibit any entity from also reporting claim service line status.

Loop ID and Name
Loop 2200D/E Claim Status Tracking Number
Data Element Segment Position, Number & Name
STC01-C043 Health Care Claim Status
STC01-1 1271 Health Care Claim Status Category Code
STC01-2 1271 Health Care Claim Status Code

This rule covers the following external code sources specified in v5010 277 response transaction for the data elements listed in the table above:

Code Source Reference # and Name
507 Health Care Claim Status Category Code
508 Health Care Claim Status Code

This rule does not cover the use of STC01-3 98 Entity Identifier Code. This data element is a situational use component of the required composite Health Care Claim Status Data Element STC01-C043 and is used to clarify the entity when referred to in the STC01-2. A situational note in v5010 277 indicates that STC01-3 is required when an entity must be identified and if not required it may be sent at the sender's discretion. A future CORE rule may address the use of this data element.

[2] *All CORE rules do not repeat Federal requirements but rather go above and beyond the Federal requirements in order to advance the industry. When Federal requirements on which CORE rules are based change, relevant CORE rules are reviewed and updated as appropriate.*

3.3 When the Rule Applies

This rule applies when a Phase III CORE-certified entity uses, conducts, or processes v5010 276/277 request/response transactions.

3.4 What the Rule Does Not Require

This rule does not require any CORE-certified 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.

3.5 CORE Process for Maintaining CORE-Defined Claim Status Category & Claim Status Codes Combinations

The Health Care Claim Status Category Code is used to organize Health Care Claim Status Codes into logical groupings in order to convey to the health care provider a comprehensive status of an entire health care claim or a service line of a health care claim. The Health Care Claim Status Category Code and Health Care Claim Status Code lists are code lists maintained by an organization external to the ASC X12 Standards Committee. As such, these code lists are subject to revision and maintenance three times a year. Such revision and maintenance activity can result in new codes, revision to existing codes definition and description, or a stop date assigned to a code after which the code should no longer be used.

Given this code list maintenance activity, CORE recognizes that the focus of this rule and coupled with this unique maintenance activity will require a process and policy to enable the various Health Care Claim Status Category Code and Health Care Claim Status Code combinations specified in §4.1.1.2.1 through §4.1.1.2.5 to be revised and modified on a more frequent basis than is typical for CORE rules. CORE will develop such a process and policy following the approval of the Phase III CORE Operating rules.

3.6 Outside the Scope of This Rule

This rule does not cover the following specified data element and loops in the v5010 277 response transaction:

Loop ID and Name
Loop 2220D/E Service Line Information
Data Element Segment Position, Number & Name
STC01-C043 Health Care Claim Status
STC01-1 1271 Health Care Claim Status Category Code
STC01-2 1271 Health Care Claim Status Code

3.7 Abbreviations and Definitions Used in this Rule

CORE-defined Claim Status Business Scenarios: In general, a business scenario provides a complete description of a business problem such that requirements can be reviewed in relation to one another in the context of the overall problem. Business scenarios provide a way for the industry to describe processes or situations to address common problems and identify technical solutions. By making obvious what is needed, and why, the trading partners and vendors are able to solve problems using open standards and leveraging each other's skills.

Thus, in the context of this CORE rule, a *CORE-defined Claim Status Business Scenario* describes at a high-level the category of the status of a health care claim within the health plan's adjudication system to which various combinations of claim status category and claim status codes can be applied so that details can be conveyed to the provider using the v5010 277 response transaction. The CORE-defined Claim Status Business Scenarios are specified in §4.1.1.1.

3.8 How the Rule Relates to CORE Phase I and II

This rule builds upon and extends the Phase II CORE 250 Claim Status Rule Version 2.0.0 (and any revised versions[3]), the Phase III CORE Acknowledgements Rule for v5010 837 Claims, and the Phase III CORE Real Time 276/277 Claim History Availability Rule by requiring the v5010 277 response to use a uniform set of claim status category and claim status codes for specified CORE Claim Status Business Scenarios.

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.

This rule supports the CORE Guiding Principles that CORE rules will not be based on the least common denominator but rather will encourage feasible progress, and that CORE rules are a floor and not a ceiling, e.g., certified entities can go beyond the Phase III rules.

3.9 Assumptions

A goal of this rule is to establish a foundation for semantic interoperability of EDI in assuring that content of the transactions being exchanged convey a consistent business message about the status of health care claims by the uniform use of a set of specified codes.

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;

[3] *All CORE rules do not repeat Federal requirements but rather go above and beyond the Federal requirements in order to advance the industry. When Federal requirements on which CORE rules are based change, relevant CORE rules are reviewed and updated as appropriate.*

- A successful communication connection has been established.
- 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.

4 Rule Requirements

4.1 Basic Requirements for Uniform Use of Claim Status Category & Claim Status Codes

This section addresses the requirements for a CORE-certified health plan when responding to a v5010 276 claim status request, submitted either in real time or in batch.

4.1.1 Uniform Use of Claim Status Category and Claim Status Codes

A CORE-certified health plan must map its internal codes and corresponding business scenarios to the CORE-Defined Claim Status Business Scenarios specified in §4.1.1.1 and the claim status category and claim status code combinations specified in §4.1.1.2 of this rule.

4.1.1.1 CORE-Defined Claim Status Business Scenarios

A CORE-defined Claim Status Business Scenario describes at a high-level the category of the status of a health care claim within the health plan's adjudication system to which various combinations of claim status category and claim status codes can be applied so that details can be conveyed to the provider using the v5010 277 response transaction.

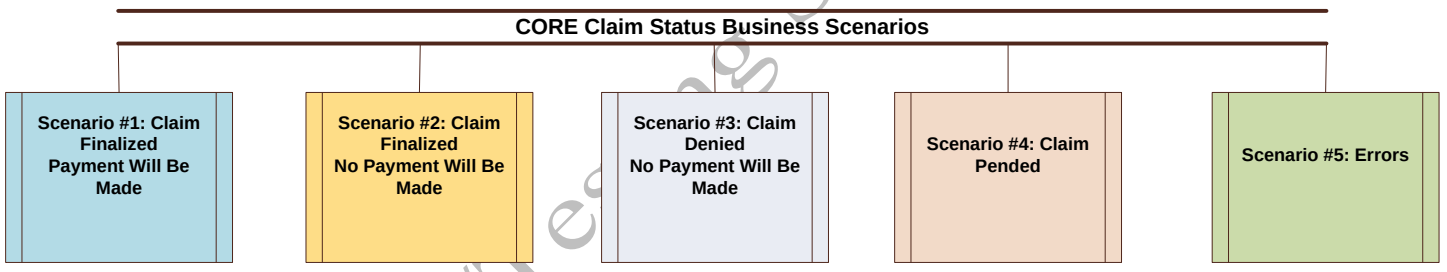
Table 4.1.1.1 defines the following five Claim Status Business Scenarios.

Table 4.1.1.1	
CORE-defined Business Scenarios	**CORE Business Scenario Description**
Scenario #1: Claim Finalized — Payment Will Be Made	Claims for which the adjudication process is complete and a payment will be made to the provider, although a payment cycle may or may not be complete. The minimum set of CORE-required code combinations to convey detailed information about the status of the claim for this business scenario is specified in §4.1.1.2.1.
Scenario #2: Claim Finalized — No Payment Will Be Made	Claims for which the adjudication process is complete and no payment will be made to the provider for various reasons. The minimum set of CORE-required code combinations to provide the details of the claim status for this business scenario is specified in §4.1.1.2.2.
Scenario #3: Claim Denied – No Payment Will Be Made	Claims for which the adjudication process is complete and the results of adjudication are a denied claim. The minimum set of

Table 4.1.1.1	
CORE-defined Business Scenarios	**CORE Business Scenario Description**
	CORE-required code combinations to provide the details regarding the claim denial for this business scenario is specified in §4.1.1.2.3.
Scenario #4: Claim Pended	Claims for which the adjudication process has been suspended by the health plan for various reasons. Suspended (pended) claims have not completed the adjudication process and/or the payment cycle. The minimum set of CORE-required code combinations to provide the details regarding the suspended (pended) claim for this business scenario is specified in §4.1.1.2.4.
Scenario #5: Errors	Claims for which the health plan encounters system or processing errors not included in the CORE-defined Business Scenarios above. Such errors may be the result of system or application errors or the inability of the health plan to accurately identify the patient. The minimum set of CORE-required code combinations to provide the details regarding the error(s) for this business scenario is specified in §4.1.1.2.5.

Below is a graphical representation of the CORE Claim Status Business Scenarios.

Figure 4.1.1.1



4.1.1.2 Use of CORE-defined Claim Status Category & Claim Status Codes Combinations

Specific details about the status of a claim are conveyed to the provider by the health plan in the v5010 277 response by the combined use of one or more specified claim status category codes along with specified claim status codes. These code combinations are defined as CORE-defined Claim Status Category and Claim Status Code Combinations. A CORE-certified health plan must support the CORE-specified combinations of claim status category and claim status codes combinations in the v5010 277 response as specified in §4.1.1.2.1 through §4.1.1.2.5. When specific CORE-defined Claim Status Category and Claim Status Code Combinations are not applicable to meet the health plan's business requirements, the health plan is not required to use them. Health plans may develop additional claim status category and claim status codes combinations to report the status of a claim and may send as many STC segments as necessary to fully detail the accurate status of a claim. *(See §4.2 for requirements for receivers of the v5010 277 response.)*

4.1.1.2.1 Code Combinations for Business Scenario #1: Claim Finalized – Payment Will Be Made

The minimum set of CORE-required code combinations to convey detailed information about the status of the claim for this business scenario is specified in Table 4.1.1.2.1. Entities can add to these codes-this is consistent with the CORE guiding principle that CORE rules are a floor; not a ceiling and that entities can exceed the minimum CORE rule requirements.

Note: It is assumed that a Claim Status Code may be grouped under more than one Claim Status Category Code and/or more than one CORE Business Scenario.

Table 4.1.1.2.1
Scenario #1: Claim Finalized – Payment Will Be Made

Claim Status Category Code (Code Source 507)	Category Code Description	Claim Status Code (Code Source 508)[4]	Status Code Description	Entity Code Required by 5010
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.	
		104	Processed according to plan provisions (Plan refers to provisions that exist between the Health Plan and the Consumer or Patient).	
		106	This amount is not entity's responsibility.	Y
		107	Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services).	
F1	Finalized/Payment-The claim/line has been paid.	65	Claim/line has been paid.	
		66	Payment reflects usual and customary charges.	
		100	Pre-certification penalty taken.	
		104	Processed according to plan provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services).	
		105	Claim/line is capitated.	
		106	This amount is not entity's responsibility	
		107	Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services).	
		171	Other insurance coverage information (health, liability, auto, etc.).	
F3	Finalized/Revised - Adjudication information has been changed.	101	Claim was processed as adjustment to previous claim	

[4] *Since the ASC X12 005010X212 Health Care Claim Status Request and Response (276/277) TR3 requires the support of Claim Status Codes 0, 1, and 2 as the minimum compliant response these codes are not included in any CORE Business Scenario Claim Status Category and Claim Status code combinations. Also reference Figure 1 in §2.1 of this rule.*

4.1.1.2.2 Code Combinations for Business Scenario #2: Claim Finalized – No Payment Will Be Made

The minimum set of CORE-required code combinations to provide the details of the claim status for this business scenario is specified in Table 4.1.1.2.2. Entities can add to these codes-this is consistent with the CORE guiding principle that CORE rules are a floor, not a ceiling and that entities can exceed the minimum CORE rule requirements.

Note: It is assumed that a Claim Status Code may be grouped under more than one Claim Status Category Code and/or more than one CORE Business Scenario.

Table 4.1.1.2.2
Scenario #2: Claim Finalized – No Payment Will Be Made

Claim Status Category Code (Code Source 507)	Category Code Description	Claim Status Code (Code Source 508)[5]	Status Code Description	Entity Code Required by 5010
F3	Finalized/Revised - Adjudication information has been changed.	98	Charges applied to deductible.	
		101	Claim was processed as adjustment to previous claim.	

[5] *Ibid.*

4.1.1.2.3 Code Combinations for Business Scenario #3: Claim Denied – No Payment Will Be Made

The minimum set of CORE-required code combinations to provide the details regarding the claim denial for this business scenario is specified in Table 4.1.1.2.3. Entities can add to these codes-this is consistent with the CORE guiding principle that CORE rules are a floor, not a ceiling and that entities can exceed the minimum CORE rule requirements.

Note: It is assumed that a Claim Status Code may be grouped under more than one Claim Status Category Code and/or more than one CORE Business Scenario.

Table 4.1.1.2.3
Scenario #3: Claim Denied – No Payment Will Be Made

Claim Status Category Code (Code Source 507)	Category Code Description	Claim Status Code (Code Source 508)[6]	Status Code Description	Entity Code Required by 5010
F2	Finalized/Denial-The claim/line has been denied.	16	Claim/encounter has been forwarded to entity.	Y
		21	Missing or invalid information. Note: At least one other status code is required to identify the missing or invalid information.	
		27	Policy canceled.	
		54	Duplicate of a previously processed claim/line.	
		81	Contract/plan does not cover pre-existing conditions.	
		83	No coverage for newborns.	
		84	Service not authorized.	
		88	Entity not eligible for benefits for submitted dates of service.	Y
		89	Entity not eligible for dental benefits for submitted dates of service.	Y
		92	Entity does not meet dependent or student qualification.	Y
		94	Entity not referred by selected primary care provider.	Y
		95	Requested additional information not received.	
		97	Patient eligibility not found with entity.	Y
		107	Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services)	
		109	Entity not eligible.	Y
		110	Claim requires pricing information.	
		114	Claim/service should be processed by entity.	Y
		116	Claim submitted to incorrect payer.	
		123	Additional information requested from	Y

[6] *Ibid.*

Claim Status Category Code (Code Source 507)	Category Code Description	Claim Status Code (Code Source 508)[6]	Status Code Description	Entity Code Required by 5010
			entity.	
		171	Other insurance coverage information (health, liability, auto, etc.).	
		474	Procedure code and patient gender mismatch	
		682	Cosmetic procedure	

4.1.1.2.4 Code Combinations for Business Scenario #4: Claim Pended

The minimum set of CORE-required code combinations to provide the details regarding the suspended (pended) claim for this business scenario is specified in Table 4.1.1.2.4. Entities can add to these codes-this is consistent with the CORE guiding principle that CORE rules are a floor, not a ceiling and that entities can exceed the minimum CORE rule requirements.

Note: It is assumed that a Claim Status Code may be grouped under more than one Claim Status Category Code and/or more than one CORE Business Scenario.

(Note: this Business Scenario includes 5 claim status category codes with respective claim status codes.)

Table 4.1.1.2.4

Scenario #4: Claim Pended

Claim Status Category Code (Code Source 507)	Category Code Description	Claim Status Code (Code Source 508)[7]	Status Code Description	Entity Code Required by 5010
P1	Pending/In Process-The claim or encounter is in the adjudication system.	40	Waiting for final approval.	
		45	Awaiting benefit determination.	
		55	Claim assigned to an approver/analyst.	
		56	Awaiting eligibility determination.	
		171	Other insurance coverage information (health, liability, auto, etc.).	
P2	Pending/Payer Review-The claim/encounter is suspended and is pending review (e.g. medical review, repricing, Third Party Administrator processing).	0	Cannot provide further status electronically.	
		41	Special handling required at payer site.	
		45	Awaiting benefit determination.	
		46	Internal review/audit.	
		52	Investigating existence of other insurance coverage.	
		55	Claim assigned to an approver/analyst.	
		56	Awaiting eligibility determination.	
		110	Claim requires pricing information.	
		123	Additional information requested from entity.	
		290	Pre-existing information.	
		297	Medical notes/report.	
		317	Patient's medical records.	
P3	Pending/Provider Requested Information - The claim or encounter is waiting for	218	NDC number.	
		290	Pre-existing information.	

[7] *Ibid.*

Claim Status Category Code (Code Source 507)	Category Code Description	Claim Status Code (Code Source 508)[7]	Status Code Description	Entity Code Required by 5010
	information that has already been requested from the provider. (Note: A Claim Status Code identifying the type of information requested, must be reported.)	286	Other payer's Explanation of Benefits/payment information.	
		297	Medical notes/report.	
		306	Detailed description of service.	
		317	Patient's medical records.	
		331	History and physical.	
P4	Pending/Patient Requested Information - The claim or encounter is waiting for information that has already been requested from the patient. (Note: A status code identifying the type of information requested must be sent.)	52	Investigating existence of other insurance coverage.	
		171	Other insurance coverage information (health, liability, auto, etc.).	
		286	Other payer's Explanation of Benefits/payment information.	
		363	Will worker's compensation cover submitted charges?	
		366	Is injury due to auto accident?	

4.1.1.2.5 Code Combinations for Business Scenario #5: Errors

The minimum set of CORE-required code combinations to provide the details regarding the error(s) for this business scenario is specified in Table 4.1.1.2.5. Entities can add to these codes-this is consistent with the CORE guiding principle that CORE rules are a floor, not a ceiling and that entities can exceed the minimum CORE rule requirements.

Note: It is assumed that a Claim Status Code may be grouped under more than one Claim Status Category Code and/or more than one CORE Business Scenario.

Table 4.1.1.2.5
Scenario #5: Errors

Claim Status Category Code (Code Source 507)	Category Code Description	Claim Status Code (Code Source 508)[8]	Status Code Description	Entity Code Required by 5010
D0	Entity not found - change search criteria. This change to be effective 10/1/2009: Data Search Unsuccessful - The payer is unable to return status on the requested claim(s) based on the submitted search criteria.	97	Patient eligibility not found with entity.	Y
E0	Response not possible - error on submitted request data.	21	Missing or invalid information. Note: At least one other status code is required to identify the missing or invalid information.	
		24	Entity not approved as an electronic submitter.	Y
		25	Entity not approved.	Y
		33	Subscriber and subscriber id not found.	
		97	Patient eligibility not found with entity.	Y
		109	Entity not eligible.	Y
E1	Response not possible - System Status.	484	Business Application Currently Not Available	

[8] *Ibid.*

4.2 Basic Requirements for Receivers of v5010 277 Responses

This section specifies the requirements for a CORE-certified entity when receiving a v5010 277 claim status response either in real time or in batch.

The receiver (defined in the context of this CORE rule as the system originating the v5010 276 claim status request transaction set) of a v5010 277 response is required

- to recognize all claim status category and claim status code combinations specified in this rule

and

- associate each claim status category and claim status code combination to the CORE-Defined Claim Status Business Scenarios as appropriate

and

- to display to the end user
    - text using the CORE-Defined Claim Status Business Scenario

    And

    - ~~o~~ text describing the CORE-specific claim status category and claim status code combinations for the associated CORE-Defined Claim Status Business Scenario, ensuring that the actual wording of the text displayed accurately represents the claim status category and claim status codes and the corresponding description specified in the related ASC X12 external code lists specifications without changing the meaning and intent of the description.

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 Abbreviations and Definitions

CORE-defined Claim Status Business Scenarios: In general, a business scenario provides a complete description of a business problem such that requirements can be reviewed in relation to one another in the context of the overall problem. Business scenarios provide a way for the industry to describe processes or situations to address common problems and identify technical solutions. By making obvious what is needed, and why, the trading partners and vendors are able to solve problems using open standards and leveraging each other's skills.

Thus, in the context of this CORE rule, a *CORE-defined Claim Status Business Scenario* describes at a high-level the category of the status of a health care claim within the health plan's adjudication system to which various combinations of claim status category and claim status codes can be applied so that details can be conveyed to the

provider using the v5010 277 response transaction. The CORE-defined Claim Status Business Scenarios are specified in §4.1.1.1.

6.2 References

- ASC X12 005010X212 Health Care Claim Status Request and Response (276/277)
- Code Source 507 Health Care Claim Status Category Code
- Code Source 508 Health Care Claim Status Code