CAQH CORE and X12 Webinar Series

Introduction to the 837 Transaction, Standard, & Operating Rules

September 21, 2023

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Agenda

- X12 Overview
- Health Care Claim: Dental, Institutional, and Professional
  - Purpose and Scope
  - Benefits
  - Users
  - Workflow
- CORE Overview
- CORE Health Care Claims Operating Rule Overview
  - CORE Health Care Claim (837) Infrastructure Rule
  - CORE Health Care Claim Data Content Rule Development
- Questions
- Call to Action

Webinar Logistics

- Accessing webinar materials:
  - Download the presentation slides from the “Handouts” section of the GoToWebinar menu.
  - An e-mail will be sent to all attendees and registrants in the next 1-2 business days with information on how to access slides and today’s recording.
- Have a question?
  - Submit your question **at any time** using the Questions panel on your GoToWebinar menu.

Thank You to Our Speakers

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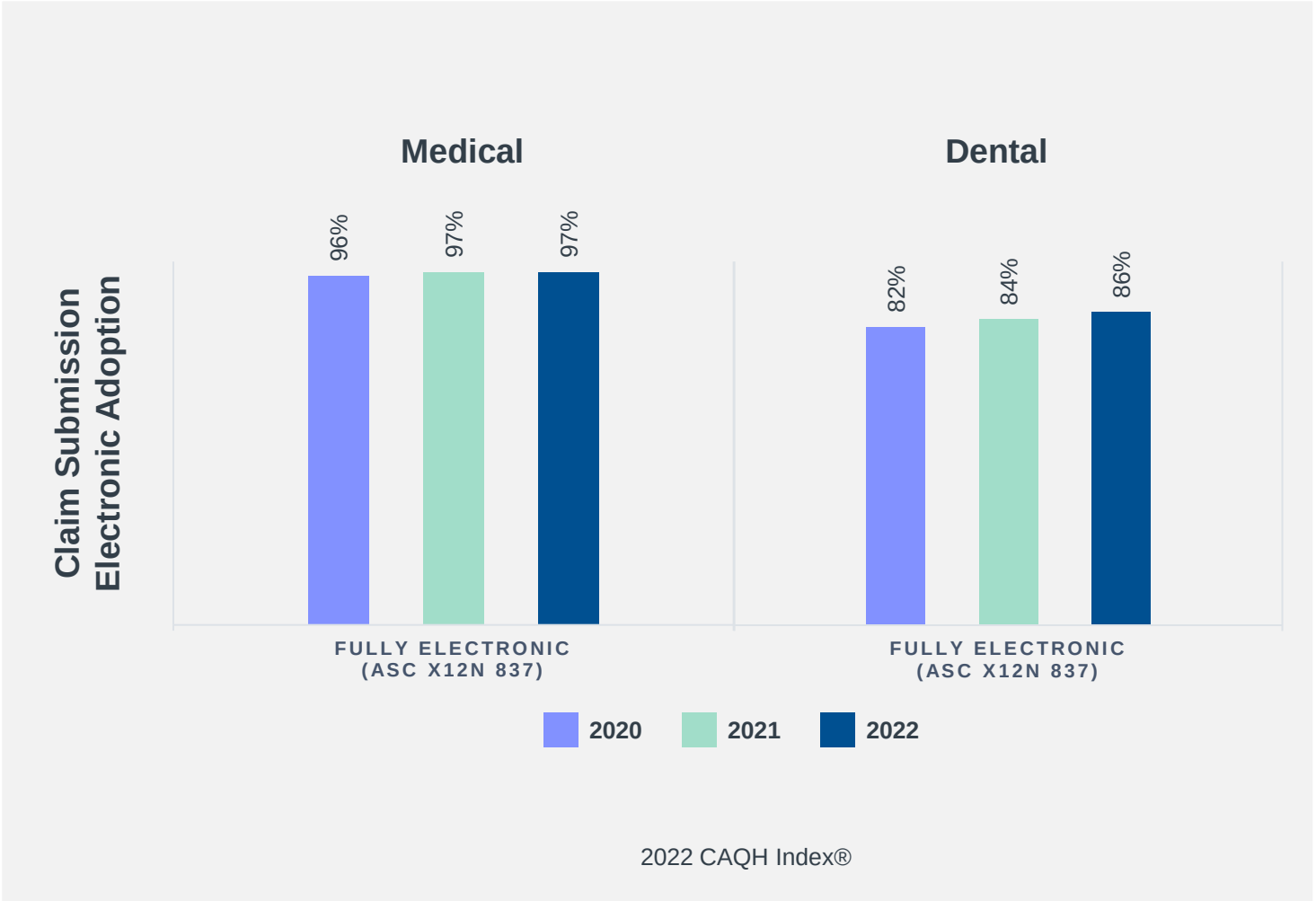
Health Care Claims
Definition and Industry Adoption

Claim Submission:

A provider submits a health care claim for an item or service provided to a patient, along with any necessary documentation, to a health plan to receive payment.



2022 CAQH Index®

CLAIMS
WHAT'S HAPPENING AT X12?

DISCLAIMER

- This presentation is for informational purposes only
- This presentation does not represent legal advice
- This presentation contains point-in-time content and is subject to revision

TOPICS

1. About X12
2. Health Care Claim: Dental, Institutional, and Professional
   - *Purpose and Scope*
   - *Benefits*
   - *Users*
   - *Workflow*
3. Wrap-Up

Background

THE X12 ORGANIZATION

- X12 is a consensus-based ANSI-accredited National Standards Developer (ASD) focusing on the development and ongoing use of cross-industry interoperable data interchange standards
- X12's standards have proven reliable, efficient, & effective in supporting organizations and industries for 40+ years
- X12 maintains electronic messaging that supports finance, government, health care, insurance, supply chain, transportation, and other industries

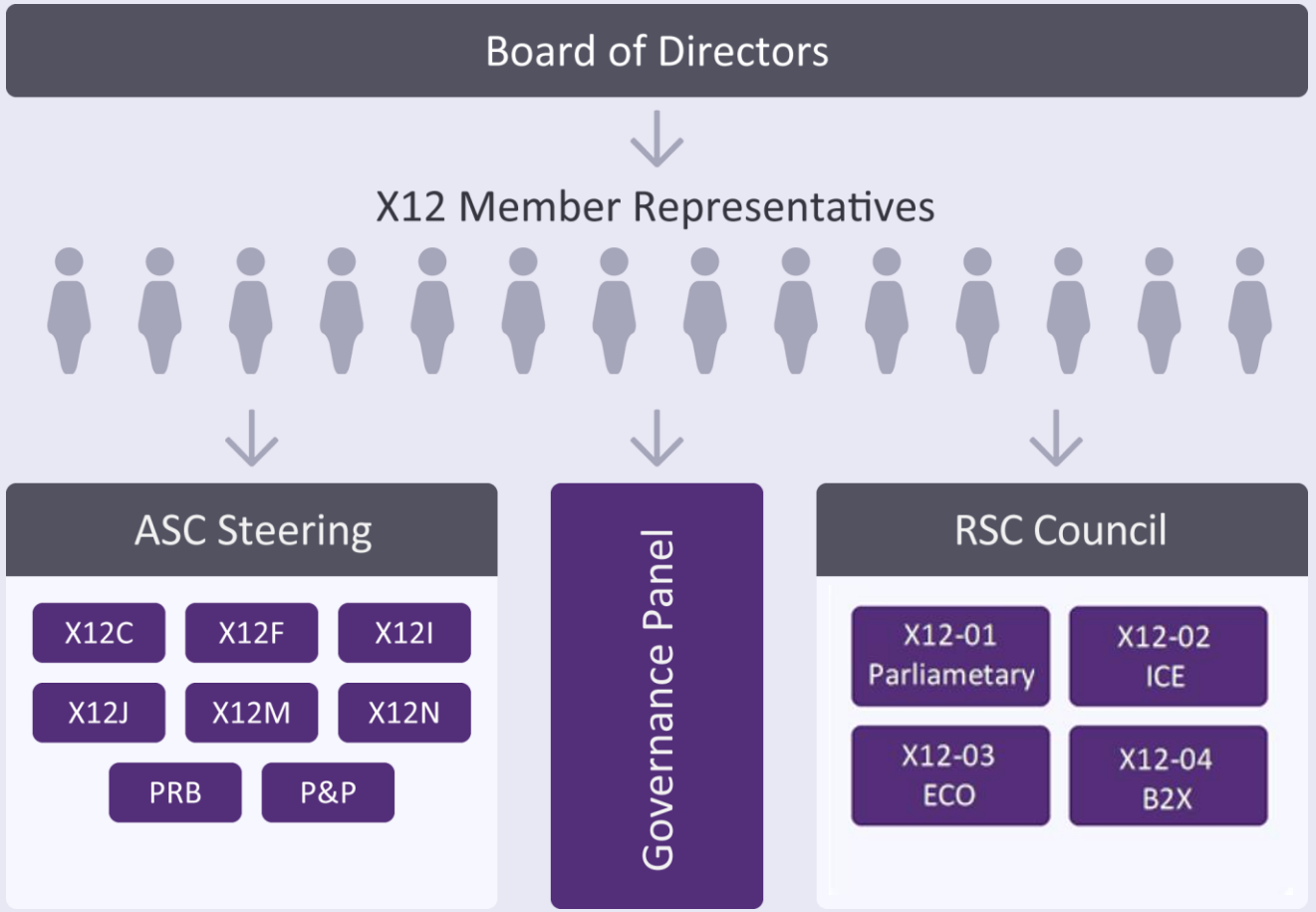
THE X12 ORGANIZATION

- X12 is comprised of a handful of staff, hundreds of members, and more than a thousand member representatives
- Members include corporations, associations, organizations, government entities, and individuals
- X12 standards are the workhorse standards for business to business exchanges
- Many partner-to-partner “standards” are developed based on X12’s intellectual property

X12 IMPLEMENTATION BASE

- Billions of transactions based on X12 standards are utilized daily across various industries including finance, government, health care, insurance, supply chain, transportation, and others
- Millions of entities around the world have an established infrastructure that supports X12 transactions, representing a significant investment in a stable and effective infrastructure
- The data exchanged in X12 transactions is well-defined and has been use-tested in production systems for over 40 years

X12 ORGANIZATIONAL STRUCTURE



THE X12 ORGANIZATION

- Most in health care are familiar with X12's Accredited Standards Committee (ASC)
  - *The ASC develops and maintains the EDI Standard and related implementation guides, including those mandated under HIPAA*
- Some are not as familiar with another X12 committee, the Registered Standards Committee (RSC)
  - *The RSC's External Code List Oversite (ECO) subcommittee develops and maintains X12's terminology, aka vocabulary, resources, excepting those defined within the EDI Standard*

X12 PRODUCTS

X12's product library includes

- *The EDI Standard which is comprised of hundreds of transactions and internal code lists*
- *Technical reports, including implementation guides, describing the business rules and data content for various uses of the EDI Standard*
- *External code lists, aka terminology or vocabulary resources*
- *Schema based on the EDI Standard and implementation guides*
- *Other offerings designed to assist implementers*

X12'S APPROACH

- Open-minded, with vision and insight related to data exchange in both current and developing technologies
- Responsive to business requirements presented by other organizations
- Collaborating enthusiastically with other SDOs, industry groups, government, and business-focused entities

Health Care Claim: Dental, Institutional and Professional

About X12

Purpose and Scope

Benefits

Users

Workflow

Wrap-Up

PURPOSE AND SCOPE

- The claim transaction standards have been developed to enable health care providers to submit requests for reimbursement (or encounters) to health plans and other entities, so that the claims can be processed for payment or reporting.
- There are multiple versions of the 837 used in the industry today.
- For payment and encounter reporting:
  - 837 Professional (HIPAA Mandated)
  - 837 Institutional (HIPAA Mandated)
  - 837 Dental (HIPAA Mandated)
- For non-payment purposes (not included in this presentation)
  - *837 Reporting*
  - *837 Post Adjudicated Claim Data Reporting (Professional, Institutional and Dental)*
  - *837 Pre-determination (Professional and Institutional)*

BENEFITS

- Used consistently by multiple stakeholders.
- Provides a vehicle to submit claims data from providers to payers either directly or through a clearinghouse in a standard format.
- Gives payers information needed to process and pay or deny submitted claims
- Allows the possibility of high percentage of first pass adjudication without the intervention of manual work.
- Allows submission of coordination of benefit claims.
- Allows for standardized data to be transmitted between trading partners.
- Uses information gathered in other transactions (eligibility, prior authorization)

USERS

- Health care providers, such as
  - *physicians,*
  - *practitioners,*
  - *suppliers,*
  - *facilities, and*
  - *hospitals*
- Health care and property/casualty (including worker's compensation payers)
- Clearinghouses, vendors, repricers, and trading partners
- Payers who submit COB claims to other payers directly

WORKFLOW

- After a service is performed, submitter (provider or billing entity) gather necessary information about the patient, health plan, and service to create the claim or encounter
- Electronic transaction created and sent directly to the payer, or to an intermediary for further transmission. There may be several intermediaries in the flow. Each may perform edits and accept or reject the transaction.
- Upon receipt by the health plan, additional business edits are performed to accept or deny the transaction.
- Health plan does additional processing to adjudicate the claim and come to a final decision.
- Provider can get an acknowledgement, can query the claim status, and will eventually get a response in a remittance advice.

Wrap Up

REMINDER

- X12N maintains a library of informational PowerPoints, position papers, checklists, etc.
- Visit X12's Info Center at x12.org to review other relevant information, including:
  - *ASCN023 – Overview of the X12N Subcommittee*
  - *ASCN024 – Overview of X12N's Task Groups*
  - *ASCN025 – Overview of X12N's Work Groups*
  - *ASCN026 through ASCN038 provide more details about each of X12's individual work groups **

* indicates planned materials

STAY CONNECTED

- Learn more about X12 and become a member at X12.org
- Stay informed by following X12
  - *@x12standards on Twitter*
  - *#X12 on LinkedIn*

FEEDBACK
IDEAS
QUESTIONS

TELL US AT

X12.ORG/FEEDBACK

CORE Overview

Bob Bowman
Principal, Interoperability and Standards, CAQH CORE

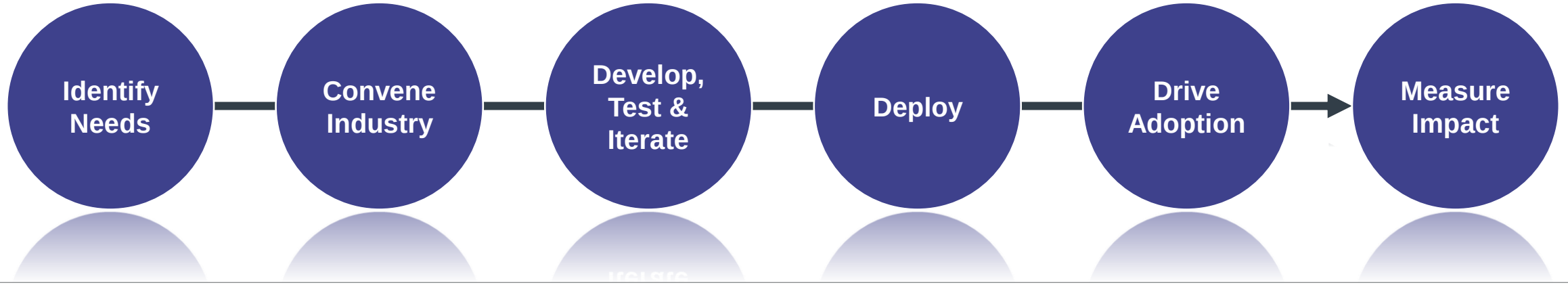
CAQH CORE Mission & Vision

Mission

Drive the creation and adoption of healthcare operating rules that **support standards, accelerate interoperability and align administrative and clinical activities** among providers, payers and consumers.

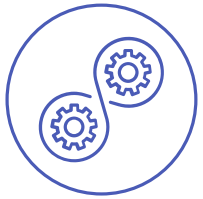
Vision

An **industry-wide facilitator** of a trusted, simple and sustainable healthcare data exchange that evolves and aligns with market needs.



Committee on **O**perating **R**ules for Information **E**xchange

Federally Designated by the Department of Health and Human Services (HHS) as the National Operating Rule Authoring Entity for all HIPAA mandated administrative transactions.



Develop business rules to help industry effectively and efficiently use electronic standards while remaining technology- and standard-agnostic.

Multi-stakeholder Board Members include health plans, providers, vendors, and government entities. Advisors to the Board include SDOs.

More than 100 CAQH 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.

Vendors & Clearinghouses

- AIM Specialty Health
- athenahealth
- Availity, LLC
- Averhealth
- Cedar Inc
- Cerner/Healthcare Data Exchange
- Change Healthcare
- ClaimMD
- Cloud Software Group
- Cognizant
- Conduent
- CSRA
- DXC Technology
- Edifecs
- Epic
- Experian
- Healthedge Software Inc
- HEALTHeNET
- HMS
- Infocrossing LLC
- JP Morgan Healthcare Payments
- NantHealth NaviNet
- NextGen Healthcare Information Systems, Inc.
- OptumInsight
- PaySpan
- PNC Bank
- PriorAuthNow
- SS&C Health
- 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
- Cleveland Clinic
- 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
- Ortho NorthEast (ONE)
- OSF HealthCare
- Peace Health
- St. Joseph's Health
- Virginia Mason Medical Center

Other

- Accenture
- ASC X12
- Cognosante
- Healthcare Business Management Association
- Healthcare Business Association of New York (HCBA)
- HL7
- NACHA The Electronic Payments Association
- National Association of Health Data Organizations (NAHDO)
- National Committee for Quality Assurance (NCQA)
- National Council for Prescription Drug Programs (NCPDP)
- New England HealthCare Exchange Network (NEHEN)
- Preferra Insurance Company Risk Retention Group
- Private Sector Technology Group
- Tata Consultancy Services Ltd
- Utilization Review Accreditation Commission (URAC)
- Work Group for Electronic Data Interchange (WEDI)

Account for 75% of total American covered lives.

Operating Rules Defined

ACA Definition

- The “necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications.”
- Federally mandated for the HIPAA adopted electronic standards.

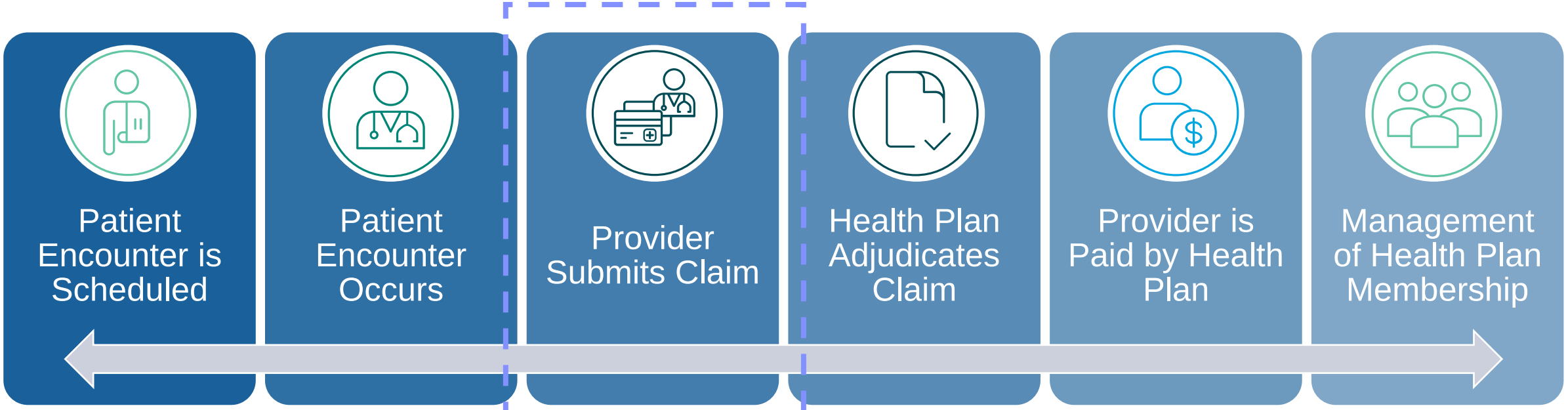
Common in Other Industries

- Many industries rely on operating rules including:
  - Financial services
  - Transportation
  - Retail

Support Revenue Cycle Automation

- Operating rules create common expectations for electronic data exchange.
- Allow provider and payer systems to automate communications across trading partners.

CAQH CORE Operating Rules Support Key Revenue Cycle Functions



*Rule Set Contains Federally Mandated Operating Rules

CORE Health Care Claims Operating Rule Overview

CORE Health Care Claim (837) Infrastructure Rule

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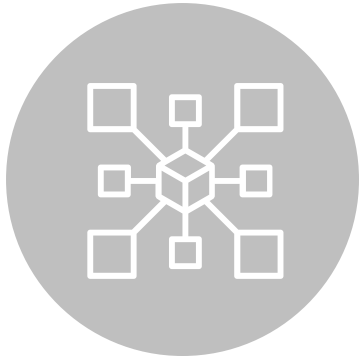
Principal, Interoperability and Standards, CAQH CORE

Infrastructure Operating Rules
Definition and Overview



Infrastructure Operating Rules

Infrastructure rules apply across transactions – establishing basic expectations on how the US data exchange “system” works; e.g., ability to track response times across all trading partners.

Note: Infrastructure rules can be used with any version of a standard.

Rule Requirements

Each set of CAQH CORE Operating Rules includes an infrastructure rule with requirements including processing mode, response time, system availability, connectivity, acknowledgements, and companion guides, by transaction.

CORE Health Care Claim (837) Infrastructure Rule

The CORE Health Care Claim (837) Infrastructure Rule Version HC.2.0 Requires Health Plans to Support:

Common connectivity method.	90% system availability.	Claim acknowledgements and response time for availability of acknowledgments.	Companion guide template.

CORE Health Care Claims Operating Rule Overview

CORE Health Care Claim Data Content Rule Development

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Principal, Interoperability and Standards, CAQH CORE

CORE Health Care Claims Data Content Rule Development – *In Progress*

Business Challenges

Inconsistent Data
Information shared in claim transactions between providers and payers varies significantly, increasing administrative burden and requiring manual intervention for claims management.

Increasing Denial Rates
According to the Change Healthcare 2022 Revenue Cycle Denials Index, the average initial denial rate across 1,500 hospitals in the United States was almost 12% in the first half of 2022 compared to just 10% in 2020 and 9% in 2016.

2023 CORE Rule Development Group Vision

Establish **data content requirements** for transactions supporting claim submission, acknowledgment, and error reporting to help avoid rejections and costly downstream appeals.

Environmental scanning and additional research conducted in 2022 and early 2023 identified preliminary opportunities to address business challenges.

The Subgroup launched on April 13, 2023 to begin evaluating opportunity areas for rule development.

CORE Health Care Claims Data Content Rule Development – *In Progress*
Focus Areas

Telehealth POS + Modifier Placement

DRAFT CORE Data Content Operating Rule for the Health Care Claim Transaction - Telehealth Claim Submission

- Modifier assignment for POS 10 and 02 is standardized to modifiers 93, 95, or GT.
- Definitions of POS + modifier combinations are established in an **accessible reference** resource.

Significant because:

- A rule provides needed clarity on place of service and modifier alignment.

277CA Data Alignment

DRAFT CORE Data Content Operating Rule for the 277CA Transaction

- Claim Status Category Codes (CSCC) and Claim Status Code (CSC) errors and rejection reasons are standardized into business scenarios and code combinations.
- Standardized data used to associate the 277CA transaction with an 837 transaction.
- Standardized data used to associate a 277CA error code with an 837 service line item.

Significant because:

- Standardized use of the 277CA could increase transaction adoption.
- With improved data quality and greater transaction adoption comes simplified claim resubmission.

COB Claim Submission

DRAFT CORE Data Content Operating Rule for the Health Care Claim Submission Transaction

- Standardized **minimum required data elements** for successful processing of COB.
- Standardized **format** for listing health plan COB data requirements.
- Alignment on **electronic access** of health plan COB data requirements.

Significant because:

- Lack of uniform 837 COB requirements creates additional administrative burden.
- Uniform data content requirements can remediate questions on payment or care attribution, among other items.

Questions

Call to Action

Call to Action

E-mail CORE@CAQH.ORG to Get Involved!

Become a CORE Participant
Collaborate with decision makers that comprise 75% of the industry to drive creation of operating rules and accelerate interoperability.

Become CORE Certified

Demonstrate conformance and commitment to streamlining administrative data exchange.

Be an Advocate
Work with CORE to measure the impact of operating rules and corresponding standards on organizations' efficiency metrics.

Upcoming Events

Webinars

Interoperability in value-based care: Standardizing information exchange using CORE Operating Rules
- October 18th, 2:30-3:30pm ET

X12 and CORE Education Series: 270/271 Transaction and Eligibility & Benefits Operating Rules
- October 24th, 2:00-3:00pm

CORE Q4 Town Hall
- November 1st, 2:00-3:00pm

Operating Rules: An Essential Conduit for Administrative and Clinical Interoperability
- November 30th, 2:00-3:00pm

X12 and CORE Education Series: X12/CORE Education Series: 275 Transaction & Attachments Operating Rules
- December 7th, 2:00-3:00pm ET

Conferences

HBMA 2023 Fall Revenue Cycle Management Conference
- Opportunities for Improving the Healthcare Claims Process with CAQH CORE Operating Rules
- *Indianapolis, IN*
- September 26th, 3:30-4:30pm ET

2023 WEDI National Conference
- *Washington, DC*
- Healthcare Standard Development Organization (SDO) Updates
- Date & time TBA

CAQH Connect 2023
- *Washington, DC*
- September 27-29th
- **Register Here**!

Thank you for joining us!

E-mail CORE@CAQH.ORG to Get Involved!