The Claim Status Transaction

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

Problem Statement

Current State Challenges:

The current claim status processes involve complex issues including mismatched expectations of claim status updates, confusion due to inconsistent error coding, and data misalignment that complicates transaction handling. These inefficiencies not only escalate operational costs but also delay the billing process.
With over 10 billion claims submitted annually, even a small reduction in resubmissions translates into significant industry cost savings.[2] When the stakeholders of a transaction are aligned on the minimum necessary data to exchange, they can rely on expected and uniform data through predictable exchange mechanisms.

Impact:

These challenges adversely affect all stakeholders— patients experience delays and transparency issues in billing, providers endure increased operational complexities, and health plans face higher service management costs. As CORE reviews opportunities for rule development for the claim status transaction, three key metrics to highlight are a combined potential annual cost savings for the medical and dental industries of $3.7B, average medical provider time savings of 17 minutes, and average dental provider time savings of 14 minutes by moving from partially or fully manual to fully electronic claim status transactions.[3]

Analysis and Opportunities

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

Industry Insights:

Providers and their vendors would like the full functionality of the transaction to be implemented more broadly by health plans and vendors, rather than the limited implementations they often experience today.

Standardizing Error Code Combinations:

Standardizing Error Code Combinations: Error-related category codes should be paired with status codes that pinpoint the issue, ensuring clarity for follow-up. Not doing so creates uncertainty and builds doubt in the usefulness of the entire code set. Clear and consistent error codes, analogous to the X12 835 model, can greatly reduce the time providers spend deciphering claim updates, thereby enhancing efficiency. Similar to how the CORE Payment & Remittance Uniform Use of CARCs and RARCs (835) Rule standardized claim payment communication, creating analogous business scenarios for CSC and CSCC codes would support uniform, clear, and actionable provider follow-up.

Data Alignment:

Uniform data requirements across health plans would decrease the need for provider-specific adjustments, fostering a more streamlined claim process. To support the identification of a claim, the claim status inquiry contains several standard data fields like Payer Claim Control Number, Line Item Control Number, and Patient Control Number; however, health plan search criteria differ between health plans, potentially causing failed inquiries where the claim cannot be found by the health plan or the return of multiple claims.

Additionally, a second data alignment challenge lies within the interplay between the claim status and the remittance advice. There are often discrepancies between what is reported by a health plan in a claim status inquiry and what is reported on the remittance advice. Associating payments with claims as soon as the information becomes available, using situationally required data like check number, strengthens provider accounting practices. Without check number, providers simply collect "paid" claim status responses and wait to close their accounts – a missed opportunity to improve accounts receivable.

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

Enabling Real-Time Data Exchange:
Current barriers to real-time data flow need to be addressed to keep providers updated promptly, thus speeding up the overall claims handling process. Providers and health plans often do not have the infrastructure to facilitate accurate real-time inquiries and responses. Barriers to building out a high quality, real-time claim status interaction often come down to a reluctance from the industry to invest time and resources that enable a real-time interaction. Multiple stakeholders shared that calling a health plan or using a health plan provider portal often produces more current information than what is available through the claim status transaction.

Opportunities for Follow-Up Efficiency:
When a claim status response indicates a potential denial or requires additional information, LOINC codes can point providers to the exact information needed to successfully process the claim. Industry desires specificity in the claim status response, as currently, calls to health plan representatives or visits to the portal are needed for clarification. The inclusion of pointer data elements such as LOINC codes could help direct and potentially automate pulling additional documentation.

An operating rule that identifies key data to support diverse use cases for claim status helps both providers and health plans by removing variability in locating a unique claim and reporting its status within the adjudication process. For health plans, this raises the floor for data available to query their systems, allowing them to create search functionality that ensures successful location and matching of an inquiry to the claim.

The last name normalization requirements in CORE's Eligibility & Benefits Operating Rules may also help bring uniformity across the claim status inquiry and response transactions that rely on consistent patient data to identify claims. Additionally, a situational requirement for check number when a paid status is returned could inform next steps for the provider with greater consistency and specificity than stakeholders see today.

Solutions and Call to Action

Proposed Solutions:
The implementation of CORE's Operating Rules in the areas of error code standardization, data alignment, and real-time data exchange can significantly mitigate existing challenges.

Benefits:
These changes are expected to reduce costs for providers and health plans, shorten processing times, and improve billing and claims accuracy. Understanding the status of a claim before the remittance advice accelerates follow-up and improves provider cash flows by moving claims rework to within days of submission rather than weeks. 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.

Leveraging the claim status inquiry and response to reduce administrative burden in the healthcare industry can address the $3.7B savings opportunity related to the transaction.[4]

Call to Action:
Stakeholders are urged to engage in the development and adoption of these rules to realize the potential benefits across the healthcare industry. Contact core@caqh.org to get involved.

Conclusion

This brief underscores the crucial need for collaborative industry efforts to enhance the claim status transaction process. By embracing standardized practices, the healthcare sector can achieve greater efficiency and accuracy, leading to substantial cost savings and improved service quality for all parties involved.

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