October 10, 2024

Tammy Feenstra Banks, MBA, FACMPE
Steven Wagner, MBA
National Committee for Vital and Health Statistics
3311 Toledo Road
Hyattsville, MD 20782-2002

RE: Request for NCVHS Review of New and Updated CAQH CORE Operating Rules for Federal Adoption

Dear Ms. Feenstra Banks and Mr. Wagner:

As the designated Operating Rule Authoring Entity for the HIPAA-mandated electronic transactions, and a leader in the development of voluntary solutions for healthcare data interoperability, the CAQH Committee on Operating Rules for Information Exchange (CORE) requests the National Committee on Vital and Health Statistics (NCVHS) review of a set of operating rules for federal adoption by the Department of Health and Human Services (HHS).

These operating rules were developed and updated through the CORE multistakeholder, consensus-based process and achieved at least 86 percent support from CORE Participating Organizations. CORE Participants represent more than 75 percent of insured Americans and includes industry leaders from health and dental plans, providers, vendors, state and federal government entities, industry associations, and standards development organizations (SDO).

CORE Operating Rules Recommended for Federally Mandated Adoption

The CORE Board proposes the following package of CORE Operating Rules for federal adoption, comprised of an updated operating rule set and a new operating rule set:

1. **Updated: CORE Operating Rules to Modernize Workflows for Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA) Enrollment.**

   Updates to these federally mandated operating rules provide critical updates to the data sets, including enabling machine readability and the ability to more easily refine the data elements in the future. Additional benefits of the rule updates include strengthening fraud detection, enhancing scalability by adding support for bulk enrollment, and clarifying timing and notification requirements for submissions. Notably, the operating rules also

empower transparency of applicable EFT fees and specify that health plans must provide guidance for providers to opt-in or out of non-EFT payment methods.

- CORE Payment & Remittance EFT Enrollment Data Rule vPR.2.0
- CORE Required Maximum EFT Enrollment Data Set Companion Document
- CORE Payment & Remittance ERA Enrollment Data Rule vPR.2.0
- CORE Required Maximum ERA Enrollment Data Set Companion Document

2. **New: CORE Operating Rules to Facilitate a Standard, Secure, and Timely Claim Submission Workflow.**

   CORE Participants developed and approved a complementary set of operating rules and resources for the federally mandated ASC X12N 837 Claim Submission Transaction and the voluntary ASC X12N 277 Claim Acknowledgment Transaction. Together, these operating rules address variation that perpetuates manual workflows for initial claim submissions, denial and appeals management, and claim resubmissions. These rules are bolstered by proven CORE infrastructure requirements that enable common protocols for real-time and batch exchange and reference industry best practices for connectivity and security between industry trading partners.

   - CORE Health Care Claim Infrastructure Rule vHC.2.0
   - CORE Health Care Claims Data Content Rule vHC.1.0
   - CORE Claim Acknowledgement Data Content Rule vCA.1.0
   - CORE-required Error Code Combinations for CORE-defined Business Scenarios

Updates to federally mandated rules to account for new and evolving business needs

Included are detailed descriptions of the CORE Operating Rule Sets submitted for review and consideration by NCVHS. Information from the comprehensive environmental scans used to support operating rule development is included to demonstrate the business needs addressed by the requirements.

I. Updates to the CORE EFT and ERA Enrollment Data Rules

Background

Fully electronic[1] delivery of claim payments and associated remittance advice aids provider operations by accelerating accurate and well-documented funds flow. Despite the benefit of and associated HIPAA-mandate for fully electronic and automated payment, industry adoption lags expected levels. In 2022, electronic claim payments facilitated through Automated Clearing House/Electronic Fund Transfer (ACH/EFT) only occurred 73 percent of the time. Remittance advice – or the information about adjustments or denials – arrived fully electronically 88 percent of the time.[2]

Electronic EFT and ERA transactions are carried out in accordance with a federally mandated set of CORE Payment and Remittance Operating Rules,[3] as well as voluntary but highly adopted standards and operating rules maintained by Nacha.[4] Together, these rules set a uniform, consensus-based framework that addresses most industry requirements for enrollment in and receipt of electronic payments.

To take part in the electronic payment ecosystem, providers must enroll with health plans and their agents. The federally mandated CORE EFT and ERA Enrollment Data Rules, required under HIPAA since 2014, address the variability encountered by providers during enrollment by defining a maximum set of data elements health plans must draw from for enrollment and validation. Additionally, the mandated operating rules establish "safe harbor" electronic exchange, ensuring flexible support for electronic enrollment between trading partners.

The foundational requirements established in these operating rules set a floor and aligned industry to the need and benefit of standardized EFT and ERA enrollment data. Since initial development, approval and mandate, the business of healthcare has evolved, necessitating updates to the operating rules and underlying data sets. CORE environmental scanning and industry engagement revealed several needs related to bulk enrollment, security and fraud protection, and the rise of alternative payment methodologies – among others – that should be addressed in operating rules to provide stability and uniformity for the industry. The CORE EFT and

[1] Transactions conducted using a HIPAA-mandated standard, unless otherwise specified.
[2] CAQH (2024). 2023 CAQH Index Report. Retrieved from: https://www.caqh.org/insights/caqh-index-report
[3] CAQH CORE. CORE Operating Rules. (2024). Available at CAQH CORE – Committee on Operating Rules for Information Exchange.
[4] Nacha. Healthcare EFT Resources. Published 2024. Accessed from https://www.nacha.org/healthcare-resources/

ERA Enrollment Data Operating Rules were updated to directly address these needs and reduce obstacles to EFT and ERA enrollment. Additionally, associated data sets were refined and externalized to support a streamlined update and maintenance process.

Rule Requirements

The updated CORE EFT and ERA Enrollment Data Operating Rules, presented here for consideration for federal mandate, provide necessary modernization that encourages greater adoption of EFT and ERA and strengthens security to avoid jeopardizing sensitive information. The new requirements and their benefits to industry stakeholders are outlined below.

a. Support for Bulk Enrollment

Consolidation in the healthcare industry through mergers and acquisitions has accelerated, and large group practices, either operating independently or as part of a hospital, are becoming more common. Updates to the CORE Operating Rules support repeated data element groups in a single submission. This requirement enables multiple providers to be enrolled at once, saving both the health plan and providers the burden of individually submitting multiple times for providers associated with a single entity.

b. Streamlined Data Set Enhancements

The CORE EFT and ERA Enrollment Data Rule Companion Documents were updated to more completely reflect current business needs by expanding the maximum set of information a health plan or its agent can collect from an enrolling provider. This information is stored centrally and is presented in a format that accommodates machine readability. Additionally, new data fields, such as tax identification numbers (TIN) and business entity type, were added to assist with backend validation following a submission. These additions increase accuracy, assist with compliance, and mitigate opportunity for fraud.

c. Notifications

Updates establish timely notification requirements that health plans must fulfill to entities who submit enrollments. Upon submission, a health plan must return notification of receipt within 24 hours. Upon completion of processing, a health plan must return a notification of completion in two weeks or less. Health plans and their agents are required to meet these requirements 90 percent of the time, measured monthly. The obligation to adhere to the requirements at least 90

percent of the time is well-aligned with industry driven, consensus-based requirements in the existing CORE Infrastructure Operating Rules.

d. Transparency and Trust Frameworks

To align with modern security considerations, the updated operating rules incorporate new fraud detection and prevention measures, such as multi-factor authentication (MFA) and the use of security codes. Additionally, the updated operating rules address challenges with alternative payment methods – such as a virtual credit cards – by requiring health plans to disclose any related EFT fees and to seek consent from providers by presenting them with the option to 'opt-out' of alternative payments. Previously, the industry defaulted to an automatic 'opt-in' without clear instruction how to 'opt-out.' These impactful changes ensure the secure exchange of information while enhancing the trust between trading partners involved in the enrollment process.

e. Accounting for Future Updates

As industry requirements shift, CORE routinely considers what updates must be applied to existing operating rules. CORE gains these insights through direct interaction with industry stakeholders, as well as through surveys, interviews, and other primary and secondary resources. To accommodate future updates to the CORE EFT and ERA Enrollment Data Rules, key data elements used in the structure, validation, and confirmation of submissions have been externalized into the respective CORE EFT and ERA Enrollment Data Rules Companion Documents. This key step allows CORE Participants to rapidly accommodate key updates when new data needs are identified and prioritized by industry without need for new regulatory action.

Industry Value and Impact

Updates to the CORE EFT and ERA Enrollment Data Rules support the continued adoption of fully electronic claim payment and remittance advice. By switching to fully automated claim payments, the medical industry could save $524 million annually. Likewise, by fully automating remittance advice the medical industry could save over $700 million annually. Additionally, automation supports reduction of provider burnout by respectively saving, on average, 3 to 5 minutes per transaction. Operating rules are essential to achieve these benefits. Similar saving opportunities

can be observed in the dental industry, with the realization of fully electronic claim payment and remittance advice respectively totaling $279 million and $314 million.[5]

CORE Participants strongly agreed that the updated rule requirements would benefit operational efficiency and improve provider and patient satisfaction. Participants further agreed that, on balance, the resources required for implementation are not significant relative to the advantages facilitated by the updated rule requirements. On average, CORE Participants estimated the rule updates would take about 22 months to implement and an additional 18 months to realize return on investment – an overall reasonable timeframe for such an investment.

Updates to the EFT and ERA Enrollment Data Operating Rules received 86 percent support in the CORE industry-led, consensus-based process. Health plans, providers, vendors, clearinghouses, government agencies, industry associations, and standards development organizations were all involved and engaged during development. The updated operating rules were unanimously approved by the multi-stakeholder CORE Board.

II. CORE Operating Rules to Strengthen Health Care Claim Workflows

Background

Fully electronic claim submission using the ASC X12N 837 transaction is approaching full adoption in the medical and dental industries – reaching 98 percent and 87 percent adoption in 2022,[6] respectively. As the industry approaches universal adoption of the X12 837 standard, CORE Participants and industry research indicates that aspects of the transaction still require costly manual intervention, namely, the denials, appeals, and resubmissions process.

According to the 2023 CAQH Index Report, despite high adoption of the claim submission transaction, over $2 billion dollars of medical industry savings opportunity remains on the table. The excess cost relative to high levels of automation indicates the persistence of manual workflows, at least partially driven by an arduous reconciliation process caused by inconsistent data submission requirements between health plans. Inconsistent requirements result in costly denials that impact nearly 12 percent of submitted claims, often due to them containing invalid or

[5] CAQH (2024). 2023 CAQH Index Report. Retrieved from: https://www.caqh.org/insights/caqh-index-report
[6] Ibid.

incomplete data.[7] CORE Operating Rules unify health plan requirements for a variety of use-cases, including those emerging for value-based care and telehealth.

The complexity of coordination of benefits (COB) workflows further perpetuates costly manual processes. Though 90 percent automated, according to the 2023 CAQH Index, manual intervention results in higher-than-anticipated costs. Stubborn, fully manual workflows account for an additional $26 million dollars in savings opportunity between the medical and dental industries. Savings opportunities are likely higher as this figure does not account for the time spent preparing the COB claim that – though technically automated since it is conducted using the X12 837 – requires increased attention to detail to ensure accuracy. Addressing the complexity of coordination of benefits by indicating a uniform, reproducible approach will empower greater automation, resulting in cost and time savings.

Standardization of data content for claim submissions helps avoid errors that result in costly denials, appeals, and resubmissions. Even with well-defined data content, however, errors can still occur. Industry stakeholders recognize this fundamental truth but cite that it can take 30-45 days for errors to be communicated, resulting in delayed payment and negatively impacting provider satisfaction. CORE Participants identified acknowledgment transactions, which have 100 percent voluntary adoption as of 2022,[8] as a method to overcome the lag between submission and error reporting.

Standardizing the data content contained in acknowledgments – specifically using the ASC X12N 277 Claim Acknowledgment transaction – accommodates front-end identification of discrepancies that can be addressed quickly and completely by submitters, expediting payment and reducing workload. Given that nearly 41 percent of denials occur at the front-end, standardizing error reporting at the point of submissions can expedite resubmission and acceptance.[9]

The proposed set of CORE Health Care Claim Operating Rules are unified by consensus-based infrastructure requirements that account for the secure, consistent exchange of data. As with other CORE Infrastructure Rules presently adopted and formally recommended for federal

[7] Change Healthcare. "The Optum 2022 Revenue Cycle Denials Index." Retrieved from: The Change Healthcare 2022 Revenue Cycle Denials Index | Change Healthcare.
[8] CAQH (2024). 2023 CAQH Index Report. Retrieved from: https://www.caqh.org/insights/caqh-index-report
[9] Change Healthcare. "The Optum 2022 Revenue Cycle Denials Index." Retrieved from: The Change Healthcare 2022 Revenue Cycle Denials Index | Change Healthcare.

mandate, requirements facilitate batch and real-time processing modes, dictate minimum health plan system availability, and reference CORE Connectivity requirements, which ensure secure exchange between industry trading partners using SOAP and REST formats. Federal adoption of CORE Infrastructure Requirements for claim transactions is essential to promote consistency with other adopted operating rule sets and to maintain the secure transfer of health data exchange.

Collectively, the CORE Health Care Claim Operating Rules provide foundational requirements that refine and strengthen the claim submission and adjudication workflow. Additionally, the operating rules establish consistent expectations for data exchange by using the X12 277CA to provide reliable, real-time indications of when a claim is successfully submitted. Universal adoption of this framework aids the secure exchange of information and could also act as a component of an "early warning system" for cyberattacks.

In the event a cyberattack has occurred that has compromised claim processing systems, the lack of a detailed acknowledgment can act as an early signal of failure. This, in turn, triggers appropriate follow-up, potentially highlighting impacts earlier and expediting mitigation. If these requirements were in place during recent cyberattacks, acknowledgment of the impact may have occurred more quickly, potentially lessening the cascading effects across industry.

Rule Requirements

The content below summarizes the requirements included in the new CORE Health Care Claim and Claim Acknowledgement (X12 837 and 277CA) Data Content Rules, and the CORE Health Care Claim Infrastructure Rule.

a. Remote Care Delivery/Telemedicine

The CORE Health Care Claims Data Content Rule standardizes how providers must use place of service (POS) and Current Procedural Terminology (CPT) modifiers when billing for Telehealth and other remote care services. Presently, health plan requirements for the documentation of POS and modifiers for an X12 837 vary. Aligning requirements to a defined set of POS and CPT modifier codes creates a simpler context for submissions, mitigating potential errors and reducing administrative burden.

b. Required Data Content for the Submission of Multiple Claims at a Single Encounter

Alternative payment and value-based care contracts expose providers to innovative methodologies, such as risk adjustment and quality measurement, that rely on the administrative

documentation of diagnoses and other services. The professional claim submission (X12 837P) is limited to 12 diagnosis fields, causing providers to de-prioritize the inclusion of select diagnoses. The CORE Health Care Claims Data Content Rule establishes a standard set of data that must be included on a claim submission to allows multiple claims to be submitted for a single encounter, without having them rejected as a duplicate. These requirements allow for the documentation of a greater number of diagnoses, allowing for clinical accuracy and support of risk adjustment and social determinants of health (SDOH).

c. Specificity of COB Requirements

The CORE Health Care Claims Data Content Rule directly indicates the type and location of data that must be included on a claim submission to facilitate COB between primary, secondary, and tertiary health plans. The data content requirements in the operating rule specifically address the most common causes of COB-related errors on the X12 837. This empowers COB to be completed correctly on the first try and limits the impact of denials or other costly "reworks" during the adjudication process. The rule requirements add significant value by providing direct and specific guidance to providers and plans at the line-item level.

d. Error Specification

The CORE Claim Acknowledgment Data Content Rule establishes the CORE-required Code Set for Error Reporting, a minimum set of business scenarios each containing a maximum set of claim status category codes (CSCC) and claim status codes (CSC) that must be used when reporting errors in the X12 277CA. The consensus-based requirements position error reporting at the front-end of the claim adjudication process, allowing providers to address deficiencies more quickly and expedite their payment. Already a highly adopted transaction, operating rule requirements enhance the impact and efficiency of the voluntary X12 277CA transaction.

e. Consistent Response Times, Availability, and Security

The CORE Health Care Claim Infrastructure Rule is consistent with the CORE Infrastructure requirements that are already mandated – or formally recommended for mandate – under HIPAA. The set of CORE Health Care Claim Operating Rules are strengthened by consensus-based CORE Infrastructure requirements that dictate conduct for real-time and batch processing, system availability, and secure connectivity requirements. The rule benefits the industry by advancing toward real-time adjudication of health care claims while progressing security requirements that can prevent harmful breaches or cyberattacks.

Impact on Industry and Other Stakeholders

The requirements in the CORE Health Care Claims Data Content and Infrastructure Rules work in concert to reduce errors, rejections, and appeals by standardizing submission content and creating a secure technical foundation for exchange. CORE Participants recognize these requirements as essential to eliminating persistent manual workflows, which in turn allows industry to recoup part or all the $2 billion cost saving opportunity.

CORE Participants further recognize the benefit of adding utility to the acknowledgment transactions that, despite being highly implemented, have limited efficacy due to inconsistent or proprietary data. The CORE Claim Acknowledgment Data Content Rule provides a basis for the industry to achieve greater fluency with and realize the utility of the X12 277CA transaction as stakeholders collectively move toward real-time adjudication of claim submissions.

Implementation of these requirements is expected to take about 19 months. Return-on-investment impact is expected to take approximately 16 months after implementation. Though full impact may take time to be fully realized, the consequence of cutting per transaction submission costs, improvements to data quality, and positive effects on provider satisfaction and workflows are expected immediately following implementation.

CORE Participants were supportive of the requirements in the CORE Health Care Claim and Claim Acknowledgment Rules, supporting both at 96 percent and 88 percent, respectively. Each rule was unanimously approved by the CORE Board and recommended for consideration for federal adoption.

Conclusion

Over 100 CORE Participant Organizations align to the consensus-based development and approval of the operating rules. The business use cases addressed by the rules represent industry-identified issues that prevent full automation and drive-up costs through persistent manual workflows. All the rules presented in this letter received at least 86 percent support from CORE Participating Organizations, lending weight to the importance of these requirements and the eagerness of industry stakeholders to integrate the rules into their operations.

CORE is available to answer questions related to these rules. You can find a detailed overview of their requirements in the appendix of this document. Our team welcomes engagement prior to the

NCVHS public hearing and looks forward to being active participants in the process. You can contact Erin Weber at eweber@caqh.org or 202-517-0435 to connect and engage on these topics.

Sincerely,

Erin Weber, MS
Chief Policy and Research Officer, CAQH
Signature: Signed by: Erin Weber 1D7E6C6E3AB0443...

Linda Reed, RN, MBA, CHCIO, FCHIME
Senior Vice President and Chief Information Officer
St. Joseph's Health
CORE Board Chair
Signature: Signed by: Linda Reed CEE29B29CC7148C...

Emily Brannen
Vice President, Digital and Service Strategy
Blue Cross Blue Shield of North Carolina
CORE Board Vice Chair
Signature: Signed by: Emily Brannen 38BE7D97D73B459...

Jamie Bittner
Senior Director of Provider Digital Transformation and Chief of Staff
UnitedHealth Group
Signature: Signed by: Jamie Bittner 49C5DCD3F5EC45F...

Paul Brient, MBA
Senior Vice President and Chief Product Officer
Athenahealth
Signature: Signed by: Paul Brient EDDA46CDABA24C2...

Brendan Crotty
Head of Healthcare Payments Product, JP. Morgan and Chief Product Officer, InstaMed, a J.P. Morgan Company
Signature: Signed by: Brendan Crotty 4E7E519A1D7D41B...

Marilyn J. Heine, MD, FACEP, FACP, FCPP
Clinical Assistant Professor of Medicine
Drexel University College of Medicine
Signature: Signed by: Marilyn J. Heine 00D88D7CBE69428...

Jim McDermott
Vice President, Research and Development – Health Plan Products
Epic
Signature: DocuSigned by: Jim McDermott 726245AE1800461...

Susan Moon
Senior Vice President of Digital & Customer Experience
Centene
Signature: Signed by: Susan Moon 4B831CB725E1404...

Margaret Schuler, MBA
Senior Vice President, Practice Support Operations and Revenue Cycle Management
Aspen Dental Management, Inc.
Signature: Signed by: Margaret Schuler BE2C069470B0498...

Walter G. Suarez, MD, MPH, FHIMSS
Executive Director of Health IT Strategy and Policy
Kaiser Permanente
Signature: DocuSigned by: Walter G. Suarez 8A5A6987EA0B4AB...

Scott Waller
Vice President
Aetna IT Application Delivery Division
Signature: DocuSigned by: Scott Waller E439E586196A432...

John Williford
Vice President and Chief Operations Officer of CMO
Montefiore Care Management
Signature: DocuSigned by: John Williford 99B5985691EE444...

Cc:
Naomi Michaelis, MPA, Acting Chair, NCVHS
Michael Cimmino, Director, CMS National Standards Group
Rachel Goldstein, Vice President, CORE, CAQH
Sarah Ahmad, CEO, CAQH

Appendix A: Required Operating Rules and Standardized Transaction Naming Conventions

Rule Status	Current Mandated Version	Current Mandated Operating Rule Name	Proposed Version
Updated	Phase III CORE 380 EFT Enrollment Data Rule	CAQH CORE Payment & Remittance EFT Enrollment Data Rule Version PR.1.0	CORE Payment & Remittance EFT Enrollment Data Rule vPR.2.0
			CORE Required Maximum EFT Enrollment Data Set Companion Document
	Phase III CORE 382 ERA Enrollment Data Rule	CAQH CORE Payment & Remittance ERA Enrollment Data Rule Version PR.1.0	CORE Payment & Remittance ERA Enrollment Data Rule vPR.2.0
			CORE Required Maximum ERA Enrollment Data Set Companion Document
New	-	-	CORE Health Care Claim (837) Infrastructure Rule vHC.2.0
	-	-	CORE Health Care Claims (837) Data Content Rule vHC.1.0
	-	-	CORE Claim Acknowledgment Data (277CA) Content Rule vCA.1.0
	-	-	CORE-required Error Code Combinations for CORE-defined Business Scenarios

Appendix B: Overview of New and Updated CORE Operating Rules

Appendix B provides a detailed review of each proposed operating rule, outlining specific requirements and their anticipated impacts.

Operating Rules Recommended for Federal Adoption

I. CORE Operating Rules to Modernize Workflows for Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA) Enrollment

Enhancements to the federally mandated operating rule set include data set updates, improved machine readability, and strengthened fraud detection. These updates also support bulk enrollment, clarify submission timing, and ensure transparency of EFT fees, allowing providers to opt in or out of non-EFT payments. These changes respond to the need for more secure enrollment and digital transaction process. Specifically, the updates to the rule:

- Create a uniform enrollment process by enabling bulk enrollment and standardizing data element groups for large entities.
- Update a streamlined data set that aligns with evolving healthcare requirements, enhancing operational efficiency and decision-making.
- Secure the enrollment process with mandatory data fields and business entity identification, strengthening validation and fraud prevention.
- Ensure timely notifications by operationalizing parameters for prompt confirmation upon provider enrollment.
- Increase transparency and trust with enhanced fraud detection measures and clearer guidance on alternative payment methods.

The impacts of enforcing these updates for all HIPAA-covered entities include:

- Flexibility and ease of updates by externalizing key validation elements into a separate, independent process.
- Enhanced security and compliance by defining data requirements that improve encryption and monitor provider information and payments.

- Broad industry consensus on implementation timelines, aligning with Nacha Operating Rules to ensure standardized adherence to fraud detection and security protocols.
- Realization of benefits in line with a predicted 22-month implementation timeline and an expected return-on-investment within 18 months. Changes result in decreased provider abrasion and more predictable, efficient process for EFT/ERA Enrollment.
- Assurance of a strong industry consensus, with the CORE EFT and ERA Enrollment Data Rules respectively receiving 86 percent support from CORE Participants. The CORE Operating Rules have received unanimous support from the CORE Board.

Rule Text:

CORE Payment & Remittance EFT Enrollment Data Rule vPR.2.0
CORE Required Maximum EFT Enrollment Data Set Companion Document
CORE Payment & Remittance ERA Enrollment Data Rule vPR.2.0
CORE Required Maximum ERA Enrollment Data Set Companion Document

II. CORE Operating Rules to Facilitate a Standard, Secure, and Timely Claim Submission Workflow

The proposed CORE Health Care Claim Operating Rules for the federally required ASC X12N 837 Claim Submission transaction and voluntary ASC X12N 277 Claim Acknowledgment transaction address high-frequency, non-standard use cases, such as telehealth and coordination of benefits, which contribute to prolonged manual workflows. These operating rules, supported by CORE Infrastructure requirements, define data requirements for the X12 v5010 837, ensuring consistent protocols for real-time and batch exchanges in line with industry best practices for connectivity and security. Specifically, the proposed rule requirements:

- Align telehealth reporting to streamline submissions, reduce errors, and lower administrative burdens.
- Expand diagnostic code capacity from 12 to 24 per claim, supporting value-based care models and improving documentation.
- Standardize COB requirements to reduce variability and errors in claims processing for primary, secondary, and tertiary plans.

- Reduce transaction costs by decreasing denial rates, shortening payment cycles, and simplifying resubmissions.

The proposed CORE Health Care Claim Operating Rules have a substantial impact on the industry and stakeholders by standardizing processes, improving data quality, and reducing costs. Key impacts include:

- Unify claim submission content and secure data exchange to reduce errors, rejections, and appeals, and help the industry capture a portion of the estimated $2 billion in cost savings.
- Enhance acknowledgment transactions using consistent data requirements, to improve the experience with the X12 277CA transaction, and support the transition to real-time claim adjudication.
- Realize benefits in line with a predicted 19-month implementation timeline and an expected return-on-investment within 16 months. Changes result in reduced submission costs, better data quality, and increased provider satisfaction.
- Assurance of a strong industry consensus, with the CORE Health Care Claim and Claim Acknowledgment Rules respectively receiving 96 percent and 88 percent support from CORE Participants. The CORE Operating Rules have received unanimous support from the CORE Board.

Rule Text:

CORE Health Care Claim Infrastructure Rule vHC.2.0
CORE Health Care Claims Data Content Rule vHC.1.0
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