



CAQH CORE Health Care Claims Focus Group

Call #2
November 2, 2022

Call Document #1

Agenda

Time	Agenda Item	Discussion Item or Action Required
2:00pm	1. Welcome, Antitrust Guidelines and Roll Call	Discussion
2:05pm	2. Call #1 Recap and Takeaways <ul style="list-style-type: none"> ▪ Summarize Key Insights ▪ Review Proposed Action Items ▪ Cover Goals for Call #2 	Discussion
2:15pm	3. Health Care Claims Areas of Opportunity <ul style="list-style-type: none"> ▪ Polling Results and Discussion: <ul style="list-style-type: none"> – Patient Data Sharing – X12 and HL7 FHIR Data Alignment – Claim Rejection Notification and Reporting – Value-Based Payments – Telehealth ▪ Additional Considerations for Priority <ul style="list-style-type: none"> – Appeals – Coordination of Benefits – No Surprises Act AEOB / GFE Requirements 	Discussion
3:25pm	5. Next Steps <ul style="list-style-type: none"> ▪ Health Care Claims Focus Group Straw Poll ▪ [Optional] Call on November 30 to Review Results 	<u>Action Required</u> <i>Agree to Next Steps</i>

Focus Group Direction and Goals of Call #2

Key insights from call #1 and a focus on solutioning

Key Insights

- Data content operating rules apply to **select use cases** in the health care claims workflow
- Health care claims workflow may interact with other transactions
- Pursuing education and industry guidance is a value-add

Takeaways

- Pursue operating rules: Claim Rejection Notification & Reporting and Value-Based Payments
- Additional diligence required: Telehealth and Health Care Claim Appeals
- Do not pursue: Patient Data Sharing and X12 and FHIR Alignment

Goals for Today's Call

- Review polling results and discuss variability present in select areas of focus
- Identify solutions that could be applied to operating rule development

Focus Group Call #1 Attendance

Participant Type	Unique Organizations	Total Individuals
Vendors and Clearinghouses	9	14
Providers	4	7
Health Plans	4	5
Government and Other	4	4

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Health Care Claims Areas of Opportunity

Summary of Opportunity Area Discussion

Conditionally Pursue Operating Rule Development

- **Claim rejection notification and error reporting:** Address error notification and coding requirements for 277CA transaction.
- **Value-based payments:** Seek uniformity of data content for existing and emerging VBP methodologies.

Additional Evaluation to Determine Utility of Operating Rules

- **Telehealth:** Clarify what variability exists in telehealth billing prior to determining the necessity of a data content operating rule.
- **Appeals:** Additional analysis is required to identify the top of reasons for appeals and the solutions that may help minimize variation and complications.

Do Not Pursue Operating Rule Development At This Time

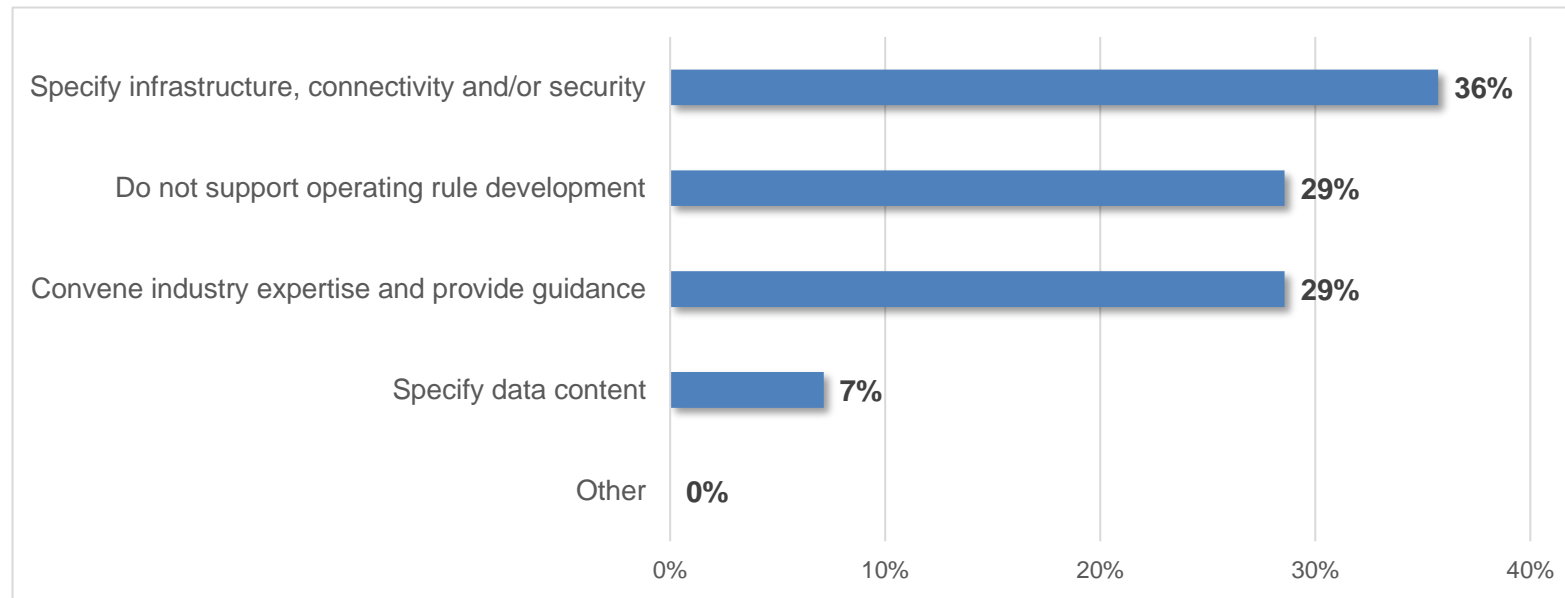
- **Patient data sharing:** Data content rules for patient data sharing generated little support and the industry is still maturing.
- **X12 and FHIR alignment:** CAQH CORE will continue to monitor developments related to X12 and FHIR data alignment and may act when better direction is identified.

Patient Data Sharing

Low interest to pursue data content operating rules; CAQH CORE will continue monitoring

How can CAQH CORE best address issues pertinent to patient data sharing?

Respondents: 11 unique organizations (52%); 14 individuals (45%)



Responses by unique organization type

Respondent Type	Number (%)
Vendor	36%
Provider	27%
Payer	18%
Gov't / Other	18%

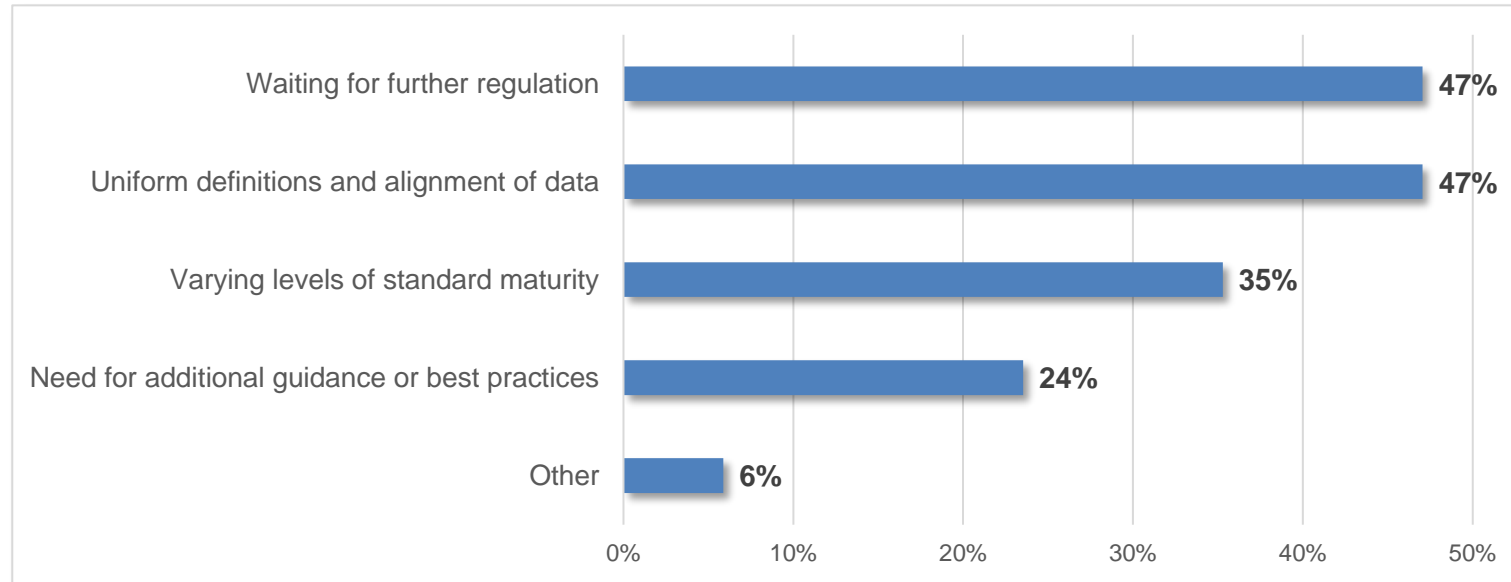
Recommended action: Do not pursue **data content operating rule development** at this time due to low support. CAQH CORE to consider education and industry engagement opportunities.

X12 and FHIR Data Alignment

Awaiting further direction and clarity around the interaction of the two standards

What is the biggest barrier to your organization when considering support of multiple standards?

Respondents: 12 unique organizations (57%); 17 individuals (55%)



Responses by unique organization type

Respondent type	Number (%)
Vendor	42%
Provider	25%
Payer	25%
Gov't / Other	8%

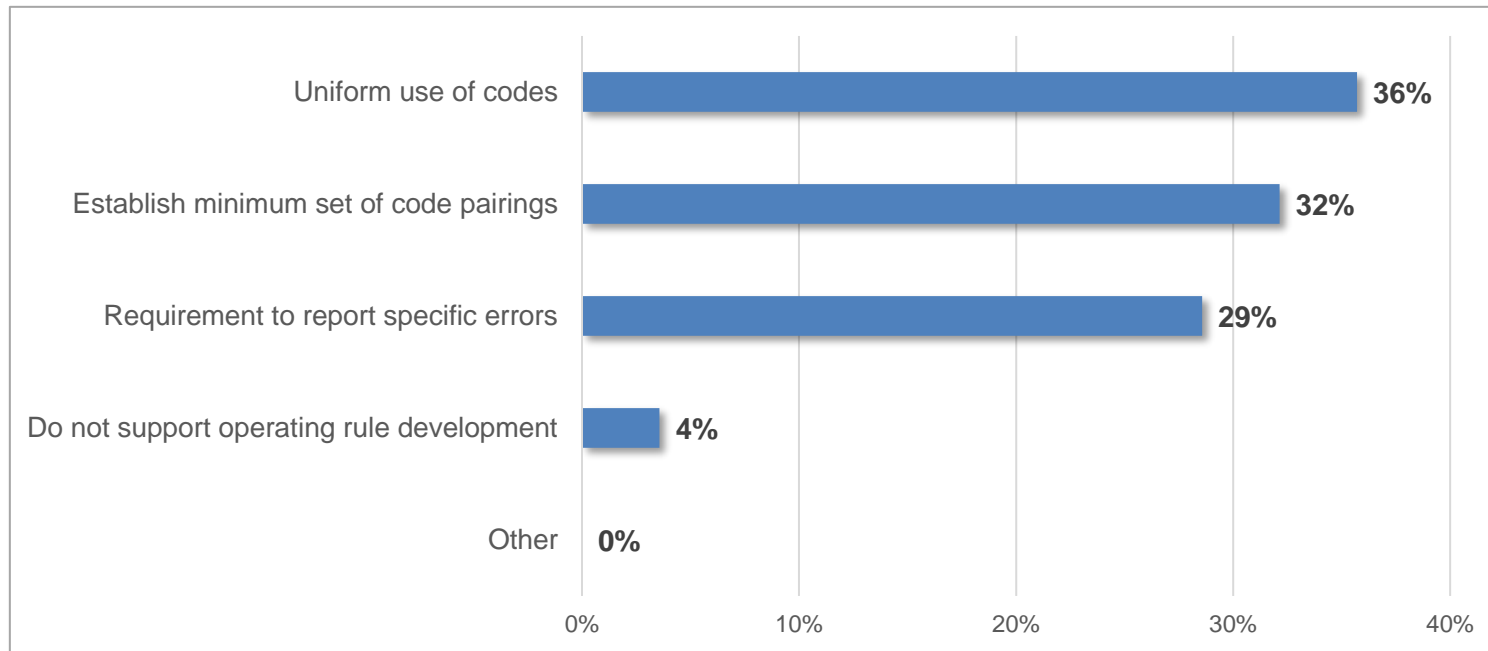
Recommended action: Do not pursue **data content operating rule development** at this time. Topic is inhibited by **lack of regulation, varying standard maturity, and a need for additional guidance**. There may be future opportunity to pursue data alignment once the industry has coalesced.

Claim Rejection Notification and Reporting

Broad support for uniformity of rejection reporting using the X12 277CA transaction

Please choose from the opportunity areas below what options would help to improve utility of the X12 277CA Transaction for claim rejections.

Respondents: 12 unique organizations (57%); 28 individuals (90%)



Responses by unique organization type

Respondent type	Number (%)
Vendor	50%
Provider	25%
Payer	17%
Gov't / Other	8%

Recommended action: Pursue development of **data content operating rule** detailing error reporting and coding requirements for the X12 277CA transaction. **96% of respondents** indicated support to promote uniformity through data content rulemaking.

Claim Rejection Notification and Reporting

What aspect of the X12 277CA transaction can be clarified through a data content operating rule?

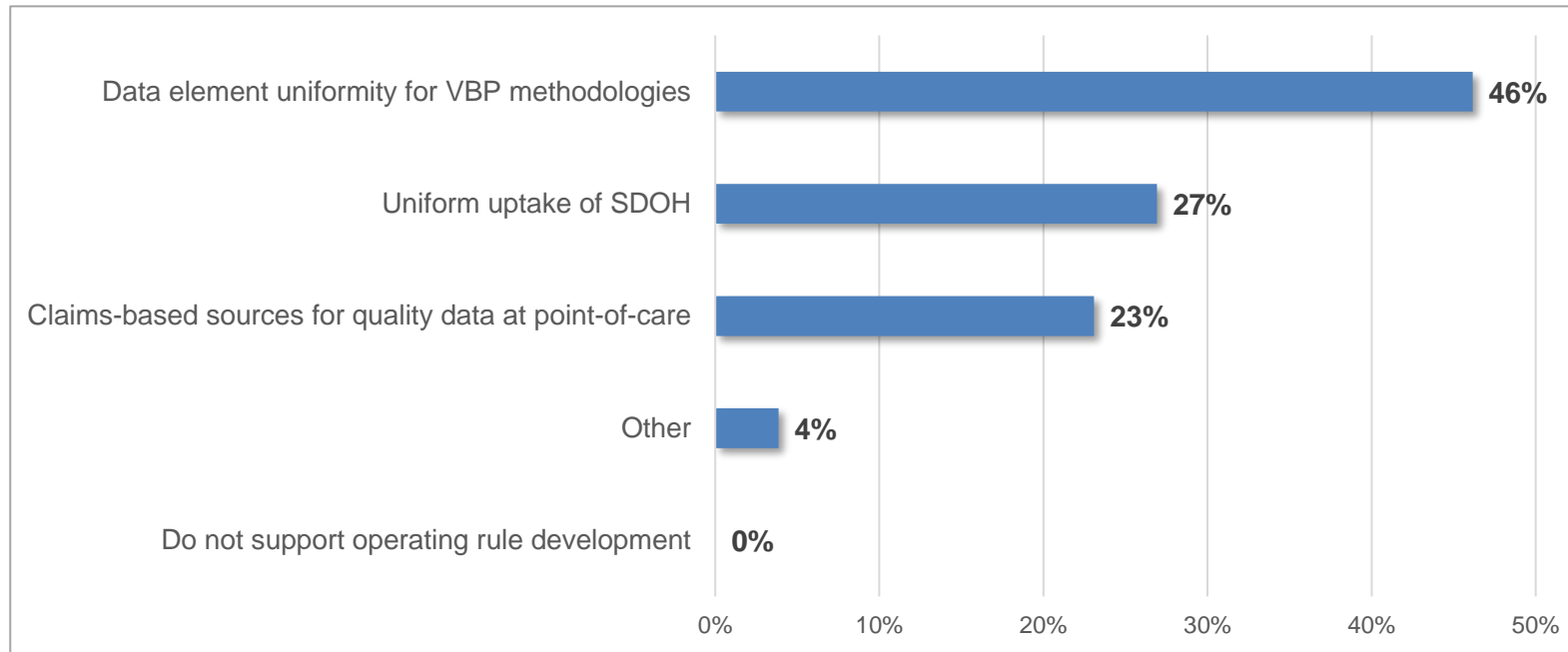
1. Is there value in establishing a set of Claim Status Category Code/Claim Status Code pairings as an industry resource to bring uniformity to how combination of codes should be used and defined by stakeholders?
2. Do opportunities exist to require health plans to offer an electronic method for identifying types of claim rejection notifications supported alongside their definitions via companion guide, spreadsheet, search tools, etc.?
3. For claim rejections with multiple errors, are multiple error reasons being reported back or just one?

Value-Based Payments

Support for aligning data elements used in VBP methodologies

Please choose from the areas below that where CAQH CORE Health Care Claims Operating Rules could best support value-based payment models.

Respondents: 10 unique organizations (48%); 26 individuals (84%)



Responses by unique organization type

Respondent type	Number (%)
Vendor	50%
Provider	30%
Payer	20%

Recommended action: Pursue development of a **data content operating rule** to align new and emerging methodologies within VBP contracts. **No respondents** felt that CAQH CORE should not pursue operating rule development.

Value-Based Payments

How can health care claims support the de-complication and growth of VBP?

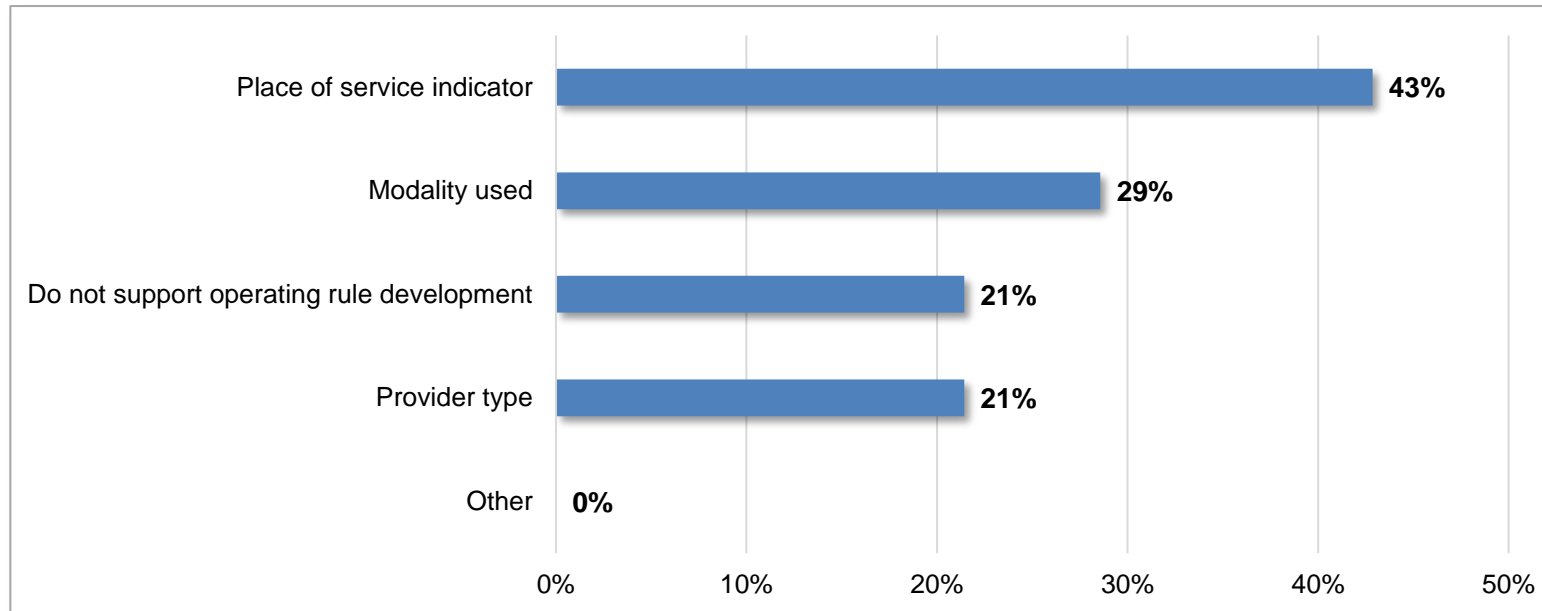
1. What aspect of claims-based methodologies in VBP present the biggest pain points for your organization?
2. How can the health care claim workflow support the submission of SDOH data? What data sets should be considered? Is the claims workflow the most appropriate to address this issue?
3. What consideration are there to ensure potential CAQH CORE Data Content Operating Rules for Health Care Claims are complementary of the Gravity Project?

Telehealth

Direction to be determined through additional diligence

Of the choices below please indicate those that CORE should address in an Operating Rule to bring consistency and ease adjudication of claims submissions for telehealth visits.

Respondents: 9 unique organizations (43%); 14 individuals (45%)



Responses by unique organization type

Respondent type	Number (%)
Vendor	44%
Provider	44%
Gov't / Other	11%

Recommended action: Evaluate **variability in data requirements** for telehealth claim submissions to determine the necessity of a **data content operating rule** to unify submissions and untangle post-PHE confusion.

Telehealth

Coding Variance Exacerbated or Caused by the PHE

CPT Codes Supporting Medicare Billing Telehealth*

*Not exhaustive

Telehealth Visits	99201-99205 (new patient) 99211-99215 (established patient)
Online Digital Visits	99421-99423 (Online digital management; established) 92970-98972; G2061-G2063 (Non-physician; established) G2012; G2010 (Brief communication / remote evaluation; established)
Remote Patient Monitoring	99453-99458 (Set-up, monitoring and treatment RPM) 99091 (Collection and interpretation of phys. data)
Self-Measured BP	99473-99474 (Self-measure BP; calibration and readings)
Telephone E/M	99441-99443 (E/M performed by audio; established)
Category III Codes	Temporary coverage via Telehealth during PHE

Select POS Indicators and Modifiers

POS '02'	Delivery of care in place other than patient's home
POS '10'	Delivery of care in patient's home
Modifier '95'	Indication that service was performed over A/V
Modifier '93'	Indication that service was performed audio-only
Modifier 'FQ'	Audio-only; CMS requires post PHE for mental health
Modifier 'UD'	Audio-only; used by AZ Medicaid

Areas of Variance

Potential approaches for resolution

Areas that could be solved by operating rules or industry guidance

- Use of 'audio-only' CPT codes differ between payers, expanding beyond Medicare coding guidance (e.g., 99211-99215 eligible for audio-only for some payers).
- Modifier '95' was inconsistently used across payers during the PHE, sometimes only applying to specific services or use cases.
- Modifier '93' took effect January 2022 and, to-date, Medicare has provided minimal guidance for its usage.

Areas that could benefit from increased education

- Medicare 'Category III' codes, and presumably lists used by private payers, will no longer be covered through telehealth 151 days after the expiration of the PHE. Education and industry guidance may "head-off" variance.

Areas that could leverage existing or developing operating rules

- POS '02' and '10' must be indicated by payers in the 271 response in an Eligibility and Benefits transaction. This may be sufficient to avoid downstream variability and rejected claims without the need to expressly develop operating rules for POS.

Telehealth

Is there significant enough variance in Telehealth billing to justify new data content operating rules?

1. Are the CAQH CORE Data Content Operating Rules for Eligibility and Benefits indicating telehealth POS requirements sufficient to prevent downstream claim rejections/denials?
2. Will inconsistent use of modality modifiers (e.g., '95' and '93') continue to be a source of variance post-pandemic?
3. Is there inconsistency in the identification of billing and/or rendering provider in claims submissions?

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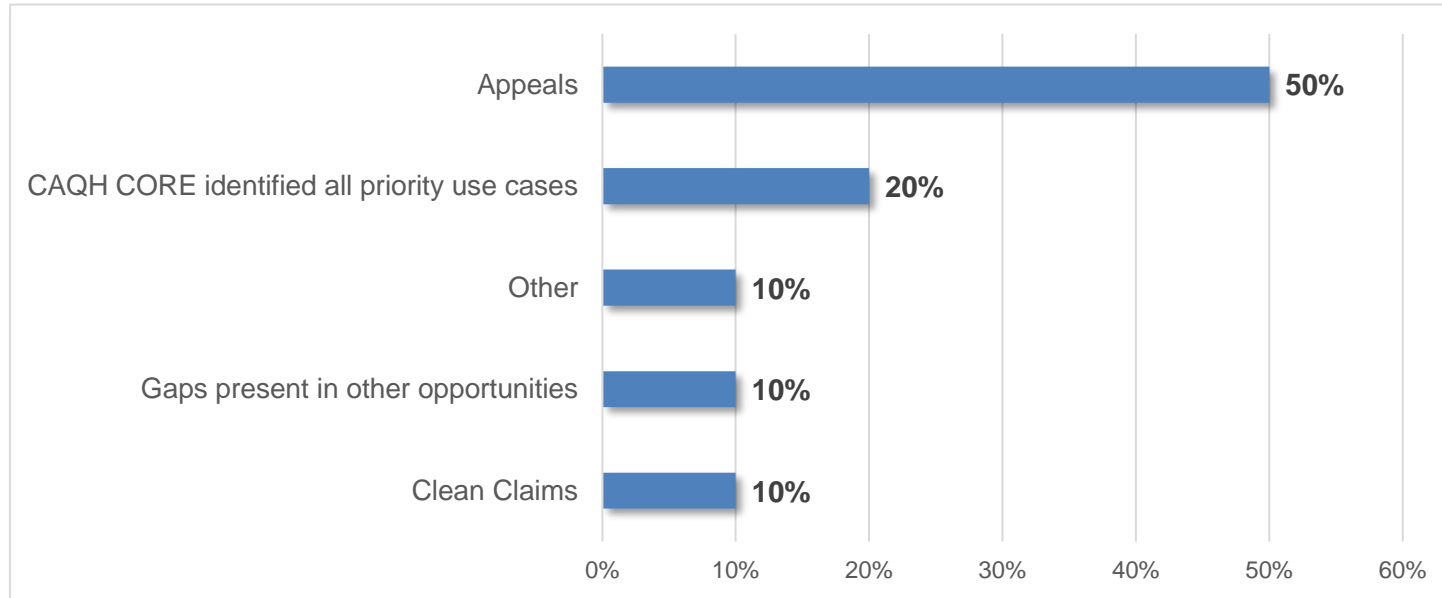
Additional Considerations for Priority

Additional Areas of Focus

Topics to consider when moving forward to operating rule development

What additional areas should CAQH CORE prioritize when considering health care claims operating rule development?

Respondents: 6 unique organizations (29%); 10 individuals (32%)



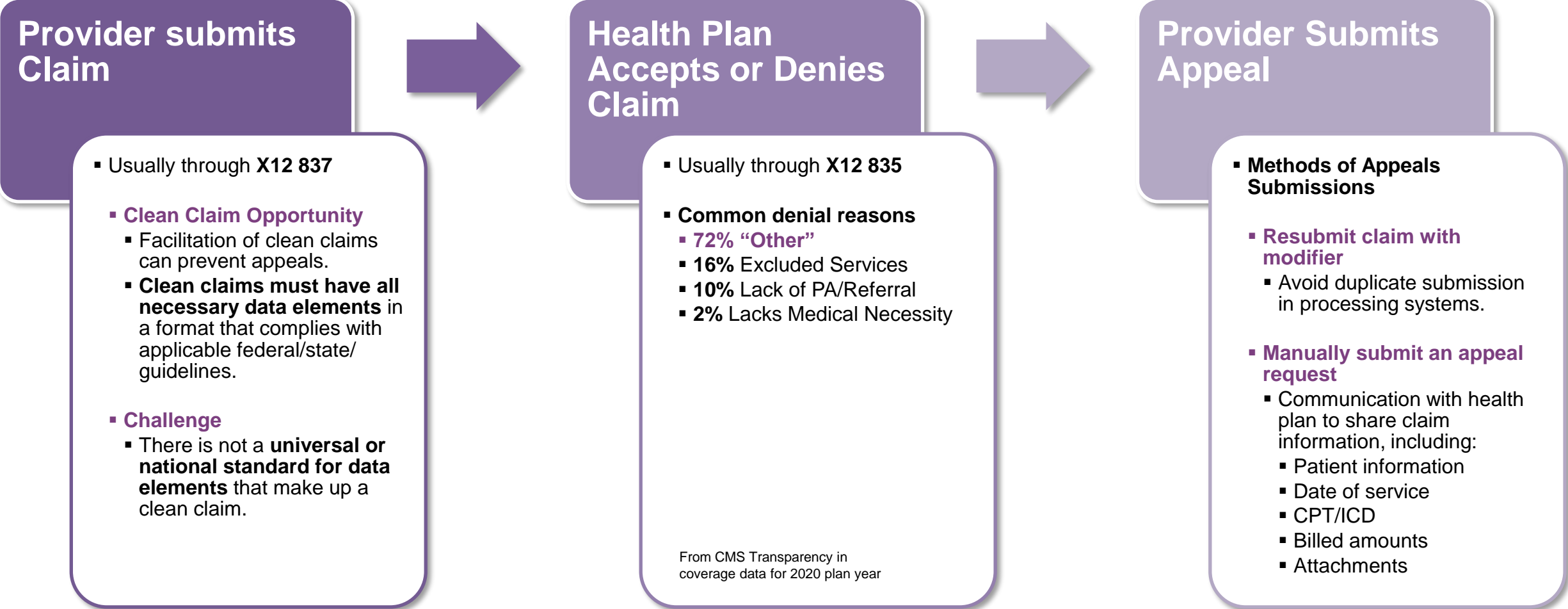
Responses by unique organization type

Respondent type	Number (%)
Vendor	67%
Provider	17%
Gov't / Other	17%

Recommended action: Perform additional diligence surrounding **health care claims appeals** to evaluate need for **data content operating rule**. Half of respondents supported this approach and asked us to consider additional areas that are addressed on separate slides.

Health Care Claims Appeals

Identified for additional diligence by Focus Group participants



Health Care Claims Appeals

What data elements, if addressed, would lead to fewer appeals or a less burdensome process?

1. What are the common denial reasons at your organization that may fall into the 'Other' category?
2. Is it realistic to align 'clean claims' requirements across payers given the variety of state regulations?
3. What is the greatest area of non-uniformity on an appeals submission? Is your organization or those you interact with equipped to report multiple reasons for a denial?

Other Topics Raised by the Focus Group

Active engagement and monitoring by CAQH CORE

CAQH CORE is actively monitoring these topics and may address them through cross-cutting initiatives to advance rule development and industry guidance

No Surprises Act Requirements

- Regulations are still being formulated, as such industry does not have a grasp of implementation variance – **at this time**.
- CAQH CORE is actively engaging with NSA requirements and will address utility or operating rules **through a different workgroup** once more direction is provided, and implementation variance is better understood.

Coordination of Benefits (COB)

- Changes between X12 v5010 and X12 v8020 of the 837 have the potential to support **automated workflows for coordination of benefits** between payers.
- This could potentially be achieved through **CAS segment changes to RAS segment** at the Claim and Service Level.
- CAQH CORE will actively monitor the adoption and implementation of future X12 versions to **assess the need for operating rules**.

Coordination of Benefits

What aspect of COB should CAQH CORE focus its diligence and efforts?

1. As claims are coordinated between multiple payers do challenges exist around data integrity or trust?
2. What considerations are there to streamline COB claims that often result as a pend between multiple payers?

Focus Group Next Steps

Thank you for your participation and input!



- Straw Poll to confirm Focus Group input and next steps for rule development will be distributed by the week of November 7.
- CAQH CORE will host a Focus Group call on November 30 to review results, attendance is optional, and summaries will be sent to attendees.
- The Health Care Claims Sub-workgroup will launch in early-2023; details and invitations are forthcoming.

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Appendix

Today's Call Documents

Document Name
Doc 1 CORE Claims FG Call 2 Deck 11.2.22
Doc 2 CORE Claims FG Call 2 Discussion 11.2.22
Doc 3 CORE Claims FG Call 1 Takeaways 10.12.22

CORE Staff	Email Address
Bob Bowman, <i>Principal, Interoperability and Standards, CORE</i>	rbowman@caqh.org
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CAQH CORE Claims Focus Group

Activity Schedule

Date	Claims Focus Group Activity
10/12/2022 2:00 – 3:30 PM ET	Focus Group Call #1 <ul style="list-style-type: none">• Level set; provide background; discuss bottlenecks in the health care claims workflow.
11/02/2022 2:00 – 3:30 PM ET	Focus Group Call #2 <ul style="list-style-type: none">• Review additional areas identified in Call #1; undertake solutioning efforts; determine preliminary recommendations.
Week of November 7	Focus Group Straw Poll <ul style="list-style-type: none">• Confirm findings shared during focus group calls.
[Optional] 11/30/2022 2:00 – 3:30 PM ET	[Optional] Focus Group Call #3 <ul style="list-style-type: none">• Continue Discussion on claims transaction improvements if needed.
TBD	Publish Recommendations

CAQH CORE Claims Focus Group

Roster

Full Name	Organization
Rose Hodges	Aetna
Marianne Davidson	Aetna
Ronald Wampler	Aetna
Swati Nanda	Aetna
Carol Midyette	Aetna
Shannon Thomas	Aetna
Teresa Carr	Aetna
Rebecca Lambe	Aetna
Suzanne Trickle	Aetna
Mark Rabuffo	Aetna
Leigh Cupelli	Aetna
Tori Rittenbach	Aetna
Christopher Sikorski	Aetna
Jeffery Miller	Aetna
Heather McComas	American Medical Association (AMA)
Nancy Spector	American Medical Association (AMA)
Tyler Scheid	American Medical Association (AMA)
Shaila Madla	Anthem
Victor Martin	Anthem
Michelle Barry	ASC X12
Kristen Bolam	Aultcare
Kathy Sites	Availity
Leah Barber	Availity
Katie Ruhl	Availity
Joshua Jordan	Availity

Full Name	Organization
Ron Knapp	Blue Cross Blue Shield of Michigan
Susan Langford	Blue Cross Blue Shield of Tennessee
Jeff Jennings	California Department of HHS
Thomas Kessler	Centers for Medicare and Medicaid Services (CMS)
Jessica Czulewicz	Centers for Medicare and Medicaid Services (CMS)
Gigi Mendenhall	Centers for Medicare and Medicaid Services (CMS)
Charlene Parks	Centers for Medicare and Medicaid Services (CMS)
Jason Kerr	Centers for Medicare and Medicaid Services (CMS)
Fred Rooke	Centers for Medicare and Medicaid Services (CMS)
Elsa Star Trewyn	Change Healthcare
Nihal Titan	Claim.MD
Dawn Duchek	Cognizant
Laura Cauldwell	CSRA
Tushar Nair	Edifecs
Christopher Gracon	HealthENet
Pauny Rezai	Kaiser Permanente
Yolanda Crosby	Kaiser Permanente
Gheisha-Ly Rosario Diaz	Labcorp
Becky Fortek	Mayo Clinic
Andrea (Annie) Brannan	Mayo Clinic

Full Name	Organization
Melanie Combs-Dyer	Mettle
Diana Fuller	Michigan DCH
Ann Wandersee	Minnesota Dept. Of HHS
Terry Schmandt	Minnesota Dept. Of HHS
Chao Yang	Minnesota Dept. Of HHS
Heather Ferriere	Minnesota Dept. Of HHS
Kristin Gardner	Minnesota Dept. Of HHS
Pansi Millage	Minnesota Dept. Of HHS
Norm Thurston	NAHDO
Charles Hawley	NAHDO
Nancy Team	NextGen Healthcare Information Systems, Inc.
Yolanda Miller	NextGen Healthcare Information Systems, Inc.
Mary Alexander	Ohio Health
Randy Gabel	Ohio Health
Kristina Townsend	Olive AI/Healthcare IP
India Duncan	OptumInsight
Nancy Buckley	Point32 Health
Althea Robinson	Tata Consultancy Services, Ltd.
Don Quackenbush	TriZetto (Cognizant)
Andy Schulz	TriZetto (Cognizant)
Kevin Chambers	Virginia Mason
Lisa Ness	Virginia Mason
Jenny Wallace	Virginia Mason

CAQH CORE Operating Rules Overview

Published Rules to Date

Rule Set	Infrastructure	Connectivity Rule	Data Content	Other		
Eligibility & Benefits	Eligibility (270/271) Infrastructure Rule*	Connectivity Rule vC1.1.0 Connectivity Rule vC2.2.0	Eligibility (270/271) Data Content Rule*	Single Patient Attribution Data Rule		
Claim Status	Claim Status (276/277) Infrastructure Rule*	Connectivity Rule vC2.2.0				
Payment & Remittance	Claim Payment/ Advice (835) Infrastructure Rule*		EFT/ERA (835/CCD+) Reassociation Rule	EFT/ERA Enrollment Data Rules	Uniform Use of CARCs and RARCs (835) Rule	
Prior Authorization & Referrals	Prior Authorization (278) Infrastructure Rule*	Connectivity Rule vC4.0.0**	Prior Authorization (278) Data Content Rule	Prior Authorization Web Portal Rule	Attachments Prior Authorization Rules*	
Health Care Claims	Health Care Claim (837) Infrastructure Rule*					Attachments Health Care Claims Rules*
Attributed Patient Roster	Attributed Patient Roster (834) Infrastructure Rule*			Attributed Patient Roster (834) Data Content Rule		
Benefit Enrollment	Benefit Enrollment (834) Infrastructure Rule*					
Premium Payment	Premium Payment (820) Infrastructure Rule*					





Rules in blue boxes are federally mandated.

*** Rule is new or updated as of February 2022.**

**** Connectivity Rule vC4.0.0 can be used to support all rule sets for CORE Certification.**

CAQH CORE Operating Rules Supporting Health Care Claims

Data Content Operating Rules Could Promote Uniformity

Transaction Type	Infrastructure	Data Content
 Health Care Claim (837)	CAQH CORE Health Care Claim (837) Infrastructure Rule vHC.2.0	N/A
 Claim Status (276/277)	CAQH CORE Claim Status (276/277) Infrastructure Rule vCS2.0	N/A
 Payment and Remittance (835)	CAQH CORE Payment & Remittance (835) Infrastructure Rule vPR2.0	CAQH CORE Payment & Remittance Uniform Use of CARCs and RARCs (835) Rule vPR.1.1 CAQH CORE Payment & Remittance (CCD+/835) Reassociation Rule vPR.1.0
 Attachments (275)	CAQH CORE Attachments Health Care Claims Infrastructure Rule vHC.1.0	CAQH CORE Attachments Health Care Claims Data Content Rule vHC.1.0

Simplified Health Care Claims Workflow

Identifying Impacts of a Data Content Rule

Workflow Step and description	EHR	Provider	Intermediaries	Health Plan
Step 1: Submit health care claim / encounter				
Step 2: Acknowledgment with accept/reject sent to submitter (277CA/999)				
Step 2a: Provider resubmission to address errors (if required)				
Step 3: Requests additional information to support health care claim/encounter (if required)				
Step 4: Retrieve additional information/documentation				
Step 5: Submit additional information to support health care claim/encounter				
Step 6: Check on status of health care claim				
Step 7: Respond with health care claim status				
Step 8: Payment/remittance advice				

Red arrow indicates point in workflow that could be **directly** impacted by data content rule

*Standard acknowledgements (999) should be occurring at each step of the workflow

X12 v8020 Recommendations

Impact to Health Care Claims and Claim Payments



- **Background:** Health care business requirements have become more complex over the last decade, as such data needs are evolving to support day-to-day operations and decision-making, and emerging payment innovations. X12 has updated claim and remittance advice transactions to support the changing health care system.



- **Policy Updates:** X12 submitted its letter of recommendation to the National Committee on Vital Health Statistics (NCHVS) on June 8, 2022, to evaluate versions 8020 (X12 v8020) of the following claim submission and claim payment implementation guides for federal adoption.
 - 008020X323 Health Care Claim: Professional (837)
 - 008020X324 Health Care Claim: Institutional (837)
 - 008020X325 Health Care Claim: Dental (837)¹
 - 008020X322 Health Care Claim Payment/Advice (835)



- **Next Steps:** CAQH CORE will monitor federal activities related to X12 v8020 of the claim submission and payment transactions and will integrate policy impacts and industry recommendations as part of health care claim rule development efforts.

¹008020X325 Health Care Claim: Dental (837) is **out of scope** for CAQH CORE Health Care Claims Focus Group