CAQH CORE Health Care Claims Focus Group Call #2: Discussion Prompts

Thank you for participating in the second CAQH CORE Health Care Claims Focus Group call. Included are several questions that will be used to prompt discussion during the meeting. Each question set is formatted to highlight the topic, the guiding or overarching inquiry, and specific operational considerations for the development of a CAQH CORE Data Content Operating Rule for Health Care Claims.

Please let any member of the CAQH CORE Health Care Claims team know if you have questions or comments.

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
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
Is there significant enough variance in telehealth billing for it to be addressed through new CAQH CORE Data Content Operating Rules for Health Care Claims?

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?

Health Care Claims Appeals
What data elements, if addressed, would lead to fewer appeals or 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?

Coordination of Benefits (COB)
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?