CORE Claim Acknowledgment (277CA) Data Content Rule
Version CA.1.0

March 2024

Revision History for CORE Claim Acknowledgment (277CA) Data Content Rule

Version	Revision	Description	Date
CA.1.0	Major	CAQH CORE Claim Acknowledgment (277CA) Data Content Rule balloted and approved via the CAQH CORE Voting Process.	March 2024

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1. Background Summary

1.1. CORE Overview

CORE is an industry-wide facilitator committed to the creation and adoption of healthcare operating rules that support standards, accelerate interoperability, and align administrative and clinical activities among providers, health plans, and patients. Guided by over 130 participating organizations – including healthcare providers, health plans, government entities, vendors, associations, and standards development organizations – CORE Operating Rules drive a trusted, simple, and sustainable healthcare information exchange that evolves and aligns with market needs.

To date, this cross-industry commitment has resulted in operating rules addressing many pain points of healthcare business transactions including eligibility and benefits verification, claims and claims status, claim payment and remittance, health plan premium payment, enrollment and disenrollment, prior authorization, and aspects of value-based healthcare such as patient attribution methodologies and addressing social determinants of health (SDOH).

1.2. Industry Interest in Claim Acknowledgment Operating Rules

In 2015, CORE published the Health Care Claim (837) Infrastructure Rule, which was updated in April 2022.[1] The rule is a byproduct of years of research on improvement opportunities related to health care claim processing.

To complement the CORE Health Care Claim (837) Infrastructure Rule vHC.2.0, CORE undertook a comprehensive environmental scan to identify industry challenges surrounding the submission and adjudication of claims that could be addressed by specifying data requirements in a data content operating rule for the health care claim transaction (hereafter referred to as the X12 v5010 837 transaction). Research identified standardization opportunities for multiple transactions supporting claim submission and claim acknowledgment.

The CORE Health Care Claims Focus Group convened in 2022 to prioritize operating rule opportunities. Focus Group participants confirmed their support for the development of data content operating rules for a refined list of claims-related opportunities including the X12 005010X214 277CA Health Care Claim Acknowledgment transaction (hereafter referred to as X12 v5010 277CA), which informs clean claim submission. Insights from the Focus Group directly informed the launch agenda for the Health Care Claims Subgroup which included potential claim acknowledgment (277CA) data content operating rule requirements.

Building on the CORE Health Care Claim (837) Infrastructure Rule vHC.2.0, which established the "electronic highway" for claims and claim acknowledgment processing, the CORE Health Care Claim Acknowledgment (277CA) Data Content Rule outlines requirements for the data payloads that are processed when conducting the X12 v5010 277CA Technical Report Type 3 (TR3) and associated errata.

2. Issues to Be Addressed and Business Requirement Justification

2.1. Problem Space

The X12 v5010 277CA is used by a health plan to acknowledge the receipt of a claim as it enters a health plan's pre-adjudication or adjudication system. An acknowledgment can communicate the transaction is accepted, accepted with errors, or rejected. Used correctly, providers can receive clear and unambiguous reporting if a claim is rejected, which allows for prompt correction and resubmission. CORE's environmental scanning found that data elements required for claims submission vary between health plans. This variability takes many forms including data formats, content requirements, and information interpretation. Variability increases provider burden as staff must consider different health plan requirements and applicable claim billing policies. To improve error reporting across this data, CORE Participants agreed to standardize specific error scenarios and associated code combinations within the

[1] See CORE Health Care Claim (837) Infrastructure Rule vHC.2.0.

X12 v5010 277CA transaction and streamline interpretation of definitions, code combinations, and scenarios.

2.1.1. Barriers to Automation of the Claim Acknowledgment Process

The X12 v5010 277CA is a valuable complement to the X12 v5010 837 transaction; however, because it is not HIPAA mandated, the use of claim acknowledgments varies in practice.[2] During operating rule development, CORE Participants agreed that aligning reporting requirements across health plans would minimize stakeholder confusion related to claim submission requirements. Additionally, a reduction in costly, manual processes will ultimately result in a decrease in overall adjudication times and faster billing processes.

CORE Participants also identified opportunities to increase uniformity of pre-adjudication error reporting delivered via the X12 v5010 277CA. Some vendors and health plans use the transaction simply as an acknowledgment of submission through acceptance or rejection. Others use a combination of Claim Status Category Codes (hereafter referred to as CSCCs) and Claim Status Codes (hereafter referred to as CSCs) to communicate greater detail about why a claim was rejected from pre-adjudication systems, helping providers focus on errors and accelerate claim correction and resubmission. While the latter example has clear utility, code combinations are not uniformly applied by health plans, leading to inconsistencies in error interpretation and the perpetuation of manual workflows.

Standardized X12 v5010 277CA data content reduces the need for manual intervention and supports development of updated workflows for clean claims submission or even robotic process automation (RPA). For example, if transactions are rejected, X12 v5010 277CA data content requirements outline consistent error messaging for providers to review and use when reworking and resubmitting a claim for payment. Building on the Health Care Claim (837) Infrastructure Rule vHC.2.0, the Health Care Claim Acknowledgment (277CA) Data Content Rule streamlines claim submissions and minimizes costly manual workflows associated with addressing errors and resubmitting claims.

2.2. Focus of the CORE Claim Acknowledgment (X12 v5010 277CA) Data Content Rule

The following requirements addressing data content of the claim acknowledgment transaction received the highest support from the CORE Health Care Claims Subgroup:

- Specification of a minimum set of information to include on an X12 v5010 277CA response that supports matching the **transaction** to its corresponding X12 v5010 837 transaction.
- Specification of information to include on an X12 v5010 277CA that supports matching an error code to its corresponding **line item (service)** on an X12 v5010 837 transaction, when applicable.
- Requirements outlining **uniform use** of X12 CSCC + CSC combinations in the X12 v5010 277CA when communicating errors in X12 v5010 837 transaction submission which result in rejection of the claim.

3. Scope

3.1. What the Rule Applies To

This CORE Health Care Claim Acknowledgment (277CA) Data Content Rule applies to the conduct of:

- X12 Interchanges containing functional groups of any HIPAA-mandated X12 v5010 837 transaction including the X12 005010X222 837 Health Care Claim: Professional (hereafter referred to as X12 v5010 837 Professional), X12 005010X223 837 Health Care Claim: Institutional (hereafter referred to as X12 v5010 837 Institutional), and X12 005010X224 837 Health Care Claim: Dental (hereafter referred to as X12 v5010 837 Dental) (collectively hereafter the X12 v5010 837 transactions).
- X12 Interchanges containing functional groups of any X12 v5010 277CA.

[2] See CMS' website for more information on HIPAA-mandated transactions and operating rules.

Table 1 defines the transactions that would be considered in scope for each set of data content requirements addressed by this rule:

Table 1 – In Scope X12 v5010 Transactions for Health Care Claim Data Content Requirements				
Data Content Requirements	**X12 v5010 277CA**	**X12 v5010 837 Professional**	**X12 v5010 837 Institutional**	**X12 v5010 837 Dental**
Transaction Data Matching	Y	Y	Y	Y
Line Item (Service) Matching	Y	Y	Y	Y
CSCC + CSC Code Combinations	Y	N	N	N

3.2. When the Rule Applies

This rule applies when any HIPAA-covered entity and its agent uses, conducts, or processes the X12 v5010 277CA to report a rejection of a claim by a health plan or its agent from a pre-adjudication or adjudication system.

3.3. What the Rule Does Not Address

This rule does not address:[3]

- The X12 v5010X212 Health Care Claim Status Request and Response (276/277) where the X12 v5010 277 is a response to a request for claim status information.
- The X12 v5010X213 Health Care Claim Request for Additional Information (277) which is a health plan's request for additional information to support a health care claim.
- The X12 v5010X228 Health Care Claim Pending Status Information (277), which is used as a listing of pended claims in a health plan's system.
- Infrastructure requirements applicable to the X12 v5010 277CA or X12 v5010 837 transactions.
- The scenarios when an X12 v5010 277CA is reporting the acceptance of a claim or the acceptance with errors of a claim into an adjudication system.
- The X12 v5010X364 Data Reporting Acknowledgment (277) transaction, where the X12 v5010X364 is an acknowledgement of the X12 v5010X298 Post Adjudicated Claim Data Reporting: Professional (837), the X12 v5010X299 Post Adjudicated Claim Data Reporting: Institutional (837), the X12 v5010X300 Post Adjudicated Claim Data Reporting: Dental (837), and X326 transactions including and after v7030.

3.4. What the Rule Does Not Require

This rule does not require any HIPAA-covered entity to modify its use and content of other loops and data elements that may be submitted in the X12 v5010 277CA that are not addressed in this rule.

3.5. Applicable Loops, Data Elements, and Code Sources

To support association of the X12 v5010 277CA with its corresponding X12 v5010 837 transaction, this rule covers the following specified loops, segments, and data elements in the X12 v5010 837 Professional, X12 v5010 837 Institutional, and X12 v5010 837 Dental:

Table 2 – X12 v5010 837 Transaction Applicable Loops and Segments (Transaction Matching)			
Data Element Name	**X12 v5010 837 Professional**	**X12 v5010 837 Institutional**	**X12 v5010 837 Dental**
Originator Application Transaction Identifier	BHT03	BHT03	BHT03

[3] The X12 v5010X214 277 TR3 §1.4.3. highlights differences of transaction usages for each Health Care Information Status transaction. The Health Care Claim Acknowledgment (277CA) Data Content Rule only addresses the business needs of the X12 v5010 277CA.

Table 2 – X12 v5010 837 Transaction Applicable Loops and Segments (Transaction Matching)			
Data Element Name	**X12 v5010 837 Professional**	**X12 v5010 837 Institutional**	**X12 v5010 837 Dental**
Billing Provider Identifier	2010AA-NM109	2010AA-NM109	2010AA-NM109
Billing Provider Tax Identification Number	2010AA-REF02	2010AA-REF02	2010AA-REF02
Subscriber Last Name	2010BA-NM103	2010BA-NM103	2010BA-NM103
Subscriber First Name	2010BA-NM104	2010BA-NM104	2010BA-NM104
Subscriber Primary Identifier	2010BA-NM109	2010BA-NM109	2010BA-NM109
Patient Last Name	2010CA-NM103	2010CA-NM103	2010CA-NM103
Patient First Name	2010CA-NM104	2010CA-NM104	2010CA-NM104
Patient Control Number (Claim Submitter's Identifier)	2300-CLM01	2300-CLM01	2300-CLM01
Total Claim Charge Amount	2300-CLM02	2300-CLM02	2300-CLM02
Payer Claim Control Number	2300-REF02	2300-REF02	2300-REF02
Value Added Network Trace Number	2300-REF02	2300-REF02	2300-REF02
Procedure Code (Product/Service ID)	2400-SV101-02	2400-SV202-02	2400-SV301-02
Line Item Charge Amount	2400-SV102	2400-SV203	2400-SV302
Service Date	2400-DTP03	2400-DTP03	2400-DTP03
Line Item Control Number	2400-REF02	2400-REF02	2400-REF02

To support association of the X12 v5010 277CA to its corresponding X12 v5010 837 transaction, this rule covers the following specified loops, segments, and data elements in the X12 v5010 277CA:

Table 3 – Applicable X12 v5010 277CA Loops and Segments (Transaction Matching)	
Data Element Name	**X12 v5010 277CA**
Claim Transaction Batch Number	2200B-TRN02
Billing Provider Identifier	2100C-NM109
Billing Provider Additional Identifier	2200C-REF02
Patient Last Name	2100D-NM103
Patient First Name	2100D-NM104
Patient Identification Number	2100D-NM109
Patient Control Number (Claim Submitter's Identifier)	2200D-TRN02
Total Claim Charge Amount	2200D-STC04
Payer Claim Control Number	2200D-REF02
Clearinghouse Trace Number	2200D-REF02

Table 3 – Applicable X12 v5010 277CA Loops and Segments (Transaction Matching)	
Data Element Name	**X12 v5010 277CA**
Procedure Code (Product/Service ID)	2220D-SVC01-02
Line Item Charge Amount	2220D-SVC02
Line Item Control Number	2220D-REF02
Service Line Date	2220D-DTP03

To support association of X12 v5010 277CA error codes with their corresponding line item (service) on an X12 v5010 837 transaction, this rule covers the following specified loops, segments, and data elements in in the X12 v5010 837 Professional, X12 v5010 837 Institutional, and X12 v5010 837 Dental transactions:

Table 4 – Applicable X12 v5010 837 Transaction Loops and Segments (Line Item Service Matching)			
Data Element Name	**X12 v5010 837 Professional**	**X12 v5010 837 Institutional**	**X12 v5010 837 Dental**
Patient Control Number (Claim Submitter's Identifier)	2300-CLM01	2300-CLM01	2300-CLM01
Payer Claim Control Number	2300-REF02	2300-REF02	2300-REF02
Value Added Network Trace Number	2300-REF02	2300-REF02	2300-REF02
Line Item Control Number	2400-REF02	2400-REF02	2400-REF02

To support association of X12 v5010 277CA error codes with their corresponding line item (service) on an X12 v5010 837 transaction, this rule covers the following specified loops, segments, and data elements in the X12 v5010 277CA:

Table 5 – Applicable X12 v5010 277CA Loops and Segments (Line Item Service Matching)	
Data Element Name	**X12 v5010 277CA**
Patient Control Number (Claim Submitter's Identifier)	2200D-TRN02
Payer Claim Control Number	2200D-REF02
Clearinghouse Trace Number	2200D-REF02
Line Item Control Number	2220D-REF02

To support error reporting, this rule covers the following specified loops, segments, and data elements in the X12 v5010 277CA:

Table 6 – Applicable X12 v5010 277CA Error Reporting Loops and Segments	
Data Element Name	**Applicable Loop & Segment**
Health Care Claim Status Category Code	2200B-STC01-01
Health Care Claim Status Code	2200B-STC01-02
Health Care Claim Status Category Code	2200B-STC10-01
Health Care Claim Status Code	2200B-STC10-02
Health Care Claim Status Category Code	2200B-STC11-01
Health Care Claim Status Code	2200B-STC11-02
Health Care Claim Status Category Code	2200C-STC01-01
Health Care Claim Status Code	2200C-STC01-02
Health Care Claim Status Category Code	2200C-STC10-01
Health Care Claim Status Code	2200C-STC10-02
Health Care Claim Status Category Code	2200C-STC11-01
Health Care Claim Status Code	2200C-STC11-02
Health Care Claim Status Category Code	2200D-STC01-01
Health Care Claim Status Code	2200D-STC01-02

Table 6 – Applicable X12 v5010 277CA Error Reporting Loops and Segments	
Data Element Name	**Applicable Loop & Segment**
Health Care Claim Status Category Code	2200D-STC10-01
Health Care Claim Status Code	2200D-STC10-02
Health Care Claim Status Category Code	2200D-STC11-01
Health Care Claim Status Code	2200D-STC11-02
Health Care Claim Status Category Code	2220D-STC01-01
Health Care Claim Status Code	2220D-STC01-02
Health Care Claim Status Category Code	2220D-STC10-01
Health Care Claim Status Code	2220D-STC10-02
Health Care Claim Status Category Code	2220D-STC11-01
Health Care Claim Status Code	2220D-STC11-02

3.5.1. Code Sources Addressed

This rule addresses the following code sources:

- X12 External Code Source 507 Health Care Claim Status Category Codes in each STC Status Information Segment of the Loops identified in Table 6 above.[4]
- X12 External Code Source 508 Health Care Claim Status Codes in each STC Status Information Segment of the Loops identified in Table 6 above.[5]

3.6. Maintenance of This Rule

Any substantive updates to the rule (i.e., change to rule requirements) are determined based on industry need as supported by the CORE Participants per the CORE Change and Maintenance Process.

3.6.1. CORE Process for Maintaining CORE-defined Claim Status Category Code and Claim Status Code Combinations

The Claim Status Category Codes (CSCC) and Claim Status Codes (CSC) code sets are returned in the X12 v5010 277CA to report errors in the submission of the X12 v5010 837 transaction. These code lists are external code lists maintained by X12 and therefore are subject to revision and maintenance multiple times each year. Such revision and maintenance activity can result in new codes, revision to existing codes' definitions and descriptions, or a stop date assigned to a code after which the code should no longer be used.

Given this code list maintenance activity, CORE recognizes that the focus of this rule will require a process and policy to enable the various CSCC + CSC combinations specified in the companion document to this rule, *CORE-required Error Code Combinations for CORE-defined Claim Rejection Business Scenarios.xlsx*, to be revised and modified.

CORE will establish an open process for soliciting feedback and input from the industry on a periodic basis for the CSCC + CSC Combinations in *CORE-required Error Code Combinations for CORE-defined Claim Rejection Business Scenarios.xlsx* and convene a Task Group to agree on appropriate revisions. As part of this process, it will be expected that health plans/providers/vendors submit any additional business scenarios that health plans or their agents may be using on a frequent basis that are not already covered by this rule to CORE.

The CORE Participants are committed to continually improving the process for reporting claim rejections to providers consistently and uniformly across the industry. To further this commitment, CORE will

[4] See X12 External Code Source 507 Health Care Claim Status Category Codes for a complete list of Claim Status Category Codes.

[5] See X12 External Code Source 508 Health Care Claim Status Codes for a complete list of Claim Status Codes.

continue to collaborate and take lessons learned from the industry to develop and enhance an ongoing quality improvement process for maintaining, updating, and supporting a stable code set.

3.7. Abbreviations and Definitions Used in this Rule

CORE-defined Claim Rejection Business Scenarios: In general, a business scenario provides a complete description of a business problem such that requirements can be reviewed in relation to one another in the context of the overall problem. Business scenarios provide a way for the industry to describe processes or situations to address common problems and identify technical solutions.

Thus, in the context of this rule, a CORE-defined Claim Rejection Business Scenario describes, at a high level, the category of the rejection of a healthcare claim within the health plan's pre-adjudication system to which various combinations of CSCC + CSC codes can be applied so that details can be conveyed to the provider using the X12 v5010 277CA. The CORE-defined Claim Rejection Business Scenarios are specified in §4.1.4.

3.8. Assumptions

A goal of this rule is to adhere to the principles of electronic data interchange (EDI) in assuring that transactions sent are accurately received and to facilitate correction of errors for electronically submitted health care claims.

The following assumptions apply to this rule:

- A successful communication connection has been established.
- This rule is a component of the larger set of CORE Health Care Claims (837) Operating Rules.[6]
- The CORE Guiding Principles apply to this rule and all other rules.
- This rule is not a comprehensive companion document addressing any content requirements of the X12 v5010 277CA, the X12 v5010 837 Professional, X12 v5010 837 Institutional, and X12 v5010 837 Dental transactions.
- Compliance with all CORE Operating Rules is a minimum requirement; any entity is free to offer more than what is required in the rule.
- Health care claim transactions are submitted electronically using the X12 v5010 837 transaction standard with all required data elements.

4. Technical Requirements

4.1. Requirements for Health Plans

4.1.1. Basic Requirements for Uniform Use of Claim Status Category Codes & Claim Status Codes

This section addresses the requirements for a health plan when sending an X12 v5010 277CA with a claim rejection in response to an X12 v5010 837 transaction submitted in either real time or in batch.

4.1.2. Association of the X12 v5010 277CA with Its Corresponding Health Care Claim

As appropriate and in alignment with the X12 TR3s, health plans and their agents must return any data elements from Table 2 of §3.5 that were included in the X12 v5010 837 Professional, X12 v5010 837 Institutional, and X12 v5010 837 Dental transactions from providers along with the X12 v5010 277CA data elements from Table 3 of §3.5 to support association of the X12 v5010 277CA transaction with its corresponding X12 v5010 837 transaction.

[6] The CORE Operating Rules are available at: https://www.caqh.org/core/operating-rules.

4.1.3. Alignment of Claim Category Status Codes and Claim Status Codes to Health Care Claim Line Items (Services)

In addition to the requirements outlined in §4.1.2, health plans and their agents receive and process an X12 v5010 837 Professional, X12 v5010 837 Institutional, or X12 v5010 837 Dental transaction from providers containing the data content in the loops and segments indicated in Table 4 of §3.5.

In addition to the requirements outlined in §4.1.2, health plans and their agents must return any data elements from Table 4 in §3.5 that were included in the X12 v5010 837 Professional, X12 v5010 837 Institutional, and X12 v5010 837 Dental transactions from providers. As appropriate and in alignment with the X12 TR3s, data must be returned along with the X12 v5010 277CA data elements from Table 5 of §3.5 to support aligning error codes on a X12 v5010 277CA to line items (services) on its corresponding X12 v5010 837 transaction.

When health plans and their agents return X12 v5010 277CA transactions with claim-level (2200D-STC) CSCCs and CSCs to providers, they must include the data content in the claim-level loops and segments indicated in Table 3 of §3.5, when the data is submitted on the X12 v5010 837 transaction.

When health plans and their agents return X12 v5010 277CA transactions with line level (2220D-STC) CSCCs and CSCs to providers, they must include the data content in the line level loops and segments indicated in Table 5 of §3.5, when the data is submitted on the X12 v5010 837 transaction.[7]

4.1.4.CORE-defined Claim Rejection Business Scenarios

Table 7 – CORE-defined Claim Rejection Business Scenarios and Descriptions

Business Scenario	CORE-defined Claim Rejection Business Scenario	CORE Business Scenario Description
Business Scenario #1	Claim Rejected: Will Not be Adjudicated.	Business Scenario #1 is based upon CSCC A3 – Acknowledgment/Returned as unprocessable claim – the claim/encounter was rejected and has not been entered into the adjudication system.
Business Scenario #2	Claim Rejected: Missing Information.	Business Scenario #2 is based upon CSCC A6 – Acknowledgment/Rejected for Missing Information – the claim/encounter is missing the information specified in the Status details and has been rejected.
Business Scenario #3	Claim Rejected: Invalid Information.	Business Scenario #3 is based upon CSCC A7 – Acknowledgment/Rejected for Invalid Information – the claim/encounter has invalid information as specified in the Status details and has been rejected.
Business Scenario #4	Claim Rejected: Data Relationship Error.	Business Scenario #4 is based upon CSCC A8 – Acknowledgment/Rejected for relational field in error.

4.1.5. Uniform Use of Claim Status Category Codes & Claim Status Codes

Specific details about a claim rejection are conveyed to the provider by health plans and their agents in the X12 v5010 277CA by the combined use of a specific CSCC and CSC code combination. These code combinations are defined as CORE-required CSCC + CSC Combinations. The CORE-required maximum CORE CSCC + CSC Combinations for each CORE-defined Claim Rejection Business Scenario are

[7] In accordance with the X12 TR3, line level rejections do not need to be returned if the line item (service) is not the cause of the rejection of the claim.

specified in the *CORE-required Error Code Combinations for CORE-defined Claim Rejection Business Scenarios.xlsx*. This document is available here on CAQH's website.

Health plans and their agents must align internal codes and corresponding business scenarios to the CORE-defined Claim Rejection Business Scenarios specified in §4.1.4 and the CSCC + CSC Combinations specified in the *CORE-required Error Code Combinations for CORE-defined Claim Rejection Business Scenarios.xlsx.*

Health plans and their agents must return applicable code combinations for all errors on a submitted X12 v5010 837 transaction. Please reference Table 6 for specific loops and segments to use in error communication as outlined in §4.1.2 and §4.1.3.

Health plans and their agents must support the maximum CORE-required CSCC + CSC Combinations in the X12 v5010 277CA as specified in *CORE-required Error Code Combinations for CORE-defined Claim Rejection Business Scenarios.xlsx*; no other CSCC + CSC Combinations are allowed for use in the CORE-defined Claim Rejection Business Scenarios. When specific CORE-required CSCC + CSC Combinations are not applicable to meet the health plan's and its agent's business requirements within the CORE-defined Claim Rejection Business Scenarios, health plans and their agents are not required to use them. CORE recognizes this rule outlines only four business scenarios, and health plans and their agents may require additional proprietary business scenarios to manage claim processing.

In the case where health plans and their agents want to use a proprietary code combination that is not included in the maximum code combination set for a given CORE-defined Claim Rejection Business Scenario, a new CSCC + CSC Combination must be requested in accordance with the CORE process for updating the CORE-required Error Code Combinations in *CORE-required Error Code Combinations for CORE-defined Claim Rejection Business Scenarios.xlsx.*

The only exception to this maximum set of CORE-required CSCC + CSC Combinations is when the respective code committees responsible for maintaining the codes create a new code or adjust an existing code. Then the new or adjusted code can be used with the business scenarios and the CORE process for updating the CSCC + CSC Combinations will review the ongoing use of these codes within the maximum set of codes for the business scenarios. A deactivated code must not be used.

4.1.6. Claim Acknowledgment Response Scenarios

When the health plan and its agent detect an error related to the unit of work, the most specific CSCC + CSC Combination must be returned in Loop ID 2200B STC segment.[8]

When health plans and their agents detect an error related to a billing provider's group of claims, the most specific CSCC + CSC Combination must be returned in Loop ID 2200C STC segment.

When health plans and their agents detect an error related to the claim, the most specific CSCC + CSC Combination must be returned in Loop ID 2200D STC segment.

When health plans and their agents detect an error related to the line item (service), the most specific CSCC + CSC Combination must be returned in Loop ID 2220D STC segment.

4.2. General Requirements

4.2.1. Detection and Display of 277CA Data Elements

The receiver of the X12 v5010 277CA (defined in the context of this CORE rule as the system originating the X12 v5010 837 transaction) is required to detect and extract all data elements, data element codes,

[8] The X12 v5010 277CA TR3 defines "unit of work" within the 2200B STC segment TR3 Notes as the single transaction of claims.

and corresponding code definitions to which this rule applies as returned by the health plan and its agent in the X12 v5010 277CA.

The receiver must display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the X12 v5010 277CA data content.

4.2.2. Detection and Display of CORE-required Error Code Combinations for CORE-defined Claim Rejection Business Scenarios

When receiving a X12 v5010 277CA, a product extracting the data (e.g., a vendor's provider-facing system or solution) from the X12 v5010 277CA for manual processing must make available to the end user:

- Text describing the CSCC + CSC reject error codes included in the transaction, ensuring that the actual wording of the text displayed accurately represents the corresponding code description specified in the code lists without changing the meaning and intent of the description.

AND

- Text describing the corresponding CORE-defined Claim Rejection Business Scenario.

The requirement to make available to the end user text describing the corresponding CORE-defined Claim Rejection Business Scenario does not apply to retail pharmacy.

This requirement does not apply to an entity that is simply forwarding the X12 v5010 277CA to another system for further processing.

5. Conformance Requirements

Conformance with this rule is considered achieved when all the required detailed step-by-step test scripts specified in the Health Care Claims CORE Certification Test Suite are successfully passed.