Fact Sheet: Claims Status Challenges and Opportunities

June 2024

The ASC X12N Health Care Claim Status- Request and response (276/277) is a HIPPA-mandated transaction set designed to help healthcare providers and systems know the status of a claim at the payer. Use of the transaction can eliminate the need for providers to log into a payer's web portal or call a payer to learn the status of a claim. Claim status responses update a provider using standard codified data elements, which are helpful to understand the pending disposition of the claim.

CLAIM STATUS FUNCTIONAL FLOW REQUEST

Providers submit an electronic request for claim status using a standard 276 request format that includes various claim identification options. Claim status requests can be sent either in real-time or batch mode.
Responses range from Pending, Acknowledgement, Rejection, Denial or Finalized. Finalized responses contain detailed information about the final processing by the payer, along with information about any payment made.

PREACTICE MANAGEMENT (PM) AND ELECTRONIC HEALTH RECORD (EHR) SYSTEMS CAPABILITIES:

Most PM and EHR systems have the ability to send a singular 276 real-time request and process the 277 responses.
Some PM and EHR systems have the ability to send batch outgoing claim status requests and process applicable 277 responses.

CLEARINGHOUSES

Most clearinghouses offer a payer listing along with the ability to receive and proves claim status requests in both batch and real-time methods from providers.
Some clearinghouses have limited connections with specific payers based on contractual relations and connectivity options.

PAYERS

Most payers have the ability to receive and proves real-time requests.
Some payers can accept only batch or offer bath and real-time as a form of processing.

ADOPTION

According to the 2023 CAQH Index fully electronic adoption of the Claim Status Inquiry transaction is 74% for medical providers and 28% for dental providers. Year over year, there was an increase in the electronic use of the transaction of 2% for medical providers and 3 for dental providers. Relative to other transactions like Claim Submission, however, fully electronic adoption remains low. At least a quarter of the industry has some manual component in their claim status workflow.
The 2023 CAQH Index projects that the healthcare industry could save a combined $3.7 billion by switching the remaining partially electronic and fully manual Claim Status Inquiry transactions to fully electronic. It is estimated that, on average, medical providers can save 17 minutes and dental providers can save 14 minutes of their time by using a fully electronic version of the standard.

Based on the research provided by CAQH's surveys, a cost-savings opportunity exists that can be achieved through more extensive use of the electronic Claims Status transaction within the health care industry.

CHALLENGES TO ADOPTION

- Some payers do not offer claim status electronically, and some that do only offer batch submissions.
- Some PM systems and clearinghouses do not offer real-time and or batch capabilities. Smaller less mature PM systems have more challenges with this.
- Significant percentage of claims are not found in claim status search requests.
- Claim status response content, including from private and public payers, is often not actionable or missing information for follow-up.
- Claim Status response content varies between payers in usage of claim status reason and category codes.
- Cost and setup time, PM system and clearinghouse, for some providers does not provide a return on investment.
- Enrollment and access challenges due to payer, including private and public, compliance rules that allow only the submitter of the claim to be authorized to request a claim status request.

STANDARDS

- The transaction is a named HIPAA standard and ASC X12N 005010X212 is the current standard.
- A CAQH CORE claims Status Infrastructure Operating Rule[1] is currently mandated, and HHS recently received a recommendation to mandate an updated version of the rule.
- There is currently no CAQH CORE Claims Status Data Content Operating Rule.

OUTLOOK

Given the macro conditions of revenue cycle consolidation within billing services and the need to optimize collections, claim status volumes and adoption will continue to grow. This growth will be stunted by the challenges that have arisen to adopt and achieve consistent responses with actionable information. Payers, providers, and vendors will need to prioritize more resources to assist the industry in these efforts. Payers that have not already done so also need to move to a more modern and industry-relevant real-time request and response methodology.

EXEC SUMMARY

- Providers and payers can achieve value in adoption and usage of the real-time claim status transaction.
- Macro climate is favorable to claims status volume and adoption growth.
- Challenges in connectivity, request and response quality need to be addressed.
- Payers that currently offer only batch processing must move to offering real-time request and response.
- Standard Development Organizations are encouraged move to develop standards that enable more consistent content.
- Payers must increase electronic availability where they are not offering today.

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[1] CAQH. "2022 CAQH Index®: A Decade of Progress." Accessed December 26, 2023 at: https://www.caqh.org/sites/default/files/2022-caqh-index-report%20FINAL%20SPREAD%20VERSION.pdf.

[2] CAQH. "CAQH CORE Claim Status (276/277) Infrastructure Rule." Published April 2022. Accessed December 26, 2023 at: https://www.caqh.org/sites/default/files/CAQH%20CORE%20Claim%20Status%20%28276_277%29%20Infrastructure%20Rule%20vCS2.0.pdf.


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