CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2792	**Date: September 20, 2013**
	Change Request 8446

SUBJECT: Claim Status Category and Claim Status Codes Update

I. SUMMARY OF CHANGES: The Claim Status and Claim Status Category Codes for use by Medicare contractors with the Health Care Claim Status Request and Response ASC X12N 276/277, Health Care Claim Acknowledgement ASC X12N 277 are updated three times per year at the Committee meeting. These meetings are held in the January/February time frame, again in June and finally in late September or early October in conjunction with the Accredited Standards Committee (ASC) X12 meetings. The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes. Contractors are to use codes posted at http://www.wpc-edi.com/codes on or about November 1, 2013, which are listed as current codes on that site. This Recurring Update Notification (RUN) can be found in Chapter 31, Section 20.7.

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 2792	Date: September 20, 2013	Change Request: 8446

SUBJECT: Claim Status Category and Claim Status Codes Update

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

I. GENERAL INFORMATION

A. Background: The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (e.g. previous HIPAA named versions included 004010X093A1, more recent HIPAA named versions). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. The National Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at

http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/

http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/

These pages have previously been referenced by the following URL address: http://www.wpc-edi.com/codes. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the September 2013 committee meeting shall be posted on that site on or about November 1, 2013. Contractors must complete entry of all applicable code text changes and new codes, and terminated use of deactivated codes by the implementation date of this Change Request (CR).

CMS will issue Recurring Update Notifications (RUNs) regarding the need for future updates to these codes. When instructed, Medicare contractors must update their claims systems to assure that the current version of these codes is used in their claim status responses. Contractor and shared system changes will be made as necessary as part of a routine release to reflect applicable changes such as retirement of previously used codes or newly created codes.

These code changes are to be used in editing of all X12 276 transactions processed on or after the date of implementation and to be reflected in the X12 277 transactions issued on and after the date of implementation of this CR.

B. Policy: CMS' Medicare contractors must comply with the requirements contained in the versions 004010X093A1 and 005010X212 of ASC X12 276/277 Implementation Guide as well as the 005101X214 of the ASC X12 277 Health Care Claim Acknowledgement Implementation Guide (inclusive of any published Errata documents) and must use valid Claim Status Category Codes and Claim Status Codes when sending 277 responses.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8446.1	Contractors and maintainers shall update claim status category and claim status codes that have been modified.	X	X		X	X	X	X	X	X			
8446.2	Contractors and maintainers shall use the new claim status category and claim status codes as applicable in 277 responses.	X	X		X	X	X	X	X	X			
8446.3	Contractors and maintainers shall not use claim status category and claim status codes that have been deactivated.	X	X		X	X	X	X	X	X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8446.4	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	X	X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Angie Bartlett, 410-786-2865 or angie.bartlett@cms.hhs.gov , Jason Jackson, 410-786-6156 or jason.jackson3@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
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Section B: For Medicare Administrative Contractors (MACs):
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