



News Flash - National Provider Identifier (NPI) News – During this testing and implementation phase for the NPI, providers should pay close attention to information from health plans and clearinghouses to understand how claims are being processed and what providers should be doing to assure no disruption in payment. Providers should also ensure that the information they are submitting on a claim is what is being transmitted to each health plan by the billing vendors or clearinghouses who may be submitting the claims on their behalf. Additional information can be found at <http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProviderStand/index.html> on the CMS website.

MLN Matters Number: MM5687

Related Change Request (CR) #: 5687

Related CR Release Date: July 23, 2007

Effective Date: January 1, 2008

Related CR Transmittal #: R1314CP

Implementation Date: January 2, 2008

Note: This article was updated on September 12, 2012, to reflect current Web addresses. All other information remains the same.

Claim Status Category Code and Claim Status Code Update

Provider Types Affected

Physicians, providers, and suppliers who submit Health Care Claim Status Transactions to Medicare contractors (carriers, Medicare administrative contractors (A/B MACs), durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs)).

Provider Action Needed

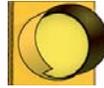


STOP – Impact to You

This article is based on Change Request (CR) 5687, which provides the January 2008 updates of the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors (carriers, A/B MACs, DME MACs, FIs, and RHHIs).

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**CAUTION – What You Need to Know**

Effective January 1, 2008, Medicare contractors are to use codes posted on July 9, 2007, at the <http://www.wpc-edi.com/codes> website. Chapter 31 of the *Medicare Claims Processing*

Manual, Section 20.7 - Health Care Claim Status Category Codes and Health Care Claims Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277 discusses these codes in more detail. You may review section 20.7 at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c31.pdf> on the Centers for Medicare & Medicaid Services (CMS) website

**GO – What You Need to Do**

See the *Background* section of this article for further details.

Background

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers (including Medicare) must use Claim Status Category and Claim Status codes approved by a recognized code set maintainer (instead of proprietary codes) to explain any status of a claim(s) sent in the Version 004010X093A1 Health Care Claim Status Request and Response transaction. These codes indicate the general category of a claim's status (accepted, rejected, additional information requested, and so on). The national Code Maintenance Committee maintains the Claim Status Category and Claim Status codes.

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/content/view/180/223/> on the CMS website. This page has previously been referenced by the following URL address: <http://www.wpc-edi.com/codes> on the CMS website. 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 June 2007 committee meeting were posted on that site on July 9, 2007. One of the decisions made during this June meeting by this Maintenance Committee was to allow the industry more lead time for implementation of code changes. At least 6 months lead time will be allowed for industry implementation of all Claim Status-related code changes as well as Claim Adjustment Reason Code changes (the same committee maintains these code

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sets). As result, changes approved in June 2007 will be effective January 1, 2008.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5687) issued to your Medicare FI, carrier, DME MAC, RHHI or A/B MAC. That instruction may be viewed by going to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1314CP.pdf> on the CMS website.

If you have questions, please contact your Medicare FI, carrier, DME MAC, RHHI or A/B MAC at their toll-free number which may be found at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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