

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



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- [“The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers,”](#) Fact Sheet, ICN 903768, Downloadable only.

MLN Matters® Number: MM8320

Related Change Request (CR) #: CR 8320

Related CR Release Date: May 24, 2013

Effective Date: October 1, 2013

Related CR Transmittal #: R2713CP

Implementation Date: October 7, 2013

Claim Status Category and Claim Status Codes Update

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, Regional Home Health Intermediaries (RHHIs), Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) and A/B Medicare Administrative Contractors (A/B MACs)) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8320 which requires Medicare contractors to use only national Code Maintenance Committee-approved Claim Status Category Codes and Claim Status Codes when sending Medicare healthcare status responses (277 transactions) to report the status of your submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. All code changes approved during the June 2013 Committee meeting will be posted on or about July 1, 2013, at <http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes> and <http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes> on the Internet. Make sure that your billing staffs are aware of these changes.

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Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only national Code Maintenance Committee-approved Claim Status Category Codes and Claim Status Codes to explain the status of submitted claims. These codes, which have been adopted as the national standard to explain the status of submitted claim(s), are the only such codes permitted for use in the X12 276/277 Health Care Claim Status Request and Response format.

The national Code Maintenance Committee meets three times each year (February, June, and October) in conjunction with the Accredited Standards Committee (ASC) X12 trimester meeting, and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of the newly added or changed codes. Therefore, on the date of implementation of CR8320 (October 7, 2013), your Medicare contractor must:

- 1) Complete the entry of all applicable code text changes and new codes;
- 2) Terminate the use of deactivated codes;
- 3) Use these new codes for editing all X12 276 transactions and reflect them in the X12 277 transactions that they issue.

Additional Information

The official instruction, CR8320 issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2713CP.pdf> on the CMS website.

If you have any questions, please contact your Medicare contractor 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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