

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1314	Date: JULY 23, 2007
	Change Request 5687

SUBJECT: Claim Status Category Code and Claim Status Code Update

I. SUMMARY OF CHANGES: The Claim Status Codes and Claim Status Category Codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 were updated during the June 2007 meeting of that Maintenance Committee. At that time, The Committee also decided to allow the industry 6 months for implementation of newly added or changed codes. Contractors are to use codes posted at www.wpc-edi.com/codes on July 9, 2007 which are listed as current codes on that site.

New / Revised Material

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

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:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2008 operating budgets.

IV. ATTACHMENTS:

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1314	Date: July 23, 2007	Change Request: 5687
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SUBJECT: Claim Status Category Code and Claim Status Code Update

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

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 (004010X093A1). 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/content/view/180/223/>. This page has 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 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 sets). As result, changes approved in June 2007 will be effective January 1, 2008. Contractors must have completed 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 Charge Request (CR).

B. Policy: CMS' Medicare contractors must comply with the requirements contained in the version 004010X093A1 ASC X12 276/277 Implementation Guide and must use valid Claim Status Category Codes and Claim Status Codes when sending 277 responses.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B M A C	D M M A C	F I M C	C A R R E R	D M R R I C	R E H I C	Shared- System Maintainers	F I S S	M C S	V M S	C W F
5687.1	Contractors and maintainers shall update claim status category and claim status codes that have been modified.	X	X	X	X		X	X	X	X		
5687.2	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		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B M A C	D M M A C	F I M C	C A R R E R	D M R R I C	R E H I C	Shared- System Maintainers	F I S S	M C S	V M S	C W F
5687.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.	X	X	X	X		X					

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
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X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use the space below: N/A

V. CONTACTS

Pre-Implementation Contact(s): Robert Huffman, 410-786-6317 regarding this Change Request.

Post-Implementation Contact(s): Robert Huffman, 410-786-6317 regarding this Change Request.

VI. FUNDING

A. For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC):

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2008 operating budgets.

B. For Medicare Administrative Contractors (MACs):

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated 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.