CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 96 **Date: February 6, 2004**

CHANGE REQUEST 3017

SUMMARY OF CHANGES: Medicare contractors are to have all applicable claims status code and claims category codes with the "new as of September 03" designation and prior dates for use in production. Medicare contractors are to inform affected providers.

MANUALIZATION EFFECTIVE/IMPLEMENTATION DATES: N/A

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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:
(R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	31/Table of Contents
N	31/20/7/Health Care Claims Status Category Codes and Health Care Claim Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277

III. FUNDING: These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

Medicare Claims Processing Manual

Chapter 31 - ANSI X12N Formats Other than Claims or Remittance

Table of Contents

(Rev.)

20.7 - Health Care Claims Status Category Codes and Health Care Claim Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277

(Rev.)

PM AB-03-029

PM AB-03-131

Medicare carriers and intermediaries must periodically update their claims system with the most current health care claims status category codes and health care claim status codes for use with the Health Care Claim Status Request and Response ASC X12N 276/277. The most current codes can be found at http://www.wpc-edi.com/codes/Codes.asp

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers must use health care claims status category codes and health care claim status codes approved by the Health Care Code Maintenance Committee. At each X12 trimester meeting (generally held the months of February, June and October) the Committee may update the claims status category codes and health care claim status codes. Included in the code list are specific details such as the date when a code was added, changed or deleted.

By July 1, 2003, Medicare carriers and intermediaries were to have all applicable code changes and new codes that were posted to that Web site as of March 31, 2003, for use in production. The HCFA Part B Standard System (HPBSS) and its carriers were exempt from that requirement until carriers transitioned to the Multi-Carrier System (MCS).

By July 1, 2003, Medicare carriers and intermediaries were to have begun providing information in a regularly scheduled provider news bulletin regarding the implementation (and subsequent updates) to the claims status category codes and health care claim status codes for use with the Health Care Claim Status Request and Response, ASC X12N 276/277.

By September 1, 2003, Medicare carriers and intermediaries were to have all applicable code changes and new codes that were posted to the Web site with the "new as of February 03" designation and prior dates for use in production. They were not to update their system to include codes that were dated post-February 2003 until instructed. Medicare carriers and intermediaries were further instructed that if a code does not apply to Medicare, they were not required to accommodate it in their adjudication system nor in their 277 responses. If a Medicare carrier's or intermediary's adjudication system did not currently support the level of detail in any code, they were not required to accommodate the code in their system.

By September 1, 2003, Medicare carriers and intermediaries were to have informed providers/submitters of any new codes providers could see in 277 responses. Options for getting that message out included provider bulletins, educational articles, provider outreach presentations or electronic mail/web page/electronic bulletin board. Medicare carriers and intermediaries were to choose from any of these options (as well as others) to reach their provider/submitter audience by the most effective and efficient means timed with their system's availability of the codes to their providers/submitters.

By July 1, 2004, Medicare carriers and intermediaries are to have all applicable code changes and new codes that are posted to the Web site with the "new as of September 03" designation and prior dates for use in production. They are not to update their system to include codes that are dated post-September 2003 until instructed. If a code does not apply to Medicare, they are not required to accommodate it in their adjudication system nor in their 277 responses. If a Medicare carrier's or intermediary's adjudication system does not currently support the level of detail in any code, they need not accommodate the code. If providers are impacted by the July 2004 update, Medicare carriers and intermediaries shall inform affected provider communities by posting either a summary or relevant portions of this instruction on their websites within two weeks of the issuance date of this instruction. In addition, this same information shall be published in the next regularly scheduled Medicare carrier or intermediary bulletin. If a Medicare carrier or intermediary has a listserv that targets the affected provider communities, they must use it to notify those communities about this update.

CMS will issue instructions through the Change Request process regarding future changes to the codes. Contractor and shared systems 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 that may impact Medicare.

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Attachment - Business Requirements

Pub. 100-04	Transmittal: 96	Date: February 6, 2004	Change Request 3017

SUBJECT: Claims Status Codes in ASC X12N 276/277 Claims Status Health Insurance Portability and Accountability Act (HIPAA) Transactions.

I. GENERAL INFORMATION

A. Background: Contractors and standard systems use the claims status codes in the ASC X12N 276/277 claims status HIPAA transaction. The codes are maintained by the X12N Health Care Code Maintenance Committee and posted at www.wpc-edi.com/codes/Codes.asp These codes are updated periodically. Recently, new codes were added to the site with the designations, respectively, "new as of 6/03" and "new as of 9/03."

B. Policy: Under HIPAA, all payers must use the applicable health care claims status category codes and health care claim status codes approved by the Committee.

C. Provider Education: None

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
Requirement #1 Ch. 31, Sec 20.7	By July 6, 2004, contractors shall have all applicable code changes and new codes, that are posted to the Web site with the "new as of September 03" designation and prior dates for use in production. Contractors are not to update their systems to include codes that are dated post-September 2003 until instructed. If a code does not apply to Medicare, a contractor need not accommodate it in their adjudication system nor in their 277 response and if the level of detail in any code is not currently supported by their adjudication system, they need not accommodate the code. By February 1, 2004, contractors shall inform providers/submitters of any new codes providers may see in 277 responses.	Contractors, shared systems

II. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
3017#1	Contractors need only to have all applicable code changes. If the level of detail in any code is not currently supported by their adjudication system, or is not applicable to Medicare, they need not accommodate the code.

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: February 1, 2004 **Implementation Date: July 6, 2004** **Pre-Implementation Contact(s): James Krall, jkrall@cms.hhs.gov 410-786-6999** **Post-Implementation Contact(s): James Krall, jkrall@cms.hhs.gov 410-786-6999**	**These instructions shall be implemented within your current operating budget.**