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

Note: This article was revised to contain web addresses that conform to the new CMS website and to show they are now MLN Matters articles. All other information remains the same.

Provider Types Affected

All providers

Provider Action Needed



STOP – Impact to You

HIPAA requires all payers to use the applicable health care claims status category codes and health care claim status codes.



CAUTION – What You Need to Know

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.



GO – What You Need to Do

Providers will need to be aware of the new codes that may appear on their response to a claims status inquiry.

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Background

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. 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.

Per the Health Insurance Portability and Accountability Act (HIPAA) of 1996, health plans must be able to conduct the standard electronic transactions mentioned in the regulation. The named HIPAA transaction for claims status is the ASC X12N 276/277 4010A1 Health Care Claims Status Request and Response. The code sets for use with the 276/277 are the Health Care Claims Status Category Codes and Health Care Claim Status Codes.

Medicare contractors are already using these code sets due to prior instructions. However, recently some new codes and code changes were made with the designation "new as of 2/04." Medicare carriers and intermediaries will start using the "new as of 2/04" codes as of January 3, 2005.

Additional Information

Claim Status codes are used in the Health Care Claim Status Notification (277) transaction in the STC01-2, STC10-2 and STC11-2 composite elements. They indicate the detail about the general status communicated in the Claim Status Category Codes carried in STC01-1, STC10-1 and STC11-1.

Claim status codes communicate information about the status of a claim, i.e., whether it's been received, pending, or paid.

For users who are new to the Claim Status transaction, please review the 276/277 Implementation Guide for utilizing claim status codes.

The Claim Status transaction is not used as a financial transaction.

Claim Status Category codes are used in the Health Care Claim Status Notification (277) transaction in the STC01-1, STC10-1 and STC11-1 composite elements. They indicate the general category of the status (accepted, rejected,

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additional information requested, etc.) which is then further detailed in the Claim Status Codes carried in STC01-2, STC10-2 and STC11-2.

The code sets for use with the 276/277 are the Health Care Claims Status Category Codes and Health Care Claim Status Codes found at <http://www.wpc-edi.com/codes/codes.asp>

By January 3, 2005, Medicare carriers and intermediaries must have all applicable code changes and new codes that are posted on the Web site with the "new as of 2/04" designation and prior dates available for use in production.

The official instruction issued to your carrier regarding this change may be found by going to <http://www.cms.hhs.gov/transmittals/Downloads/R230CP.pdf> on the CMS website.

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