CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12970	**Date: November 21, 2024**
	Change Request 13886

SUBJECT: Claim Status Category Codes (CSCC) and Claim Status Codes (CSC) Update

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update, as needed, the CSCC and CSC used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and the ASC X12 277 Health Care Claim Acknowledgment transactions. This Recurring Update Notification (RUN) can be found in chapter 31, section 20.7 of Publication (Pub.) 100-04.

EFFECTIVE DATE: November 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 7, 2025

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	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. 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.

IV. ATTACHMENTS:

Recurring Update Notification

Attachment - Recurring Update Notification

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II. GENERAL INFORMATION

A. Background: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of the submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status. This RUN can be found in chapter 31, section 20.7 of Pub. 100-04.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry six (6) months for implementation of newly added or changed codes.

The codes sets are available on the official ASC X12 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 September 2024 committee meeting shall be posted on these sites on or about November 1, 2024.

The CMS will issue RUNs regarding the need for future updates to these codes. When instructed, Medicare contractors must update their claims systems to ensure that the current version of these codes is used in their claim status responses Contractor and shared systems changes will be made as necessary as part of a routine release to reflect applicable changes such as the retirement of previously used codes or newly created codes.

These code changes are to be used in editing all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of this CR.

The CMS Medicare contractors must comply with the requirements contained in the current standards adopted under HIPAA for electronically submitting certain health care transactions, among them the ASC X12 276/277 Health Care Claim Status Request and Response. These contractors must use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Health Care Claim Status Responses. They must also use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Healthcare Claim Acknowledgments. References in this CR to "277 responses" and "claim status responses" encompass both the ASC X12 277 Health Care Claim Status Response and the ASC X12 277 Healthcare Claim Acknowledgment transactions.

Upon implementation of this CR, the most recently published X12 Claim Status Category and Claim Status Codes will be used by Medicare FFS systems to ensure HIPAA compliancy.

This CR will update, as needed, the Claim Status and Claim Status Category Codes used for the ASC X12 276/277 Health Care Claim Status Request and Response and the ASC X12 277 Health Care Claim Acknowledgement transactions. This RUN can be found in chapter 31, section 20.7 of Pub. 100.04.

B. Policy: HIPAA; Code of Federal Regulations Title 45 (162.1401 – 162.1403).

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13886.1	Contractors and Maintainers shall update the most current Claim Status Category Codes and Claim Status Codes that are published on the official ASC X12 website on or about November 1, 2024.	X	X	X	X	X	X			CEDI
13886.2	Contractors and Maintainers shall use current new claim status category codes and claim status codes as appropriate in 277 responses.	X	X	X	X	X	X			CEDI
13886.3	Contractors and Maintainers shall not use Claim Status Category Codes and Claim Status Codes that have been deactivated.	X	X	X	X	X	X			CEDI
13886.4	Contractors and Maintainers shall complete entry of all current code text changes, new codes, and terminate use of all deactivated codes, by the implementation date of this CR.	X	X	X	X	X	X			CEDI

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don’t need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A, A/B MAC Part B, A/B MAC Part HHH, DME MAC, CEDI

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	N/A

Section B: All other recommendations and supporting information:N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

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ATTACHMENTS: 0