CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2937	Date: April 25, 2014
	Change Request 8640

Transmittal 2909, dated March 14, 2014, is being rescinded and replaced by Transmittal 2937 dated April 25, 2014, to add section 10.1 to the Manual Instructions and to make additional minor technical edits. All other information remains the same.

SUBJECT: Medicare Claims Processing Pub. 100-04 Chapter 31 Update

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to publish an update to IOM, Medicare Claims Processing Manual, Pub.100-04 Chapter 31, to reflect changes to Medicare Fee-For-Service's Electronic Data Interchange (EDI) practices, and corresponding EDI requirements for Medicare contractors that are being implemented as part of the 5010 implementation project. In addition, general changes are being made across the chapter to standardize language around the use of contractors and general standard wording.

All procedures described herein have been published previously. This is a language-only update.

EFFECTIVE DATE: April 14, 2014
*Unless otherwise specified, the effective date is the date of service.
IMPLEMENTATION DATE: April 14, 2014

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
R	31/ Table of Contents
R	31/10/ ASC X12 270/271 Health Care Eligibility Benefit Inquiry and Response Implementation
R	31/10/10.1/ Background
R	31.10/10.2/ Eligibility Connectivity Workflow
D	31/10/10.3/ Medicare HIPAA Eligibility Transaction System Inquiries Rules of Behavior
R	31/20/ ASC X12 276/277 Claim Status Request/Response Transaction Standard
R	31/20/20.1/ Transmission Requirements
R	31/20/20.1.1/ Batch Transactions
R	31/20/20.1.2/ Online Direct Data Entry
R	31/20/20.1.3/ Interactive/Online (Non-DDE)
R	31/20/20.2/ Summary of the ASC X12 276/277 Claim Status Request and Response Process for A/B Medicare Administrative Contractors, DME MACs, CEDI
R	31/20/20.3/ Flat File
R	31/20/20.4/ Translation Requirements
R	31/20/20.5/ Transmission Mode
R	31/20/20.7/ Health Care Claim Status Category Codes and Health Care Claim Status Codes for Use with the Health Care Claim Status Request and Response ASC X12 276/277 Claim Status Request and Response

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 obliged 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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2937	Date: April 25, 2014	Change Request: 8640

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SUBJECT: Medicare Claims Processing Pub. 100-04 Chapter 31 Update

EFFECTIVE DATE: April 14, 2014
Unless otherwise specified, the effective date is the date of service
IMPLEMENTATION DATE: April 14, 2014

I.   GENERAL INFORMATION

A.   Background: The purpose of this Change Request (CR) is to publish an update to IOM, Medicare Claims Processing Manual, Pub.100-04 Chapter 31, to reflect changes to Medicare Fee-For-Service's Electronic Data Interchange (EDI) practices, and corresponding EDI requirements for Medicare contractors that are being implemented as part of the 5010 implementation project. In addition, general changes are being made across the chapter to standardize language around the use of contractors and general standard wording.

There are no new policies or procedures introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

B.   Policy: Legislation 45 CFR Part 162

II.   BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8640.1	Contractors shall be aware of the updates being made within IOM Pub. 100-04, Chapter 31, and shall ensure compliance with these requirements.	X	X	X	X					CEDI

III.   PROVIDER EDUCATION TABLE

Number	Requirement	A/B MAC	DME MAC	CEDI

		A	B	H H H		
	None					

IV.   SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

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

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

V. CONTACTS

Pre-Implementation Contact(s): Angie Bartlett, 410-786-2865 or angie.bartlett@cms.hhs.gov

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

VI. FUNDING

Section A: 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.

Medicare Claims Processing Manual
Chapter 31 - *ASC X12* Formats Other than Claims or Remittance

Table of Contents
(Rev. 2937, Issued; 04-25-14)

Transmittals for Chapter 31

10 - ASC X12 270/271 Health Care Eligibility Benefit Inquiry and Response Implementation
(Rev. 2937, Issued; 04-25-14, Effective: 04-14-14, Implementation: 04-14-14)

10.1 - Background
(Rev. 2937, Issued; 04-25-14, Effective: 04-14-14, Implementation: 04-14-14)

This section provides information on Medicare's implementation of the *Accredited Standards Committee (ASC)* X12 *Health Care Eligibility Benefit Inquiry and Response (270/271) transaction (short reference: ASC X12 270/271 eligibility transaction). The CMS supports the currently mandated version of the transaction based upon the currently mandated version of the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3--Health Care Eligibility Benefit Inquiry and Response (270/271), both of* which *were* adopted as the *N*ational standard for the health care eligibility benefit inquiry and response under the Health Insurance Portability and Accountability Act *of 1996* (HIPAA). *The technical report 3 is also known as a TR3 or implementation guide (IG). (Refer to chapter 24 for current versions adopted under HIPAA.)*

10.2 - Eligibility *Connectivity* Workflow
(Rev. 2937, Issued; 04-25-14, Effective: 04-14-14, Implementation: 04-14-14)

In 2006, the Centers for Medicare & Medicaid Services (CMS) implemented the HIPAA Eligibility Transaction System (HETS) 270/271 application to address the standards for the Medicare beneficiary eligibility inquiries, creating a centralized ASC X12 270/271 health care eligibility inquiry that provides eligibility transaction on a real-time basis:

1. *Submitters may access the HETS 270/271 application in the CMS Baltimore Data Center using the CMS Extranet or by establishing internet connectivity using Simple Object Access Protocol (SOAP) + Web Services Description Language (WSDL) envelope standards hereafter referred to simply as SOAP or Hypertext Transfer Protocol (HTTP)/Multipurpose Internet Mail Extensions (MIME) Multi-part envelope standards hereafter referred to simply as MIME.*

   The CMS Extranet is a secure, closed, private network currently used to transmit data between CMS and CMS Business Partners. Connections using SOAP or MIME are secured by the use and verification of Digital Certificates.

   For an ASC X12 270 real-time eligibility inquiry, the software at the CMS Baltimore Data Center will translate the incoming ASC X12 270 transaction, perform validations, request beneficiary eligibility information from the CMS eligibility database, and create either an ASC X12 271eligibility response, ASC X12 999 implementation acknowledgment, ASC X12 TA1 interchange acknowledgment or proprietary response.

2. *For more information regarding the HETS application, visit the HETS Help web site. This web site is designed to provide technical system support to CMS Business Partners for the initiation, implementation, and operation of the HETS 270/271 application - Extranet or Internet Transaction Submission. This information is provided to assist external Business Partners with connectivity, testing, and data exchange with CMS and to keep users informed of any system issues that may arise.*

   http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html

20 - *ASC X12 276*/277 Claims Status Request/Response Transaction Standard
(Rev. 2937, Issued; 04-25-14, Effective: 04-14-14, Implementation: 04-14-14)

These instructions apply to Medicare Administrative Contractors (MACs), *Durable Medical Equipment* Medicare Administrative Contractors (*DME MACs*), the Common Electronic Data Interchange (CEDI) contractor for *DME MACs*, and their shared systems on Medicare requirements for their implementation of the current HIPAA compliant version of the *ASC X12 Health Care Claim Status Request and Response (276/277) transaction (short reference: ASC X12 276/277 claim status request and response.)*

CMS supports the current version of this transaction as established in its TR3 adopted under HIPAA: the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim Status Request and Response (276/277).

In order to implement the HIPAA administrative simplification provisions, the *ASC X12* 276/277 *claim status request and response and its implementation specification (now TR3) have* been named under part 162 of title 45 of the Code of Federal Regulations as the electronic data interchange (EDI) standard for Health Care Claim Status Request/Response. All other EDI formats for health care claims status request and response bec*a*me obsolete October 16, 2003. The Final Rule for Health Insurance Reform: Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards published in the [Federal Register on January 16th, 2009,](#) adopts updated versions of the electronic transactions *and TR3* for *the ASC X12 276/277 c*laim *s*tatus *r*equest and *r*esponse. Furthermore, the Final Rule conveys inclusion of errata to the transaction standard. CMS therefore incorporates by reference any errata documents by the original mandated regulation compliance date through the Federal Register notice(s). Moving forward, all newly adopted errata documents are to be accepted and integrated as part of the EDI transaction.

The ASC X12 *TR3 f*or the *ASC X12 2*76/277 *claim status request and response* standard may be found at the following Website: http://Store.X12.org . The *ASC X12* 276/277 is a "paired" transaction (*the ASC X12 276 is an in-bound claim status request*, and the 277 is an outbound claims status response).

20.1 - Transmission Requirements
(Rev. 2937, Issued; 04-25-14, Effective: 04-14-14, Implementation: 04-14-14)

A/B MACs, DME MACs, *and* CEDI may continue to operate automated response unit (ARU) capability for providers to request and receive claim status information. ARUs are not considered EDI and are not affected by the HIPAA requirements. Nor do they impact response time requirements for the standard transactions implemented under HIPAA.

20.1.1 - Batch Transactions
(Rev. 2937, Issued; 04-25-14, Effective: 04-14-14, Implementation: 04-14-14)

Contractors must be able to accept the current *ASC X12 276 claim status request* in batch mode, and respond via the *ASC X12* 277 *c*laim *s*tatus *r*esponse in batch mode. If a contractor currently supports batch capability in any EDI batch format to request claim status, the response time for issuance of a*n ASC X12* 277 *claim status response* transaction in response must be within one business day of *the* receipt of a valid *ASC X12* 276 *claim status request transaction*.

20.1.2 - Online Direct Data Entry (DDE)
(Rev. 2937, Issued; 04-25-14, Effective: 04-14-14, Implementation: 04-14-14)

The HIPAA uses the term "direct data entry" generically to refer to a type of functionality operated by many different payers under a variety of titles. Within this instruction, the acronym DDE is being used to refer to any type of direct data entry system maintained by contractors, or shared system maintainers, including intermediary DDE or equivalent functionality that may have a different title. Although DDE operates online, DDE does not typically operate on a detailed inquiry and response basis. For claim status purposes, data is maintained within an interactive database that providers may access to view screens containing a wide variety of information on their claims. A provider accesses that data by furnishing certain identifying

data for security purposes to establish their right to read the data and to specify those claim records the provider wishes to review.

The information in this database for specific claims or providers is initiated when a provider enters claim data, and is then updated by a contractor to include subsequent actions taken that affect that claim. DDE was specifically permitted to continue in the HIPAA initial transactions final rule (45 CFR 162.923), with the stipulation that direct data entry is subject to "…the applicable data content and data condition requirements of the standard when conducting the transaction. The health care provider is not required to use the format requirements of the standard."

Data content conformity means that the same information permitted or required by the *ASC X12* 277 *claim status response* implementation guide must be reported in the claims status screens (the DDE outbound). The DDE outbound may not report a data element for claim status purposes that is not included in the *ASC X12* 277 *claim status response*, exceeds the maximum length of the data element in the *ASC X12* 277 *claim status response*, does not meet the minimum length for the data element in the *ASC X12* 277 *claim status response*, or that does not meet the *ASC X12* 277 *claim status response* requirement that the data element be numeric, alpha-numeric, an amount, or meet another characteristic as specified in the *ASC X12* 277 *claim status response*. On the inbound, the DDE system can require less information than the *ASC X12* 276 *claim status request*, but not more. The inquirer is not required to furnish information in the DDE inquiry that is available by other means to the contractor. Any data element keyed in a DDE system must conform to the requirements. *The ASC X12* standard *TR3* include data element length and characteristics in their definition of data attributes.

Conformity does not mean that a DDE screen that includes claim status information must display each of the data qualifiers or other means of data identification contained in the *ASC X12* 277 *claim status response* implementation guide. DDE screens typically identify, explicitly or by context, the type of information being reported in a field, e.g., would identify if a number represents a HCPCS, health insurance claim number, amount, grams, date of birth, etc. DDE screens would not be expected to use a qualifier contained in the *ASC X12* 277 *claim status response* to identify data type if that is otherwise evident in the design or content of the DDE screen.

Shared system maintainers must map the DDE claim status data elements to the *ASC X12* 276/277 *claim status request and response* implementation guide to determine if the DDE claim status data elements meet the conformity requirements above. If needed, changes must be made to enable contractor DDE claim status data elements to conform.

If a contractor continues to support DDE, it must be offered in addition to batch *ASC X12* 276/277 *claim status request and response*, but the contractor must take one of two approaches to assure their claim status data content conforms to the requirements:

1. Eliminate claim status data elements from the DDE screens, unless those data elements are also needed for a purpose other than claim status. For example, if a data element is needed in a DDE screen for claim entry or claim correction, and it is also used to help determine claim status, retain the data element so it can continue to be used for claim entry or correction. If a data element is used solely for claim status, and is not essential for an alternate purpose, eliminate it; or

2. If a contractor elects to continue to display claim status-specific data elements in their DDE screens, those data elements must at a minimum contain/report data that conforms to:

   - All required and applicable conditional data elements for those segments in the *ASC X12* 277 *claim status response*; and

- Data content as specified for those data elements in the *ASC X12* 277 *claim status response*, as applicable, including compliance with the data attributes for those data elements as defined in the *ASC X12* 277 implementation guide.

Preliminary feedback from contractors suggests that existing DDE screens used for Medicare may already conform to the *ASC X12* 277 *claim status response* implementation guide requirements, but data element mapping is required to verify. For example, since industry input was used to develop the *ASC X12* 277 *claim status response* implementation guide as well as, presumably the data elements for claim status currently furnished via DDE, it is unlikely that DDE screen field sizes would be larger than the *ASC X12* 277 *claim status response* maximum length or shorter than the *ASC X12* 277 *claim status response* minimum length. It is also unlikely that a DDE screen would contain a data element considered important for claim status that is not included in the *ASC X12* 277 *claim status response*, or vice versa.

If a shared system maintainer determines that DDE screen changes are required, the maintainer in conjunction with its users must determine if it would be cost effective to modify the DDE screens to conform to the *ASC X12* 277 *claim status response* implementation guide. If not cost effective, the maintainer must eliminate the claim status-only data elements from the DDE screens and require the contractors to use the batch *ASC X12* 276/277 *claim status request and response*, an ARU, and/or other non-EDI means to obtain claim status information.

If retention is cost effective, the maintainer must modify these screens as necessary to *en*sure that providers are able to access all applicable data content available in the *ASC X12* 277 *claim status response*. The DDE screens must be able to furnish providers information that conforms to the data that would have been issued to the provider in a*n ASC X12* 277 *claim status response*. See above for the discussion of conformity.

20.1.3 - Interactive/Online (Non-DDE)
(Rev. 2937, Issued; 04-25-14, Effective: 04-14-14, Implementation: 04-14-14)

Contractors are not required to accept a*n ASC X12* 276 *claim status inquiry* or respond with a*n ASC X12* 277 *claim status response* in an interactive, online mode if they do not already do so. If contractors do support the *ASC X12* 276/277 *claim status request and response* in an interactive online mode, it must be offered in addition to batch *ASC X12* 276/277 *claim status request and response*

20.2 - Summary of the *ASC X12* 276/277 *Claim Status Request and Response* Process for *A/B* Medicare Administrative Contractors, DME MACs, CEDI
(Rev. 2937, Issued; 04-25-14, Effective: 04-14-14, Implementation: 04-14-14)

A. The contractor's translator must perform *editing* on the submitted *ASC X12* 276 *claim status request transaction* at the ASC X12 standard *and implementation* level*s, and* generate a *ASC X12* TA1 *interchange acknowledgment* in batch if an interchange control error was detected. *The contractor shall* generate an appropriate *ASC X12 999 implementation acknowledgment* in batch if a syntax error is detected. In the absence of any interchange control or syntax error, a*n ASC X12 999 implementation a*cknowledgement is issued in the batch mode only, to confirm receipt of a *ASC X12* 276 received via batch*.* See §20.4 for additional translation requirements. Translation does not apply to DDE screens.

A*n ASC X12* TA1 *interchange a*cknowledgment *and an ASC X12 999 i*mplementation *a*cknowledgment (issued for a*n ASC X12* 276 *claim status request* submitted in a batch*)* must be issued within 1 business day of receipt of the *ASC X12* 276 *claim status request*.

A*n ASC X12* TA1 interchange acknowledgment and *ASC X12* 999 *implementation a*cknowledgment of a*n ASC X12* 276 *claim status request* submitted in an interactive/online mode must be issued as quickly as the *ASC X12* 277 *claim status response* would have been issued had the *ASC X12* 276

claim status request been valid.

Under the current HIPAA adopted ASC X12 version, inclusive of any adopted Errata moving forward, the contractor's translator shall edit the incoming ASC X12 276 claim status request transaction as documented by the CMS 276/277 Edits spreadsheet (as updated per quarterly release) from the CMS Website:
http://www.cms.gov/ElectronicBillingEDITrans/10_ClaimStatus.asp#TopOfPage

B. The shared system shall continue to *process* claim status transactions in current *ASC X12* version to include edits to verify that the submitted *ASC X12* 276 data complies with IG and Medicare requirements. If edits are failed, the shared system must generate an edit report following the model established for *TR3* and Medicare program edit reporting for the HIPAA compliant version of the *ASC X*12 837 *claim* implementation. The edit report must include any reason(s) for the rejection in a concise but explicit manner that can be understood by provider staff as well as contractor staff. Contractors will forward the edit messages to submitters for correction of the edit condition. The shared system must generate these edit reports within 1 business day.

The *TR3* edits must be performed as defined in the *TR3* segment and data element notes, data element attributes, conditions of use, and overall guiding principles for use of the standards as contained in the introduction section and addenda to the IG. The Medicare program edits must be performed as required by current Medicare program instructions.

C. The A/B MAC or, for DME, the CEDI contractor, shall process inbound claim status transactions in *the current* ASC X12 version(s) (inclusive of any ASC X12 Errata) and beyond to include the edits defined in the CMS 276/277 Edits spreadsheet as translator applicable in order to pass to the Part A or Part B Common Edits and Enhancement Module (CEM) software a CMS defined flat file format (inclusive of Control Record(s) hereafter referred to as CTRD).

For Part A and Part B, the CEM software shall perform all edits not marked as Translator on the CMS 276/277 Edits spreadsheet for inbound claim status transactions in order to pass the fully edited inbound claim status transaction on to the appropriate Part A or Part B shared system for appropriate claim status request processing in the shared system.

For DME, the CEDI contractor shall also process inbound claim status transactions in *the current* ASC X12 version(s) (inclusive of any ASC X12 Errata) and beyond to also include edits defined in the CMS 276/277 Edits spreadsheet other than translator applicable in order to pass the fully edited inbound claim status transaction on to the DME shared system for appropriate claim status request processing in the shared system.

D. For claim status request and response transactions formatted in *the current* ASC X12 version(s) and beyond the shared system:

- Updates the Control Record database with the CTRD record for the activities being processed (e.g. interchange – ISA segment to IEA) and appropriate content of the Control Record. Stores any *ASC X12* 276 *claim status request* data elements required for preparation of a compliant *ASC X12* 277 *claim status* response that are either not retained in the Medicare core system, or exceed the size limits for that type of data in the Medicare core system in a temporary file

- Completes the application request/inquiry according to the components that outbound claim status response requires, as well as, generates and populates the outbound Control Record for the outbound claim status response. These processes shall comply with the TR3 for the ASC X12

transaction and the CMS defined Control Record definition (inclusive of any quarterly release updates). The shared system shall also perform data scrubbing of outbound data prior to the data exiting the Enterprise Data Center (EDC) and being transferred to the Local Data Center (LDC) as deemed appropriate by CMS and the MACs. The initial instructions for the outbound data scrubbing were contained in Transmittal 702, Change Request 6946. This edit process shall be implemented beginning with the October 2010 release for DME and in the January 2011 release for Part A and Part B shared systems. The processes shall be modified through subsequent releases, as directed via future Change Requests, add to the editing process of the reference file mechanism designed for each shared system to perform the data scrubbing conversion process.

20.3 - Flat Files
(Rev. 2937, Issued; 04-25-14, Effective: 04-14-14, Implementation: 04-14-14)

For the current ASC X12 276/277 claim status request and response and beyond inclusive of any adopted Errata by ASC X12, the CMS developed flat files that maintainers and *contractors* may use. These files are available on the following CMS Web page:
http://www.cms.gov/ElectronicBillingEDITrans/10_ClaimStatus.asp#TopOfPage

20.4 - Translation Requirements
(Rev. 2937, Issued; 04-25-14, Effective: 04-14-14, Implementation: 04-14-14)

For the current ASC X12 276/277 claim status request and response transactions and beyond inclusive of any adopted Errata by ASC X12, *contractors* and shared system maintainers shall exchange *ASC X12 claim status request and* response transactions using the Extended Character Set. except when a CMS and the contractors have deemed to be data scrubbed under the initial instructions for the outbound data scrubbing as contained in Transmittal 702, Change Request 6946 and the modifications through subsequent releases, as directed via future Change Request. Detailed information about the Extended Character Set can be obtain*ed* in Appendix B of any ASC X12 TR3.

20.5 - Transmission Mode
(Rev. 2937, Issued; 04-25-14, Effective: 04-14-14, Implementation: 04-14-14)

The HIPAA compliant version of the *ASC X12* 276/277 *claim status request and response* transaction is a variable-length record designed for wire transmission. The CMS requires that the contractor accept the inbound and transmit the outbound over a wire connection.

20.7 – Health Care Claim Status Category Codes and Health Care Claim Status Codes for Use with the Health Care Claim Status Request and Response ASC X12 276/277 *Claim Status Request and Response*
(Rev. 2937, Issued; 04-25-14, Effective: 04-14-14, Implementation: 04-14-14)

Under *HIPAA*, all payers must use health care claim status category codes and health care claim status codes approved by the Health Care Code Maintenance Committee as applicable. At each *ASC* X12 trimester meeting (generally held the months of February, June and October), the Committee may update the claim status category codes and the claim status 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. The codes sets are available at http://www.wpc-edi.com/codes/Codes.asp. Included in the code lists are specific details, including the date when a code was added, changed or deleted.

CMS will issue recurring, one-time change requests regarding the need for and deadline for future updates to these codes. 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 that may impact Medicare. Shortly after the release of each code update, a provider education article will be available at http://www.cms.hhs.gov/medlearn/matters for contractors to use to conduct provider outreach.