

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



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Non-Specific Procedure Code Description Requirement for HIPAA Version 5010 Claims

Note: This article was revised on June 22, 2015, to delete the last two sentences of the "Background" section on page 2. All other information remains the same.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for all physicians, providers, and suppliers who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), Home Health and Hospice MACs (HH+H MACs), and Durable Medical Equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

What You Need to Know

The Office of E-Health Standards and Services (OESS) announced on November 17, 2011, that although the 5010/D.0 compliance date of January 1, 2012 will not change, HIPAA enforcement of compliance with the standards will be deferred until March 31, 2012.

The 5010 versions of the institutional and professional claim implementation guides mandate that when claims use non-specific procedure codes a corresponding description of the service is now required. Please make certain your billing and coding staff follow these requirements for submitting a HIPAA compliant claim when Non-Specific Procedure codes are used. Please ensure these implementation guide requirements are followed when submitting a HIPAA compliant claim for all Non-Specific Procedure codes.

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Background

The HIPAA Version 5010 implementation guide describes Non-Specific Procedure Codes as codes that may include, in their descriptor, terms such as: “Not Otherwise Classified (NOC); Unlisted; Unspecified; Unclassified; Other; Miscellaneous; Prescription Drug Generic; or Prescription Drug, Brand Name”. If a procedure code containing any of these descriptor terms is billed, a corresponding description of that procedure is required; otherwise, the claim is not HIPAA compliant. Note that there is no crosswalk of non-specified procedure codes with corresponding descriptions.

Detailed information regarding this new requirement can be found in the 837I and 837P implementation guides (837I – 005010X223A2 and 837P – 005010X222A1). If the corresponding non-specific procedure code description is not submitted, the transaction does not comply with the implementation guide and is not, therefore, HIPAA compliant.

Additional Information

For 5010/D.O implementation information and deadlines, refer to MLN Matters® Special Edition Article #SE1131, which is available at <http://www.cms.gov/MLN MattersArticles/downloads/SE1131.pdf> on the CMS website.

If you are not ready, consider contacting your Medicare contractor to receive the free Version 5010 software (PC-Ace Pro32) and begin testing now. Or, consider contracting with a Version 5010 compliant clearinghouse who can translate the non-compliant transactions into compliant 5010 transactions.

If you are billing Part B and DME claims, you may download the free Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices. This software is available at http://www.cms.gov/AccessToDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website. Part A billers may download the free PC-Print software to view and print a compliant HIPAA 5010 835 remittance advice from their A/B MACs website.

Contact your respective professional associations and other payers for guidance and resources in order to meet their deadlines.

Please note, Change Request (CR) 7392, “Common Edits and Enhancements Module (CEM) and Receipt, Control, and Balancing Updates,” dated July 21, 2011, established the requirements that all procedures shall comply with the HIPAA 5010 version claim process. CR7392 was implemented by Medicare contractors on October 1, 2011, and does not override any previous claims processing instructions.

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