MEDICARE FEE-FOR-SERVICE
HIPAA 5010 & D.O.
Taking EDI to the next level

HIPAA 5010 December 7th National Call: Troubleshooting

Resource Mailbox Questions and Answers

Background: As mentioned on previous HIPAA 5010 national calls, there is a resource box that accepts questions for a 72 hour period around these national calls. Below are questions that were submitted along with their answers.

1) **Q: For the non-specified procedure codes, is there a minimal type of description you're looking for? Such as a minimal number of bytes or lay type of description?**

   A: The submitter should provide Medicare with as much of a description as possible, because there is a limitation for that particular field of 80 bytes. There is not a minimal type description for non-specific procedure codes.

2) **Q: What is Medicare doing to expedite the MACs moving submitters into productions?**

   A: Medicare is lightening the MACs role in the test process (as we did for 4010 implementation) so that the provider may test and request to submit 5010 production.

3) **Q: Will PC-ACE Pro32 users become effective with ACS X12 5010 on January 1, 2012?**

   A: Effective January 1, 2012 all Trading Partners using PC-ACE Pro32 Version 2.32, will only be permitted to select 5010 as the only output format. The January 1st changeover was established as part of the 2.32 (ASC X12 5010) update, prior to issuance of the OESS 90-Day Discretionary Enforcement announcement. This Pro32 v2.32 update file includes software changes necessary to ensure your Pro32 claims are submitted in the ASC X12 837 v5010 format. All Trading Partners should be on the current version of the PC-ACE Pro 32 as the software is set up to automatically expire every 8 months therefore requiring the new version to be downloaded/installed.

   PC-ACE Pro32 software has been updated to version 2.32.0.100 for ASC X12 v5010 with several CMS Medicare mandates and enhancements.

   - This Pro32 upgrade is applicable to 1.82.0.100 (January 2007) and later versions for the PC-ACE Pro32 software
   - ASC X12 version 5010 Errata production software changes:
     - ASC X12 version 4010A1 prohibited after January 1, 2012
     - Zip code requires full 9-position value
     - Billing provider must include physical address. Post office and lock boxes are not permitted.
     - Zip code on all Facility Reference file records must include full 9-position value

Links to information on Version 5010, NCPDP D.0, and NCPDP 3.0 are available at: http://www.cms.gov/Versions5010andDO.

4) **Q: Is there a complete list of non-specific procedure codes and if so, where can it be located?**

A: Medicare has posted to its website the complete list of non-specific procedure codes. That list can be found at http://www.cms.gov/ElectronicBillingEDITrans/40_FFSEditing.asp. Medicare will be updating the code set on a quarterly basis (January, April, July, and October) as the parent code sets are updated.

5) **Q: What does the Medicare Fee or Service 90 Day Enforcement Discretionary period consist of?**

A: Medicare Fee-for-Service (FFS) has experienced significant increases in 5010 production transactions during the last few months. However, there are many submitters that have tested but have not taken the step to move into production for 5010 and D.0. In addition, there are many submitters that have not yet initiated testing with their Medicare Administrative Contractor (MAC). Therefore, to ensure that progress continues to be made, Medicare FFS is planning to take the following steps for submitters and receivers of Medicare Part B and Durable Medical Equipment (DME). All submitters and receivers of Medicare Part A transactions will follow the same action plan starting 30 days after Part B and DME:

- In December 2011, submitters/receivers that have tested and been approved for 5010/D.0 will be notified that they have 30 days to cutover to the 5010/D.0 versions.
- Submitters/receivers that have not yet tested will be notified in December 2011 that they must submit their transition plan and timeline to their MAC in 30 days.
- MACs will notify the submitters/receivers; submitters/receivers have the responsibility to notify the providers they service.

For more information on ASCX12Version 5010, NCPDP D.0, and NCPDP 3.0 please visit http://www.cms.gov/Versions5010andDO.

6) **Q: Will submitters who have not tested 5010 be able to continue to submit 4010 claims after January 1st while their transition plan for the 90 day enforcement discretionary period is being reviewed by the Medicare Administrative Contractor (MAC) and if the plan is approved how much grace time will they be granted?**

A: Submitters who have not tested will need to submit their transition plan within 30 calendar days of the date of the notice from the MAC. Those who submit a transition plan by the deadline will have until April 1, 2012 to complete their transition to the 5010 formats.

7) **Q: What will happen if submitters don't submit a test plan related to the 90 day enforcement discretionary period? Will their 4010 claims be rejected as of the 31st day?**

A: If no transition plan is submitted Medicare FFS may direct the MACs to reject 4010 claims. The MACs have not been directed to reject 4010 claims at this time.

8) **Q: Is Medicare going to release information about exactly what a compliance plan will look like for the 90 day discretionary period?**

A: Medicare will not specify the format of the compliance plan. Submitters should outline the steps they have taken and the steps needed to successfully achieve compliance.

9) **Q: Will the MACs be able to accept a mix of 5010 and 4010 claims during the 90 day enforcement discretionary period?**

A: Yes, MACs will be able to accept a mix of 5010 and 4010 claims during the 90 day non-enforcement period.

10) **Q: How is version 5010 affecting crossover claims to secondary payers? Please explain what will happen if claims are crossing over in version 5010 to a payer that is not 5010 compliant on January 1, 2012.**

A: In light of the 90 day non-enforcement period announcement, Medicare will be allowing Coordination of Benefit (COB) payers to continue to receive 4010A1 claims if they are unable to accept 5010 claims as of the January 1, 2012 compliance date. Medicare systematically has the ability to take 4010A1 claims and convert them to 5010 equivalent claims and to take incoming 5010 claims and convert them to 4010A1 claims for production use within the crossover process. Please note that some COB payers, such as Medicaid payers, are pursuing "hard cut-over dates." This means that they will not accept 4010A1 claims beyond their 5010 production cut-over date, even though Medicare is allowing for the possibility of acceptance of HIPAA 4010A1 claims, under the circumstances specified in the 90-day non-enforcement period announcement, as well as the opportunity to transmit these claim formats to those COB payers that cannot meet the January 1, 2012 compliance date.

11) **Q: Please give information as to where the error codes and meanings/descriptions of those error messages that will be returned on claims submitted in Version 5010 are located.**

A: All error codes and their meanings/descriptions can be found on the Washington Publishing Website (http://www.wpc-edi.com/)

There are two different types of codes that make up the error message that Medicare Fee-for-Service is using for version 5010:

Claim Status Category Codes
Claim Status Category codes indicate the general category of the status (accepted, rejected, additional information requested, etc.) which is then further detailed in the Claim Status Codes.
http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/

Health Care Claim Status Codes
Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/

12) Q: Must the NPI be sent on the NM1 segment of the 2010AA loop? What happens if the Billing Provider does not have an NPI?

A: Yes, Medicare FSS claims must contain the NPI in the NM1 segment of the 2010AA loop. A billing provider submitting Medicare FFS claims is required to provide its NPI at the time of enrollment in the Medicare FFS program. Therefore, all Medicare FFS billing providers shall have an NPI.

13) Q: Will the screens in the Direct Data Entry (DDE) system change to reflect the different fields for version 5010? Will submitters be able to correct Medicare Secondary Payer (MSP) claims in DDE?

A: No, Medicare DDE is proprietary in nature. DDE is not required to include all version 5010 837I data. No, Medicare DDE is not required to provide submitters the capability to correct MSP claims data. Claims correction is not established under HIPAA. MSP claims data can be corrected via a subsequent “corrected” 837I.

14) Q: Will there be any direction related to loosening the requirement that the Billing Provider address must not be a PO Box?

A: ASC X12 has issued the following response regarding the Billing provider PO Box:

“This issue is explicitly addressed in guide 005010X222A1. There is no direction available related to loosening the requirement that the Billing Provider address must not be a PO Box. Sending a PO Box in loop 2100AA is not compliant with the TR3 instructions. X12 does not govern the receiver's actions when receiving a transaction that is not compliant with the specified implementation guide. Section 2.2.1.1 makes this clear with the statement "The receiver will handle non-compliant transactions based on its business process and any applicable regulations."