

EDI CONNECTION

Index

Benefits of Electronic Data Interchange (EDI).....	1
EDI Tip of the Month.....	2
Tips commonly associated with errors for completing the EDI Applications.....	2
Why not “go electronic”?.....	2
Tips for completing J15 Online Inquiry Service Form.....	2
When should you contact PCC versus EDI?.....	3
Need help with PC-ACE?.....	3
Saving 999 and 277CA Reports to PC-ACE.....	3
ICD-10 Acknowledgement Testing Week is Coming - November 17th-21st, 2014.....	4
International Classification of Diseases ICD-10 Acknowledgement Testing with Providers.....	4
Changes to the myCGS Web Portal effective September 26, 2014.....	5
Direct Data Entry (DDE).....	5
What is a Response Report?.....	5
Checking Claim Status.....	6
Submitting Medicare Secondary Payer (MSP) Claims Electronically: Important Changes.....	6
Hints to Avoid 5010 Claim Rejections.....	7
Top 10 ANSI 5010 Claim Rejections - Ohio and Kentucky Part B.....	8

Benefits of Electronic Data Interchange (EDI)

There are advantages to providers who conduct business with Medicare electronically. Some of those benefits include:

- No more paper claims:** EDI (submitting claims to CGS electronically) eliminates paperwork so your staff can accomplish more in less time. You will also save money on postage and claim forms.
- Earlier payment floor.** Electronic claims may be paid as soon as 13 days after the date of submission, versus 29 days after the date of receipt for paper claims.
- Earlier detection of errors.** EDI edits ensure the validity of certain fields for electronic claims, which helps reduce reopening's, claim adjustments, and redeterminations (appeals).
- Accurate payment.** EDI reduces the possibility of manual entry errors, so your claims process more accurately and consistently.
- Medicare claims submitted electronically may be accepted into our processing system in as little as 24 hours.**
 - Faster receipt of your claims means faster payment to you.
- For Part A and HHH, Using the Direct Data Entry (DDE)/ FISS application, you have the ability to correct errors online, saving administrative costs as well as postage and handling.**
 - Home Health & Hospice providers: <http://www.cgsmedicare.com/hhh/edi/DDE.html>
 - Part A providers: <http://www.cgsmedicare.com/parta/edi/DDE.html>
- Flexibility.** With EDI, you can control the frequency and volume of claims submission. You can also submit claims for several practitioners or facility locations at one time.
- Electronic reports for better business management.** Several reports are available only to electronic billers.
- Support personnel.** CGS EDI Help Desk Staff are dedicated to supporting electronic claim submitters.
 - EDI Help Desk staff is available Monday through Friday 8:00 a.m. to 5:00 p.m. ET.
- We provide information about electronic billing and offer support to all electronic billers in the testing and production process.

Coming Soon to myCGS - Part B Claim Submission!



EDI Tip of the Month

Why was my Direct Data Entry (DDE) Online Inquiry Returned?

Helpful Tips to avoid delay in DDE Confirmations

- User already has ID but not included on application
- PTAN/NPI does not match what we have on file
- Entity Name and Address does not match our system
- Include the EDI Contact Person on the application. This is the person CGS will contact if there are questions regarding the application or future questions about their communications.
- Include the area code and phone number of the Contact Person listed.
- Since email is the primary method for DDE confirmations ONLY include the e-mail address of the contact person listed.
- If Individual Provider is selected, the name and address listed must match what we show in our system.
- Please ensure **handwritten** Online Inquiry forms are legible to avoid confirmation delays.

Tips commonly associated with errors for completing the EDI Applications

The following tips will ensure accuracy and prevent the EDI forms from being returned for errors:

- Please make sure all Profiles are accompanied by a Provider Authorization form unless you are only using approved 5010 software and requesting your own submitter ID number be assigned to your office. EDI forms may be found by accessing <http://www.cgsmedicare.com>. In the Medicare tab select the line of business for your segment then choose the EDI icon to the left. In the section of bulleted topics within the middle of the page, select the EDI ENROLLMENT PACKETS topic.
- Choose only one Line of Business per Application.
- The PTAN name and address for the Provider must match what is listed in our system before setup can be completed.

- The Multiple Provider List form is only required when there are multiple GROUP PTAN/NPI numbers.
- Enrollment forms are only needed if your provider has never setup to file electronic claims.
- Make sure to always use the **most recent** forms from the CGSmedicare website.
- Any forms requiring a signature should be signed by a fully authorized official from the office. The signature binds you to the agreement and changes requested.

Why not "go electronic"?

Electronic Remittance Advice (ERA) is an electronic version of your Standard Paper Remit (SPR) and allows you the ability to automatically post your accounts, minimizing data entry by eliminating your manual posting procedures. Electronic Remittance Advice's are available to providers, billing companies and clearinghouses who currently submit claims to CGS Administrators, LLC regardless if claims are submitted electronically to CGS.

The ERA is available for download as soon as the claim is finalized and the payment floor has passed. No need to wait for the mail!

Here are a few benefits to receiving ERAs:

- Receive your remittances the day the claim finalizes
- Reduce costs associated with:
 - Storage and maintenance of SPRs
 - Staff time to review and file SPRs

ERA will be available on a daily basis, based on claim finalization, and is only available for 45 days in version 5010, Only one receiver can be sent the ERA per PTAN/NPI.

Interested in signing up for ERAs today? A completed CGS J15 EDI Application and a Provider Authorization is needed. The Online version of the EDI Application include the signature form is available at http://www.cgsmedicare.com/medicare_dynamic/edi_application/disclaimer.html. For additional assistance please contact the J15 EDI Help desk.

Tips for completing J15 Online Inquiry Service Form

DDE for HHH/Part A Customer-PPTN for Part B Customers

Online Inquiry Services is an online computer inquiry system that provides easy and immediate access to claims processing and beneficiary eligibility information for Medicare providers. Each User must have an individual DDE or PPTN User ID. You must include an individual's name with each user ID requested. For security reason, you should not share your DDE or PPTN User ID. One ID can access multiple provider numbers.

- Must select the Line of Business
- Please enter the date the application is completed.
- Enter the name of the entity (provider, corporate office, vendor, billing service or clearinghouse) that will actually be communicating electronically with CGS.
- Type of Entity-Check the appropriate box.
- The name of the submitter's primary EDI contact.
- Phone number of the Contact Person list.
- Fax number, Address, City, State, ZIP
- E-mail Address—this is the primary method of communication
- List each group practice/provider for which Online Inquiry Services access is being requested. Include the Group Medicare Provider Number and Group National Provider Identifier (NPI) for each group practice/provider listed.
- Please list the name(s) of the person(s) responsible for the DDE or PPTN ID(s) assigned by CGS. Full name including middle initial is required before a DDE or PPTN ID can be assigned. Each person accessing Online Inquiry Services must have his or her own unique ID. If previously assigned an ID, please include that ID in the Existing ID field. NOTE: We cannot accept a "generic" name for an Online Inquiry Services ID.

When should you contact PCC versus EDI?

The provider should contact the Provider Contact Center (PCC) for inquiries such as Eligibility, Claim Status, Claim Denials, Appeal status and for dates a patient was in Hospice or Skilled Nursing facility. The first point of contact is PCC for information not available on the CGS website, web portal or Interactive Voice Response (IVR).

The Electronic Data Interchange (EDI) should be contacted for calls pertaining to 999 or 277CA front-end rejections, myCGS, EDI Enrollment and Direct Data Entry (DDE) access.

CGS J15 Home Health and Hospice: 1-877-299-4500

- Option 1: PCC
- Option 2: EDI
- Option 3: Provider Enrollment (PE)
- Option 4: Overpayment Recovery (OPR)

CGS J15 Part A: 1-866-590-6703

- Option 1: PCC
- Option 2: EDI
- Option 3: Provider Enrollment (PE)
- Option 4: Overpayment Recovery (OPR)

CGS J15 Part B: 1-866-276-9558

- Option 1: PCC
- Option 2: EDI
- Option 3: Provider Enrollment (PE)
- Option 4: Overpayment Recovery (OPR)

Need help with PC ACE?

Do you need assistance with PC ACE? If so, your resolution may be found on our website under Education & Events, Online Education Center or at http://www.cgsmedicare.com/medicare_dynamic/education/001.asp. New users for the Online Education Center will be required to create a profile. The following PC ACE courses are available under J15 Courses:

- PC-ACE Pro32 Overview
- PC-ACE Pro32: Building Reference Modules
- PC-ACE Pro32: Uploading Claims & Downloading Reports
- PC-ACE Pro32: Part A: Institutional & HH+H Basic Claims
- PC-ACE Pro32: Part A: Institutional & HH+H MSP Claims
- PC-ACE Pro32: Part B: Professional Basic Claims
- PC-ACE Pro32: Part B: Professional MSP Claims

If you have time please, check out many other courses that may help improve your Medicare experience.

Saving 999 and 277CA Reports to PC-ACE

PC-ACE Pro32 software can translate 999 and 277CA raw data response files into a readable report.

Download 999 files into the appropriate folder:

- C:/WINPCACE/Ansi997/Ack1500 for Professional 999 reports.
- C:/WINPCACE/Ansi997/Ackub92 for Institutional 999 reports.

Downloaded 277ca files into the appropriate folder:

- C:/WINPCACE/Ansi277/STAT1500 for Professional 277CA reports.
- C:/WINPCACE/Ansi277/STATUB92 for Institutional 277CA reports.

The files should never be downloaded or moved into the Archive folders. That is a process that PC-Ace will handle automatically.

Please see the PCACE User's manual for additional information.

<http://www.cgsmedicare.com/partb/edi/pro32/index.html>

ICD-10 Acknowledgement Testing Week is Coming - November 17th - 21st, 2014

Acknowledgement Testing

Providers, suppliers, billing companies, and clearinghouses are welcome to submit acknowledgement test claims anytime up to the October 1, 2015, implementation date. In addition, CMS will be highlighting this testing by offering three separate weeks of ICD-10 acknowledgement testing. These special acknowledgement testing weeks give submitters access to real-time help desk support and allows CMS to analyze testing data. Registration is not required for these virtual events.

All MACs and the DME MAC Common Electronic Data Interchange (CEDI) contractor will promote this ICD-10 acknowledgement testing with trading partners. This testing allows all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes. While test claims will not be adjudicated, the MACs will return an acknowledgment to the submitter (a 277A) that confirms whether the submitted test claims were accepted or rejected.

MACs and CEDI will be appropriately staffed to handle increased call volume on their Electronic Data Interchange (EDI) help desk numbers, especially during the hours of 9:00 a.m. to 4:00 p.m. local MAC time, during these testing weeks. The testing weeks will occur in November 2014, March 2015, and June 2015. For more information about acknowledgement testing, refer to the information on your MAC's website.

See MLN Article SE1409 for more detailed information

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2014-Transmittals-Items/SE1409.html>

Stay up to date on all ICD 10 information:

CMS Resources

- Access three new Medscape Education resources that provide guidance around the transition to ICD-10. Continuing medical education (CME) and nursing continuing education (CE) credits are available to health care professionals who complete the learning modules, but anyone can take them and earn a certificate of completion. If you are a first-time visitor to Medscape, **you will need to create a free account to access these resources.**
 - Video: ICD-10: Getting From Here to There -- Navigating the Road Ahead
<http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html>
 - Video: ICD-10 and Clinical Documentation
<http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html>
 - Expert Column: Preparing for ICD-10: Now Is the Time
<http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html>
- View the ICD-10 Introduction fact sheet (<http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10Introduction20140819.pdf>) and FAQs (<http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10FAQs2013.pdf>) for an overview of ICD-10.
- Find official resources designed to help providers (<http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html>), payers (http://www.cms.gov/Medicare/Coding/ICD10/Payer_Resources.html), vendors (http://www.cms.gov/Medicare/Coding/ICD10/Vendor_Resources.html), and non-covered entities (<http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10NoncoveredEntities20140819.pdf>) with the transition to ICD-10

International Classification of Diseases ICD-10 Acknowledgement Testing with Providers

Is your system ready to submit ICD-10 codes electronically? The implementation date for ICD-10 is less than a year away. You may begin testing your electronic claims to ensure they are ICD-10 ready. CMS has established three Acknowledgement

testing weeks.

- November 17 – 21, 2014
- March 2-6, 2015
- June 1-5, 2015

Please see the MLN article <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8858.pdf> for additional information.

Changes to the myCGS Web Portal effective September 26, 2014

Starting September 26, 2014, two changes are being implemented in the myCGS web portal.

The myCGS lockout period has been extended for Provider Administrators and Provider Users. Previously, Administrators and Users were locked out after 30 days. However, effective September 26, 2014, this lockout period is being extended to 60 days. This means that all Provider Administrators and Provider Users must log in to the myCGS portal at least once every 60 days. However, CGS still recommends all users, particularly Provider Administrators, log in to myCGS at least once every 30 days.

In addition, in the past, myCGS would allow beneficiary eligibility requests up to 27 months prior to the date of the request. However, to align with changes made to the CMS HIPAA Eligibility Transaction System (HETS), the myCGS portal will now only provide eligibility information for the prior 12 months. However, to address issues with hospice benefit periods, the Hospice/Home Health tab now provides the "Total Occurrence Count" field, which provides the total number of hospice benefit periods the beneficiary has received

Please ensure that staff are aware of these changes.

Direct Data Entry (DDE)

Direct Data Entry (DDE) user should refer to the following chapters of the DDE Manual for detailed information about the Fiscal Intermediary Standard System (FISS) and how to correct and enter claims, check claim status and eligibility. The new DDE manual may be found on the CGS website (<https://www.cgsmedicare.com/>).

- **Chapter One: FISS Overview**
https://www.cgsmedicare.com/parta/edi/pdf/DDE_Chapter1.pdf

This chapter provides a FISS overview, including information about direct access to Direct Data Entry (DDE), system sign-on/sign-off procedures, menu options, function keys, shortcuts, and common status and locations.

- **Chapter Two: Checking Beneficiary Eligibility**
https://www.cgsmedicare.com/parta/edi/pdf/DDE_Chapter2.pdf

This chapter explains how to access beneficiary eligibility information via the Common Working File (CWF) screen, ELGA, to verify and ensure correct information is submitted on your Medicare claim. Screen examples and field definitions are provided.

- **Chapter Three: Inquiry Menu**
https://www.cgsmedicare.com/parta/edi/pdf/DDE_Chapter3.pdf

Chapter Three provides information about the inquiry options available in FISS, such as checking the status of claims, including how to check for Additional Development Requests (ADRs), claim count summary, Medicare check history, and viewing inquiry screens to check the validity of diagnosis codes, revenue codes, and HCPCS codes.

- **Chapter Four: Claims and Attachments Menu**
https://www.cgsmedicare.com/parta/edi/pdf/DDE_Chapter4.pdf

This chapter includes instructions, screen illustrations, and field descriptions on how to enter UB-04 claim information, including roster bill data entry.

- **Chapter Five: Claims Correction**
https://www.cgsmedicare.com/parta/edi/pdf/DDE_Chapter5.pdf

Access this chapter for instructions, screen illustrations, and field descriptions on how to correct claims that are in the Return to Provider (RTP) file, adjust claims, and cancel a claim.

What is a Response Report?

Since the adoption and implementation of the 5010 version of the 837 transaction there has been many changes. One of the many major changes was the method from which acceptance or rejection of claims is determined. Although there are many different levels of edits that the claims go through, rejections on the 999 and 277CA levels are most common. Either of these types of rejections can impact your practice financially since they prevent them from going into the adjudication system.

A 999 level rejection will usually be enough to cause the whole

file or batch to reject. These are usually caused by something important missing or in the wrong place and are best solved by taking the issue to your software vendor. A 277CA level rejection is usually caused by something being invalid such as a HCPCS or Diagnosis code. A 277CA level rejection will mostly cause the one claim in error to reject, not the whole batch. They can usually be fixed by reviewing the error, replacing the incorrect data with valid data and resubmitting the claim.

For your practice, if you submit claims in the batch (837) format, it is important to check your response reports to ensure that there are no rejections on either the 999 or 277CA levels. This will give you the best perspective on whether your claims made it into the adjudication system correctly. Both the 999 and 277CA's are automatically sent in their native ANSI format, which makes for a challenging time to read and interpret. It is recommended that you obtain a response report (999, 277ca) reader program through your software vendor in order to have the capability to open and interpret your 999's and 277CA's in a more legible format.

Checking Claim Status

Use one of the following self-service tools to check the status of your claims.

- **Call the Interactive Voice Response (IVR) at 1-877-220-6289.** The IVR provides the status of a claim (e.g., processed, pending, denied, returned to provider, rejected), when it was received, the type of bill, claim location, and total charges. For additional information on using the IVR, access the IVR User Guide (http://www.cgsmedicare.com/partb/cs/partb_ivr_user_guide.pdf)
- **Access the Fiscal Intermediary Standard System (FISS) via Direct Data Entry (DDE):**
 - From the FISS Main Menu, select **01** "Inquiries."
 - From the Inquiry Menu, select **12** "Claim Summary."
 - From the Claim Summary Inquiry screen, enter your facility's NPI number in the **NPI** field, and the beneficiary's HICN in the **HIC** field.
 - Press *Enter*

For additional information, refer to the Inquiry Menu (Chapter 3) (http://www.cgsmedicare.com/parta/edi/pdf/DDE_Chapter3.pdf) of the Fiscal Intermediary Standard System Guide and the Checking Claims Status Frequently Asked Questions (FAQs) (<http://www.cgsmedicare.com/partb/faqs/index.html>).

- **Access myCGS**, a free, and easy-to-use online web portal that provides you with a safe and secure access to your claim information allowing you to check the status of your claims, beneficiary eligibility, MSP information, and payment information. For additional information about myCGS and how to register, refer to the myCGS User Manual (<http://www.cgsmedicare.com/mycgs/index.html>).

Electronically providers can send a Health Care Claim Status request (276 transaction) electronically and receive a Health Care Claim Status Response (277 transactions) back from CGS. Contact your software vendor or billing service for availability of this software.

Submitting Medicare Secondary Payer (MSP) Claims Electronically: Important Changes

Based on Change Request 6426 (<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R70MSP.pdf>), CGS has implemented changes for submitting Medicare Secondary Payer (MSP) claims. **When an MSP Group Health Plan (GHP) record exists for a beneficiary, providers must submit the claim to CGS electronically, using the 5010 format. CGS will no longer accept these claims direct data entry (DDE), even in situations where services were applied to the deductible or benefits were exhausted.** Claims that are submitted to CGS via DDE that include MSP information will be returned to the provider (RTP) with reason code 31265.

As a reminder, if services are unrelated to a Non-group Health Plan (non-GHP), such as liability, no-fault, workers' compensation or black lung record, and the claim **does not** include any related diagnosis codes, the claim should be submitted to Medicare as primary.

A detailed list of the various MSP situations and how the MSP claim must be submitted (electronic, DDE, or paper) is available on the "Submitting MSP Claims and Adjustments" webpage (http://www.cgsmedicare.com/hhh/education/materials/submitting_msp.html). In addition, refer to the Medicare Secondary Payer (MSP) Online Tool (<http://www.cgsmedicare.com/hhh/coverage/msptool.html>) for assistance.

Hints to Avoid 5010 Claim Rejections

Take a look at 3 common mistakes that will cause your ASCX12 837 version 5010 claims to reject

- **ZIP Code:** Include a 9-digit ZIP code for the billing provider and service facility location. The 9 digit zip code although not required for other areas on the claim, if sent must be a valid 9 digit zip code.
- **Billing Provider Address:** The PO Box cannot be sent with Version 5010 but must be the physical address for the Billing Provider. The PO Box however can still be used as your address for payments and correspondence from payers and may be reported as the pay-to address.
- **National Provider Identifier (NPI):** You were previously allowed to report an Employer's Identification Number (Tax ID) or Social Security Number (SSN) as a primary identifier for the billing provider. For v5010 claims, however, you are only allowed to report an NPI as a primary identifier.

For additional assistance submitting ANSI 5010 claims review the Job Aides, 5010 Articles and Companion Guide on our EDI Page. Go to our website <http://www.cgsmedicare.com/>. Select the Electronic Data Interchange (EDI) page for detailed informational sources.

Top 10 ANSI 5010 Claim Rejections - Ohio and Kentucky Part B

	Edit Number	Business Edit Message	Resolution
1	X222.087.2010AA. NM109.050	This Claim is rejected for relational field due to a Billing Provider's submitter not approved for electronic claim submission on behalf of this billing Provider	2010AA NM109 Billing provider must be "associated" to the submitter. Verify the Submitter ID (IS06) is valid and setup for electronic submission (EDI) for the Billing provider NPI sent in the electronic file.
2	X222.262.2310B. NM109.030	This Claim is rejected for invalid information for a Rendering Provider's National Provider Identifier(NPI)	Verify the Rendering Provider NPI is valid, contains 10 digits and matches what we have on file.
3	X222.121.2010BA. NM109.020	This Claim is rejected for invalid information for a Subscriber's contract/member number	Verify the Patient member ID number (Patient's Medicare Number, HICN) is valid.
4	X222.351.2400.SV101- 2.020	This Claim is rejected for relational field information within the HCPCS	Verify procedure code (HCPCS or CPT) submitted is valid.
5	X222.094.2010AA. REF02.050	This Claim is rejected for relational field Billing Provider's NPI (National Provider ID) and Tax ID	Verify Billing Providers tax ID is valid.
6	X222.087.2010AA. NM109.030	This Claim is rejected for invalid information for a Billing Provider's National Provider Identifier(NPI)	Verify the Billing Provider NPI is valid, contains 10 digits and matches what is on the file with CGS.
7	X222.262.2310B. NM109.030	This Claim is rejected for invalid information for a Rendering Provider's National Provider Identifier(NPI)	Verify the Rendering Provider NPI is valid, contains 10 digits and matches what we have on file.
8	X222.351.2400.SV101- 7.020	This Claim is rejected for relational field information within the Detailed description of service	2400.SV101-7 must be present when 2400.SV101-2 is present on the table of procedure codes that require a description. When you send a procedure code that does not describe the service provided specifically, the description of the service provided is required in the field. (Example-SV1*HC:97760:GO::::Occupational Therapy*50*UN*1~)
9	X222.226.2300.HI01- 2.030	This Claim is rejected for Invalid Information within the Primary diagnosis code	Please verify that the Primary diagnosis code is not invalid or expired.
10	X222.351.2400.SV101- 3.010	This Claim is rejected for relational field Information within the Procedure Code Modifier(s) for Service(s) Rendered	Please verify that the Procedure code Modifier(s) for Service(S) rendering is not invalid or expired.