FALL 2022

EDI CONNECTION

Contents

How to File an Appeal on myCGS

Home Health and Hospice, Part A and Part B providers and beneficiaries may appeal an initial claim determination when a claim denies or partially denies. This first level appeal is a Redetermination. You have 120 days from the date of receipt of the initial determination to submit a request.

There are two ways to access the Redeterminations form on myCGS: Claims tab and Forms tab. When you access the form from the Claims tab, the form will correctly auto-populate with the information needed to process your request.

When you access it from the Forms tab, under "Select a Topic" drop down box, click Redeterminations. From "Select a Type" drop down box, click Redeterminations. At the bottom of the page, select the Redeterminations: 1st Level Appeal link.

You may utilize the Appeals Calculator if you need to determine if your redetermination request is timely.

When completing the Redeterminations form, the fields with a RED* are required. The specific CPT/HCPCS codes and modifiers being appealed must be added to the form by clicking the ADD button to populate the appropriate box. Once all codes for the specific Internal Control Number (ICN) are populated, click ADD CLAIMS INFORMATION. You will see the details of the ICN below on the form.

You must identify whether the request is to appeal an overpayment. The Reasons/ Rationale field is an area to provide a reason the redetermination request is being submitted. The field will hold up to 1200 characters. It is not required.

Once all fields are complete, click validate. myCGS will verify that all required fields are populated. A message will appear **AT THE TOP OF THE SCREEN IN GREEN** confirming this. At least one attachment must be sent with the request. Attachments can be up to 40 MBs in size not to exceed 150 MBs. Documents must be in PDF format.

Enter the name of the person submitting the Redetermination. An e-signature box will appear, asking you to verify that the information entered, and attachments are correct.

After submitting the form, you will be taken to the MESSAGE tab. You will receive a message confirming receipt of your Redetermination request. A separate message will be sent indicating your Submission ID which is needed to track the status of your request.

Top 10 EDI Online Application Errors: Resulting in Processing Delays

Are you looking for ways to avoid multiple send-backs due to applications completed Incorrectly?

Look at some of the common application errors received so far in 2022:

- Incorrect Line of Business Information (selecting Part A when the Provider Number is Part B, etc.)
- Group Practice/Provider Name incorrect (does not match our records)
- Sending Individual Provider Number instead of the Group (list individual number if not part of group)
- Provider Address incorrect (does not match our records)
- Name of Software Vendor or Network Service Vendor not approved
- Invalid Zip Code

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- Missing Authorized Signature or TIN (Taxpayer Identification Number) on the Provider Authorization Form
- EDI Enrollment Agreement missing (required if never setup as an electronic biller)

Please view the J15 EDI Application Form Instructions (part of the Online Application) prior to submitting.

Incomplete forms will be retuned to the applicant, thus delaying processing.

How Do You Reach EDI?

The EDI Department receives many calls that have been transferred to EDI, due to not choosing the correct prompts, when calling. To ensure you get to the correct department, the first time, listen to the prompts carefully when calling.

Contact numbers and prompts are as follows:

- **Part B:** 1.866.276.9558
  - Option 1 ..... KY B
  - Option 2 ..... OH B
    - Option 2 .... EDI
    - Option 1 .... DDE/FISS
    - Option 2 .... PCAce Pro32 Software
    - Option 3 .... All other EDI issues
- **Part A:** 1.866.590.6703
  - Option 1 ..... KY A
  - Option 2 ..... OH A
  - Option 2 ..... EDI
    - Option 1 .... DDE/FISS
    - Option 2 .... PCAce Pro32 Software
    - Option 3 .... All other EDI issues
- **HHH:** 1.877.299.4500
  - Option 2 ..... EDI
    - Option 1 .... DDE/FISS
    - Option 2 .... PCAce Pro32 Software
    - Option 3 .... All other EDI issues

Applications & Provider Authorization Form Reminders

The EDI Department has been receiving an increased amount of Online EDI Application errors. Please see the "Top 10 EDI Online Application Error Results" article for a list of the application errors. Additionally, the Provider Authorization Form being received after the deadline or not received at all. Here are a few tips/reminders to ensure your setup process is completed:

- **ONLINE APPLICATIONS:** We no longer accept paper or PDF printed applications. The **only application** for setting up PTANS/NPI to transmit and receive 837/835 files is the **ONLINE EDI Application** which can be accessed at https://www.cgsmedicare.com
  - Select correct line of business
  - Select "Electronic Data Interchange (EDI)" on the left side of the screen
  - Select "Enrollment"
  - Select "Online EDI Application" and read the information. Click on "ACCEPT" in green at the bottom of the page.
  - Review the instructions on how to fill out the application and then select "Continue to EDI Application"
- **PROVIDER AUTHORIZATION FORMS:** Many Provider Authorization Forms are not being received within the time allotted once the online application has been submitted. This will result in the EDI application being rejected and a new application will need to be completed and submitted with a new Provider Authorization form. The Provider Authorization form will automatically be populated with the information formerly filled out on the Online EDI Application. ***The only 2 additional tasks to complete are to include the TAX ID NUMBER and a legible SIGNATURE. It must be physically signed, not printed and readable.**
  - Once you have submitted the online application, you will have 7 calendar days (5 business days) to submit the Provider Authorization Form.
  - The cutoff time to return the Provider Authorization form without it being rejected for "non-received Provider Authorization form," is by 10am est. on the 7th day. ***It must be received by 10am est. of the 7th day.**

myCGS System Requirements

To optimize usability of myCGS, we recommend that users verify their system adheres to the following requirements:

Operating System

- Windows 10 (latest security patches)
- Mac OS X 11.x or above

Supported Internet Browsers

- Microsoft Edge
- Google Chrome: Version 98.x and above

Recommended Screen Resolution

1024x 768

Additional Requirements

- Adobe Acrobat Reader Version DC or Adobe Acrobat Pro Version DC
- JavaScript enabled
- Compatibility view disabled
- Pop-up blocker disabled
- Use TLS 1.2 selected in browser settings

Note: Although myCGS may still be accessible without meeting these requirements, only the options above are supported. Failure to meet these requirements may adversely affect the functionality and layout of myCGS.

myCGS: Recertification vs Profile Verification

Read Carefully; Which message did you received?

System Message: "In order to maintain your access, you must complete the **profile verification process** by xx-xx-2022. This process must be completed every 250 days."

Instructions - Update Profile:

- Select the My Account Tab> myProfile
- Review all fields listed and update if necessary
- Hit Re-Verify button
- Terms of Use Page Populates (Select "Accept or Reject at end of page)

Note: Once verified, the counter will restart at 250 days

System Message: "In order to maintain your access you must complete the **recertification process** by xx-xx-2022. This process must be completed every 360 days."

Instructions - Recertify Users:

- Select the Admin Tab > Sub-Tab User Listing
- Scroll to the bottom of the Page -Hit Recertify Users
- Review all users listed and select every user that still needs access to the portal including yourself
- Click Submit
- Review again; If you are sure of users selected, hit OK (all unchecked users will be deactivated)

Note: Once recertified; the date will be updated and due again in 360 days

Part A Top Ten Edits

	Edit Number	Business Edit Message	Resolution
1	X223.387.2330B.N403.030	This Claim is rejected for Invalid Information within the Other payer's Explanation of Benefits/payment information's Postal/Zip Code.	""2330B.N403 must be a valid US zip code when N404 is US or blank. Verify Postal/Zip Codes for the Other Payer on the USPS website prior to submitting claims.""
2	X223.112.2010BA.NM109.020	This Claim is rejected for containing Invalid Information within the Subscriber's contract/member number.	""The subscriber HICN is invalid. Verify the HICN is entered exactly as it appears on the beneficiary's red, white, and blue Medicare card. Medicare number can only be 10 to 11 characters only. Here are the valid formats: NNNNNNNNNA or NNNNNNNNNAA or NNNNNNNNNAN. If MBI: 2010BA.NM109 must be 11 positions in the format of C A AN N A AN N A A N N , where "C" represents a constrained numeric 1 thru 9, "A" represents alphabetic character A-Z but excluding S, L, I, O, B, Z, "N" represents numeric 0 thru 9 and "AN" represents "A" or "N." If the patient's Medicare number is not in these formats, your claim will reject.""
3	X223.424.2400.SV203.060	This Claim is rejected for the Acknowledgement / Rejected for Invalid Information within the Claim is out of balance due to Line Item Charge Amount within the Service Line Paid Amount	SV203 must = the payer amount paid found in 2430 SVD02 and the sum of all line adjustments found in 2430 CAS Adjustment Amounts for each other payer occurrence.
4	X223.424.2400.SV202-7.025	This Claim is rejected for a relational field in error for Service(s) Rendered.	If the procedure is a non-specific code you must submit a description of the procedure code in SV202-7. Non-specific codes may include in their descriptors terms such as: Not Otherwise Classified (NOC); Unlisted; Unspecified, Unclassified; Other; Miscellaneous; Prescription Drug, Generic; or Prescription Drug, Brand Name. 2400.SV202-7 must be present when 2400.SV202-2 contains a non-specific procedure code.
5	X223.112.2010BA.NM109.040	Added edit for MBI/HICN claim effective date.	If the HIC/MBI format is valid, and 2300 CLM05-1 is not = 11X, 32X or 41X OR 2300 CLM05-3 is not = 7, 8 or Q, then 2010BA.NM109 must be a valid HICN prior to the MBI transition start date, must be a valid HICN or valid MBI on or after the MBI transition start date, must be a valid MBI after the MBI transition end date based on the date in the +RC DTP segment.
6	X223.090.2010AA.REF02.050	This Claim is rejected for a relational field in error within the Billing Provider's National Provider Identifier (NPI) and Billing Provider's Tax ID.	""2010AA.REF must be associated with the provider identified in 2010AA.NM109""
7	X223.284.2300.HI03-2.010	This Claim is rejected for containing Invalid Information with the Value code.	If 2300.HI03-1 is "BE" then 2300.HI03-2 must be a valid Value code on the receipt date and is within the codes effective and termination date.
8	X223.184.2300.HI.016	ICD-9 qualifiers and ICD-10 qualifiers cannot be on the same claim.	If 2300.HI with HI01-1 = "ABK" all applicable diagnosis and procedure code HI segments must contain only ICD-10 qualifiers.
9	X223.220.2300.HI05-2.010	This Claim is rejected for containing Invalid Information within the Diagnosis Code.	If 2300.HI05-1 is "BF" then 2300.HI05-2 must be a valid ICD-9 Diagnosis code.
10	X223.424.2400.SV201.020	This Claim is rejected for Invalid Information within the Revenue code for services rendered.	2400.SV201 must be a valid revenue code.

Part B Top 10 Edits

	Edit Number	Business Edit Message	Resolution
1	X222.121.2010BA.NM109.030	The claim is rejected for invalid format of Subscriber's contract/member number	If the HIC/MBI format is valid, 2010BA.NM109 must be a valid HICN prior to the MBI transition start date, must be a valid HICN or valid MBI on or after the MBI transition start date, must be a valid MBI after the MBI transition end date based on the date in the +RC DTP segment.
2	X222.125.2010BA.N404.010	This Claim is rejected for Invalid Information for the Subscriber's Country	2010BA.N404 must be a valid 2 character Country Code.
3	X222.262.2310B.NM109.030	CSC 400: “Claim is out of Balance”	2310B.NM109 must be a valid NPI on the Crosswalk when evaluated with 1000B.NM109, except when 2300.REF with REF01 = “P4” and REF02 = “82.”
4	X222.121.2010BA.NM109.020	CSC 672: “Payer's payment information is out of balance”	“If Medicare HICN: 2010BA.NM109 must be 10-11 positions formatted NNNNNNNNA or NNNNNNNNAA or NNNNNNNNAN where “A” is an alpha character and “N” is a numeric digit. -OR- If an MBI: must be 11 positions formatted C A AN N A AN N A A N N, (without spaces) where: ““C”” is numeric 1-9, ““A”” is alphabetic characters A-Z (excluding S, L, I, O, B, Z), ““N”” is numeric 0-9 and ““AN”” is either alphabetic A-Z (excluding S, L, I, O, B, Z), or numeric 0-9.”
5	X222.430.2420A.NM109.030	This Claim is rejected for Invalid Information within the Rendering Provider's National Provider Identifier (NPI)	Valid NPI Crosswalk must be available for this edit. Coach NPIs will not be present on the NPI xwalk, when REF02 = 82 the coach NPIs are excluded from this edit.
6	X222.087.2010AA.NM109.050	This Claim is rejected for relational field due to Billing Provider's submitter not approved for electronic claim submissions on behalf of this Billing Provider	2010AA.NM109 billing provider must be “associated” to the submitter (from a trading partner management perspective) in 1000A.NM109.
7	X222.157.2300.CLM05-3.020	This Claim is rejected for Invalid Information within the Claim Frequency Code	*Part B Medicare only accepts original claims. ****CLM05-3 must be 1 for Medicare Part B claims only****
8	X222.351.2400.SV101-2.020	This Claim is rejected for relational field Information within the HCPCS	When 2400.SV101-1 = “HC,” 2400.SV101-2 must be a valid HCPCS Code on the date in 2400.DTP03 when DTP01 = “472.”
9	X222.094.2010AA.REF02.050	This Claim is rejected for relational field Billing Provider's NPI (National Provider ID) and Tax ID	2010AA.REF must be associated with the provider identified in 2010AA.NM109
10	X222.087.2010AA.NM109.030	This Claim is rejected for Invalid Information in the Billing Provider's NPI (National Provider ID)	2010AA.NM109 must be a valid NPI on the Crosswalk when evaluated with 1000B.NM109.