EDI CONNECTION
Spring 2013

Index

myCGS Web Portal Tip: User IDs and Access

Important!

User IDs will be deactivated after 90 days of inactivity. We strongly suggest that each user log into myCGS at least once every 30 days to maintain access. This is especially important for Provider Administrators. If the Provider Administrator's ID is deactivated, all of the additional users associated with that Provider Administrator will also be deactivated.

To keep you myCGS access current, please login to myCGS at least once every 90 days. If you have forgotten your password, please use the "Forgot or Change Your Password?" link on the returning user screen.

If you have been disabled, you will receive this message:

> Your myCGS access has expired and your user ID is now invalid. If you are a Provider Administrator, please register. If you are a provider user, please contact your Provider Administrator for access. You must login at least once every 90 days to keep your user ID valid.

If you receive this error message and you are a Provider User, please contact your Provider Administrator. Your Provider Administrator must add you again as a new user. You will receive a new myCGS user ID.

Electronic Remittance Advantages

What are the Benefits of Electronic Remittances?

Electronic Remittances save TIME and MONEY by taking advantage of FREE Medicare Remit Easy Print (MREP) or PCPRINT software now available for viewing and printing of the HIPAA compliant Electronic Remittance (835). For more information please access the MREP or PCPRINT page.

- MREP (http://www.cgsmedicare.com/ohb/claims/edi/easy_print.html) for Part B
- PC Print (http://www.cgsmedicare.com/hhh/pubs/news/2011/0611/cope15043.html) for Part A and HHH

The ERA is available for download when the claim completes the payment floor and is released for payment.

No waiting for the remit to come in the mail.

Why "go electronic"?

Here are a few benefits to receiving Electronic Remittance Advice (ERA):

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

The Centers for Medicare & Medicaid Services (CMS) provides free software for you so that you can download, view, and print duplicate copies of Part A or B Electronic Remittances whenever you wish.

You may also view and print past and present remittances through our free online tool, myCGS. Using myCGS will save you time because you do not have to wait for your remittances to become available for downloading.

If you have comments or suggestions for future issues of the *EDI Connection*, please email us from our website at: http://www.cgsmedicare.com/.

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

How do you get this free software?

- MREP (http://www.cgsmedicare.com/ohb/claims/edi/easy_print.html) for Part B
- PC Print (http://www.cgsmedicare.com/hhh/pubs/news/2011/0611/cope15043.html) for Part A and HHH

Your time and money are valuable. Save both by downloading the software for utilizing Electronic Remittance Advices today.

Windows 8 & HyperTerminal Compatibility Fast Facts

1. There are no known HyperTerminal program issues specifically caused by the Windows 8 Operating System at this time.
2. Windows 8 DOES NOT come with a HyperTerminal program integrated into the Operating system. You will need to download and install a third party HyperTerminal program. The CGS EDI Department cannot advise or endorse ANY third-party vendor.
3. It is highly recommended before downloading and installing the third party HyperTerminal program to make sure it is compatible with Windows 8 if this is your current Operating System.
4. Your system support team may have alternate HyperTerminal Settings for you, but our suggested settings are as follows:

Port Speed:	115200	**Data Bits:**	8
Data Protocol:	Standard EC	**Parity:**	None
Compression:	Enabled	**Modulation:**	Standard
Flow Control:	Hardware	**Emulation:**	Auto detect

Are You Requesting a Waiver to Send Paper Claims?

IMPORTANT DOCUMENTATION TIPS

The Administrative Simplification Compliance ACT (ASCA) prohibits payment of initial health care claims not sent electronically as of October 16, 2003, except in limited situations:

- **Small Provider Claims** - The word “provider” is being used generically here to refer to physicians, suppliers, and other providers of health care services. Providers that have fewer than 25 full-time equivalent employees (FTEs) and that are required to bill a Medicare intermediary are considered to be small. **Physicians and suppliers with fewer than 10 FTEs and that are required to bill a Medicare carrier or durable medical equipment regional carrier** (DMERC) are classified as small. See section 90.1 of Chapter 24 of the Medicare Claims Processing Manual (Pub. 100-04) for more detailed information on calculation of FTE employees and this ASCA requirement in general.
- **Roster billing** of inoculations covered by Medicare, except for those companies that agreed to submit these claims electronically as a condition for submission of flu shots administered in multiple states to a single carrier.
- **Dental** Claims
- Providers who submit **less than 10** claims per month on average during a calendar year

Medicare contractors are required to contact providers that appear to be submitting high numbers of paper claims to verify that those providers meet one or more of the exception criteria for continued submission of their claims on paper. Providers are not to submit that information unless requested as part of an enforcement review. Providers are selected for review based upon the number of paper claims they filed in the prior quarter.

Providers selected for review that are unable to establish that they meet one or more exception criteria, or that fail to respond to a request for the applicable information will have their claims submitted on paper denied effective with the 91st day after the date of the first letter requesting the documentation. One follow-up notice is issued after 4 days if there is no response to the initial request. Providers that submit information to justify their continued submission of certain types or all of their claims on paper are notified by mail whether the information is acceptable and they have been approved for submission of paper claims. (See the Medicare Claims Processing Manual, (Pub.100-04), Chapter 24, Section 90.5 for further information.

Acceptable Documentation for Waiver

Small Provider Claims – Copy of actual payroll or Quarterly Tax and Wage Report

Roster Billing – Copy of flyer or list of locations where inoculations were given

Dental Claims – Copy of Dental License

Fewer than 10 claims per month – CGS will research system to determine if this is applicable

REMINDER: All documentation must include, PTAN, NPI and Tax ID number. Please contact the EDI Help Desk for additional questions or clarity.

- Kentucky Part B and Ohio Part B: 1.866.276.9558 (Option 2)

Updated April 16, 2013.

- Home Health: 1.877.299.4500
- Hospice: 1.877.299.4500
- Kentucky Part A and Ohio Part A: 1.866.590.6703 (Option 2)

EDI Phone Number Change

Effective March 1, 2013, the CGS Electronic Data Interchange (EDI) number (1.866.758.5666) was eliminated. CGS implemented a new phone system in which Ohio Part A/B, Kentucky Part A/B, and Home Health/Hospice providers will call the Provider Contact Center at the appropriate number below and select Option 2 for EDI.

- Ohio/Kentucky Part A customers: 1.866.590.6703
- Ohio/Kentucky Part B customers: 1.866.276.9558
- Home Health/Hospice: 1.877.299.4500

We are hopeful that this streamlined system for taking your calls will make it easier for you to reach us.

Please continue to use the Interactive Voice Response (IVR) number to obtain beneficiary eligibility, claim status, check and general information. Refer to the *IVR User Guide* (http://www.cgsmedicare.com/hhh/help/pdf/IVR_User_Guide.pdf) for assistance.

As a reminder, myCGS, our free Web portal is also available for registered users to obtain beneficiary eligibility, claim status and financial inquiries. For information about myCGS, go to http://www.cgsmedicare.com/Medicare.html.

CMS Has Noted the Version 5010 Upgrade and How It Paved the Way for ICD-10

In addition to its 'Valuable Insights,' CMS has Sponsored ICD-10 Teleconferences up and coming. The various national provider education teleconferences available to the provider community may be accessed via this website (link): http://www.cms.gov/Medicare/Coding/ICD10/CMS-Sponsored-ICD-10-Teleconferences.html

The Version 5010 upgrade paved the way for ICD-10, (CMS has noted and offers valuable insights):

1. Early planning and preparation will smooth your transition to ICD-10. Practices that planned for the Version 5010 upgrade were well prepared and transitioned smoothly. For ICD-10, your office can start planning by developing a checklist of activities that will need to be completed and a timeline for accomplishing these tasks.
2. Communication and coordination must occur not only in your office, but also between your practice and the trading partners you conduct business with – software vendors, clearinghouses and billing companies, commercial and government health plans and other payers.
3. Risk mitigation is important to address any disruptions that may occur as your practice transitions to ICD-10. You may want to consider planning for possible short-term cash flow disruptions and for securing the services of billing companies or clearinghouses.
4. Testing should be conducted within your Office and/or Clearinghouse. You will need to begin ICD-10 testing in 2013 to allow for ample time to test multiple types of transactions, including claims. Share your ICD-10 plans with one another now to ensure you are on track to test at the same time.

If you conduct electronic transactions and have not made the upgrade to Version 5010 standards get a compliance plan in place right away.

Questions? Contact Us Stay Connected:

You must use Version 5010 standards before your practice management or billing system can accommodate the structure of ICD-10 codes.

Keep Up to Date on ICD-10

Visit the CMS ICD-10 website for the latest news and resources to help you prepare.

For practical transition tips:

- Read recent ICD-10 email update messages
- Access the ICD-10 continuing medical education modules developed by CMS in partnership with Medscape

The deadline for ICD-10 is October 1, 2014.

Works Cited: Office of E-Health Standards & Services, ICD-10. (2013, January 3). Centers For Medicare & Medicaid Services. Retrieved March 25, 2013, from www.cms.gov: http://www.cms.gov/Medicare/Coding/ICD10/Downloads/LookingBackatVersiopn5010andAheadtoICD10.pdf

Updated April 16, 2013.

Kentucky Part B Top 10 5010 EDI Errors

Edit Number	277CA Edit Message	Resolution
X999.DUPE	**N/A** Rejected due to duplicate ST/SE submission	Data in transaction set (between ST and SE a previously submitted transaction set. Rejected due to duplicate ST/SE submission
X222.087.2010AA.NM109.050	**"CSCC A8: "Acknowledgement/Rejected for relational field in error""** **CSC 496 "Submitter not approved for electronic claim submissions on behalf of this entity."** **EIC: 85 "Billing Provider"** 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	The billing provider must be "associated" to the submitter (from a trading partner perspective) in 1000A.NM109. The NPI submitted is not linked to the Submitter ID. If this error is received, the supplier must complete and sign the CGS EDI Application and the CGS Enrollment form. It can be located at http://www.cgsmedicare.com/pdf/EDI_Enroll_Packet.pdf
X222.351.2400.SV101-2.020	**"CSCC A7: "Acknowledgement /Rejected for Invalid Information…""** **CSC 507: "HCPCS"** 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". When Product or Service ID Qualifier = "HC", the Procedure Code must be a valid HCPCS Code for the Service Date (DTP01 = "472"). This can also be caused by sending an invalid HCPCS and modifier combination. For more information on the valid combination, please contact the Provider Contact Center (PCC) at 1.866.276.9558.
X222.094.2010AA.REF02.050	**"CSCC A8: "Acknowledgement/Rejected for relational field in error""** **CSC 562: "Entity's National Provider Identifier (NPI)"** **CSC 128: "Entity's tax id"** **EIC: 85 "Billing Provider"** This Claim is rejected for relational field Billing Provider's NPI (National Provider ID) and Tax ID	Billing Provider Tax Identification Number must be associated with the billing provider's NPI. Verify that the information you are submitting matches the information on file with the NPPES.
X222.087.2010AA.NM109.030	**"CSCC A7: "Acknowledgement /Rejected for Invalid Information…"** **CSC 562: "Entity's National Provider Identifier (NPI)"** **EIC: 85 "Billing Provider"** This Claim is rejected for Invalid Information in the Billing Provider's NPI (National Provider ID)	2010AA.REF must be associated with the provider identified in 2010AA.NM109 Billing Provider Identifier must be a valid NPI on the Crosswalk. Verify that the NPI and PTAN are linked together.
X222.262.2310B.NM109.030	**CSCC A7: "Acknowledgement/Rejected for Invalid Information…"** **CSC 562: "Entity's National Provider Identifier (NPI)"** **EIC: 82 "Rendering Provider"** This Claim is rejected for Invalid Information for a Rendering Provider's National Provider Identifier (NPI).	The rendering provider NPI was not found on the crosswalk. **Note:** We recommend Sole-proprietors, IDTFs, and Ambulance providers, with only a group NPI, not send the Rendering Provider Loop(s) 2310B or 2420A in the Medicare Part B claims to avoid unnecessary front-end rejections. CGS only requires NPIs in the Billing Provider Loop for the above types of providers.
X222.121.2010BA.NM109.020	**"CSCC A7: "Acknowledgement /Rejected for Invalid Information…""** **CSC 164: "Entity's contract/member number"** **EIC: IL "Subscriber"** This Claim is rejected for Invalid Information for a 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: NNNNNNNNA or NNNNNNNNAA or NNNNNNNNAN. If the patient's Medicare number is not in these formats, your claim will reject.

Updated April 16, 2013.

Edit Number	277CA Edit Message	Resolution
X222.351.2400. SV101-3.010	**CSCC A7: "Acknowledgement /Rejected for Invalid Information…"** **CSC 453: "Procedure Code Modifier(s) for Service(s) Rendered"** This Claim is rejected for relational field Information within the Procedure Code Modifier(s) for Service(s) Rendered	Procedure Modifier must be valid for the Service Date. (DTP01 = "472")
X222.351.2400. SV101-7.020	**"CSCC A8: "Acknowledgement/Rejected for relational field in error""** **CSC 306 "Detailed description of service"** This Claim is rejected for relational field Information within the Detailed description of service	Description must be present when Procedure Code requires a description/additional information. CMS has released a NOC Code List to help providers identify procedure codes that will require the SV101-7 field to be sent. For more information visit: http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html?redirect=/ElectronicBillingEDITrans/40_FFSEditing.asp
X222.125.2010BA. N403.020	**CSCC A7: "Acknowledgement /Rejected for Invalid Information…"** **CSC 500: "Entity's Postal/Zip Code"** **EIC IL: Subscriber** This Claim is rejected for Invalid Information for the Subscriber's Postal/Zip Code	Subscriber Postal Zone or ZIP Code must be a valid US Postal Service Zip Code.

Ohio Part B Top 10 5010 EDI Errors

Edit Number	277CA Edit Message	Resolution
X222.087.2010AA. NM109.050	**"CSCC A8: "Acknowledgement/Rejected for relational field in error""** **CSC 496 "Submitter not approved for electronic claim submissions on behalf of this entity."** **EIC: 85 "Billing Provider"** 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	The billing provider must be "associated" to the submitter (from a trading partner perspective) in 1000A.NM109. The NPI submitted is not linked to the Submitter ID. If this error is received, the supplier must complete and sign the CGS EDI Application and the CGS EDI Enrollment form. It can be located at http://www.cgsmedicare.com/pdf/EDI_Enroll_Packet.pdf
X222.094.2010AA. REF02.050	**"CSCC A8: "Acknowledgement/Rejected for relational field in error""** **CSC 562: "Entity's National Provider Identifier (NPI)"** **CSC 128: "Entity's tax id"** **EIC: 85 "Billing Provider"** This Claim is rejected for relational field Billing Provider's NPI (National Provider ID) and Tax ID	Billing Provider Tax Identification Number must be associated with the billing provider's NPI. Verify that the information you are submitting matches the information on file with the NPPES.
X222.087.2010AA. NM109.030	**"CSCC A7: "Acknowledgement /Rejected for Invalid Information…""** **CSC 562: "Entity's National Provider Identifier (NPI)"** **EIC: 85 "Billing Provider"** This Claim is rejected for Invalid Information in the Billing Provider's NPI (National Provider ID)	2010AA.REF must be associated with the provider identified in 2010AA. NM109 Billing Provider Identifier must be a valid NPI on the Crosswalk. Verify that the NPI and PTAN are linked together.
X999.DUPE	**N/A** Rejected due to duplicate ST/SE submission	Data in transaction set (between ST and SE a previously submitted transaction set.

Updated April 16, 2013.

Edit Number	277CA Edit Message	Resolution
X222.351.2400. SV101-2.020	**"CSCC A7: ""Acknowledgement /Rejected for Invalid Information…""** **CSC 507: "HCPCS"** 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". When Product or Service ID Qualifier = "HC", the Procedure Code must be a valid HCPCS Code for the Service Date (DTP01 = "472"). This can also be caused by sending an invalid HCPCS and modifier combination. For more information on the valid combination, please contact the Provider Contact Center (PCC) at 1.866.276.9558.
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X222.351.2400. SV101-7.020	**"CSCC A8: "Acknowledgement/Rejected for relational field in error""** **CSC 306 Detailed description of service"** This Claim is rejected for relational field Information within the Detailed description of service	A description must be present when the Procedure Code requires a description/additional information. CMS has released a NOC Code List to help providers identify procedure codes that will require the SV101-7 field to be sent. For more information visit: http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html?redirect=/ElectronicBillingEDITrans/40_FFSEditing.asp
X222.351.2400. SV101-3.010	**CSCC A7: "Acknowledgement /Rejected for Invalid Information…"** **CSC 453: "Procedure Code Modifier(s) for Service(s) Rendered"** This Claim is rejected for relational field Information within the Procedure Code Modifier(s) for Service(s) Rendered	Procedure Modifier must be valid for the Service Date. (DTP01 = "472")
X222.226.2300. HI01-2.030	**CSCC A7: "Acknowledgement /Rejected for Invalid Information…"** **CSC 254: "Primary diagnosis code"** This Claim is rejected for Invalid Information within the Primary diagnosis code	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service. The diagnosis code pointed to by diagnosis code pointer 1 (SV107-1, SV107-2, SV107-3, or SV107-4) is invalid for the claim line date of service. Please ensure the diagnosis is effective for date of service. Questions regarding the effective dates of a diagnosis code should be directed to the Provider Contact Center (PCC) at 1.866.276.9558.

Updated April 16, 2013.

Top Application Errors

At CGS, we take pride in getting our Providers enrolled to use EDI as quickly and accurately as possible. It is our responsibility to get applications entered correctly into our system to facilitate this. However, we are held to very strict standards by CMS as to what we can accept. These rejection reasons are typically something small, but can cause delays and possibly impact your finances.

There are many mistakes that cause rejections, but these are the most common:

Names do not match: The name on the EDI Application and Provider Authorization form have to match what we have on file within our system. Typically a provider will put their name or the owner's name, when we have the company name listed, or vice versa. Please send correct names on the *EDI Application and Provider Authorization Form*.

Invalid PTAN or NPI: Providers often send their individual PTAN or NPI when they are part of a group. Providers often send a non-related NPI along with their PTAN. Please send the correct Group PTAN/NPI if applicable. If no group PTAN or NPI exists, send the individual PTAN or NPI. CMS requires us to confirm that the NPI/PTAN match, if not they will be returned.

Invalid address: The address on the Provider Authorization form must match what we have in our system. Many times the provider will not list a mailing address when they are being set up with Provider Enrollment, but it is listed on their EDI application. If the address coming through does not match what we have in our system, we have to send it back. Please send the correct address for the Provider.

Missing Provider Authorization: In order for us to make changes to your account, we would like to make sure that you as the Provider are aware of the change. We require all third parties to submit a Provider Authorization signed by the Provider in order to ensure the Provider is aware of the change to their account. If a third party requests certain changes to be made but fails to submit a Provider Authorization, the application will be returned. If you are a third party looking to make changes to a Providers Account, please include a Provider Authorization signed by the Provider.

PC-ACE Pro32 Tutorials and Helpful Hints

- Do you need to get an idea of what PC-ACE Pro32 can do for you? To see an overview of PC-ACE Pro32, go to our website at the following link: http://www.cgsmedicare.com/captivate/Pro32A/Course.html
- You will find out how to set up PC-ACE Pro32 by using our "Building Reference Files" Learning Module at: http://www.cgsmedicare.com/captivate/Pro32B/Course.html
- This is a tutorial on how to enter Part B (Professional) claims into PC-ACE Pro32: http://www.cgsmedicare.com/captivate/Pro32D/Course.html
- Do you have Part B Medicare Secondary Claims? Here's a step-by-step guide: http://www.cgsmedicare.com/captivate/Pro32F/Course.html
- Need help reading your 999 and 277ca with PC-Ace? Try this link: http://www.cgsmedicare.com/pdf/New_EDI_Reports.pdf
- Need more help? See the PC-ACE Pro32 User Guide at http://www.cgsmedicare.com/ohb/claims/edi/pro32/index.html

TIP: WHEN BILLING PLACE OF SERVICE (POS) 12

When billing for place of service (POS) 12 (home), using the PC-Ace software, you must choose a (Y) in the facility indicator box on the Patient Info & General screen. On the Billing Line Items screen, choose 12 (home) in the 24b PS box. You will then need to enter the patient name, address, city, state, and 9-digit zip in the Facility Information of the Est. Patient/General screen. This will populate correctly in the electronic file being sent to Medicare for proper adjudication.

Updated April 16, 2013.

Response Reports and Their Impact On Your Practice

Checking your claim response reports is one of the most important steps you can take to keep your cash flow running smoothly. We have all arrived home from a store to find out that we have overpaid for an item after thoroughly examining the receipt. Response reports (999's and 277ca's) are a form of receipt from the submission of a claim file. Response reports deserve attention and it cannot be assumed that your claims are making it into the adjudication system to eventually be processed.

Your response reports contain vital information about the status of your claims. Unless you're checking your response reports daily, you cannot assume that they were accepted into the adjudication system. We know that regardless of cash flow coming in, there will still be the need for cash flow going out to pay the bills. If a claim or batch of claims rejects, they WILL NOT be paid, since they do not make it into the adjudication system.

Set up with a reminder to check your response reports when you transmit your claims. If you have trouble remembering to review the response reports, set yourself up with a Microsoft Outlook reminder or other calendar reminder. Smartphones often have reminder functions that can be put to use for this as well. Not checking your response reports in a timely fashion may be money left on the table for your practice. If the claims have possibly rejected, you will not know unless you check the response reports. Correcting and retransmitting claims only takes a few minutes and will pay off in dividends for your practice if you invest the time.

Understanding your response reports is important to your practice. Especially with the implementation of ANSI 5010, response reports can require more steps to open, read, and interpret correctly. If you are using third party software, your vendor can often get you a 999 and 277ca reader to help you interpret the 5010 response reports correctly. The latest version of PC-ACE Pro32 can be used to read and the 999 and 277ca reports. Instructions can be found here: http://www.cgsmedicare.com/kyb/pubs/mb_J15/2012/01_2012/PDFs/CGS%20Pro32%20999%20277CA%20reports%20_3_.pdf.

If for some reason you cannot figure out the rejection reason and your third party cannot help you, please give us a call at the appropriate number below with some information about the transmission time frame and we will be more than happy to help you identify and correct the rejected claims(s):

- Kentucky and Ohio Part B: 1.866.276.9558
- Kentucky and Ohio Part A: 1.866.590.6703
- Home Health/Hospice: 1.877.299.4500

Benefits of myCGS

myCGS is a FREE online tool that provides you with the convenience of accessing your claims payment information, beneficiary eligibility information, claims status and remits, directly from your office computer.

Why register for myCGS?

- No calling or waiting for information to be mailed.
- Ability to view and print copies of your remittance advice.
- Convenient because you decide when you want to use it.
- Safe and secure. CGS follows strict federal information and data protection guidelines.
- Part A can file redetermination forms in MyCGS (coming soon for Part B and HHH)
- It is FREE!!

You may register for myCGS by visiting our website at http://www.cgsmedicare.com/Medicare.html — click on your contract link and choose myCGS.

Updated April 16, 2013.