

EDI CONNECTION

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Important: Change for Dial-Up Claim Submitters

Effective July 1, 2014, CGS will no longer offer asynchronous (async) and FTP dial-up connectivity. **This change only affects those CGS providers (e.g., Part A, Part B, and Home Health & Hospice) who submit claims to CGS using a dial-up**

connection. It is imperative that impacted providers read and take action on the following information.

If you currently submit claims to CGS using a dial-up connection, consider an Approved Network Service Vendor (NSV). A list of NSVs can be located on the CGS website under the EDI tab.

CGS recommends that you take immediate action to transition from dial-up to avoid any disruption to your claim submission.

If you have questions, please contact the CGS EDI department at **866.276.9558, Option 2**, for assistance.

Ways To Get and Stay Connected with myCGS

myCGS is a very helpful tool to the providers, listed are a few ways to get and stay connected with the web portal. Listed are some helpful hints to being connected.

Get Connected-

- Each PTAN/NPI combination has to be registered separately
- If you are trying to register, and not sure of the correct information to put in the system (ex. Last payment amount, Line of business etc.), please contact CGS EDI helpdesk to ensure you are not locked out on registration.
- Once the registration application is submitted, an email will be sent to the address that was on the application to verify your registration. Click on the link within that email and myCGS will be available to you! You will receive your User ID, and have the ability to change your password at that point.
- There can be more than one administrator for the group:
 - o The original person who registers for the program will be considered the Provider Administrator. Each organization (PTAN/NPI combination) must identify at least one person to be the Provider Administrator. However, it is recommended that more than one person be given administrative rights. The Provider Administrator is responsible for granting access for other users in the organization. The Provider Administrator can also reset passwords for the other user in your office. Reminder: Provider Administrators



must sign into myCGS once every 60 days or the account will become inactive for all users.

Stay Connected-

- Make sure that your administrator stays current with his/her login for the group.
- If the administrator has not logged in within 60 days the group will have to be registered.
- Make sure that your user ID provided by myCGS is correct. (This username is system generated and cannot be changed).
 - Please note all myCGS user IDs begin with the number "0" and **NOT** the letter "O".

REMINDER: myCGS Login Requirements

If your organization/office is not already signed up for the myCGS Web portal, go to <http://www.cgsmedicare.com/mycgs/index.html> and click on the "Register for myCGS" button.

To comply with CMS requirements, the myCGS lockout period for Provider Administrators and Provider Users are 60 days. This means that all Provider Administrators and Provider Users must now log in to the myCGS portal at least once every 60 days. On the 61st day all user accounts will be inactive. The registration process will have to be completed before myCGS access it available to your practice.

CGS recommends all users, particularly Provider Administrators, log in to myCGS at least once every 30 days. Please ensure all staff members are aware of these login requirements.

CGS EDI Electronic Enrollment

CGS's EDI department now offers an online process that allows providers to submit applications on our website, for adding and removing submitter IDs of clearinghouses as well as adding individuals to Provider Transaction Access Numbers (PTAN) for FISS access. The advantages of the online application process are that it allows for less mistakes and less paper work that has to be faxed in. The only documentation that would be required to be faxed is the Provider Authorization or Signature page.

The Provider Authorization or Signature page is the last required piece of the process. This important document has a tracking number on it that links to your online application. Its purpose is to have your provider information on it, including your Tax

Identification Number (TIN) and an authorized signature. When it links to your online application it is then placed in a bucket for processing. This links everything together so that you can be serviced in a quicker manner. Please visit our website for more details on our electronic EDI Enrollment process at: CGS EDI Electronic Enrollment (http://www.cgsmedicare.com/medicare_dynamic/edi_application/disclaimer.html)

EDI Tip of the Month

Welcome to EDI Tip of the Month! A recent trend in our call volume has provided the outline to initiate "EDI Tip of the Month" to detect call topics.

This month's Tip:

Understanding 277CA and 999 Rejections when claims are transmitted using a 3rd Party (Clearinghouse or Billing Service).

Important Note: We appreciate the dedication to our clearinghouses and the services they provide to our customers daily. If you are a provider, that uses these services, please remember your clearinghouse is your first point of contact for EDI issues. Anything they cannot resolve for you should then be referred to the EDI Help Desk. On contact please provide one of the following pieces of information to one of our "EDI Support Staff", so timely assistance might be provided:

- REF-D9 (clearinghouse stamp)---**for clearinghouses only**
- FILE ID=ISA-13 (of the file submitted and date file sent to Medicare by clearinghouse) ----**provider should be able to provide this to the EDI department, as provided by the clearinghouse. This will ensure that we are looking at the correct file and can provide accurate assistance.**

In addition we have 277CA and 999 Job Aids in the EDI section available at <http://www.cgsmediare.com> to assist locating any rejections.

We understand our customer's needs and will continue to provide Confidence, Clarity and Caring Attitudes.

EDI Help Desk Hours

Monday – Friday 8:00AM – 5:00PM (ET)

Direct Data Entry (DDE)

Direct Data Entry (DDE) allows you to verify eligibility and check claim status.

DDE users must use a connectivity service provided by an external company.

If an employee no longer works for the practice you should not assign that ID to anyone else. You should request to have it deactivated.

For password reset please contact Security at 615.660.5444 or email CGS.Medicare.OPID@cgsadmin.com. Remember emails requesting a password reset must contain the user's name and RACFID.

The RACFIDs are revoked after 30 days of non-use. If the RACFID is not used in 90 days it will be deactivated and you will need to send in new Online Inquiry applications to CGS.

Direct Data Entry (DDE) Professional Provider Telecommunications Network (PPTN) Online Inquiry For Process

CGS EDI would like to share with you how your Online Inquiry Form request is processed from the time we receive your form to the time you receive your IDs.

The EDI department receives your form directly into our system --- whether faxed or submitted from our website.

Once the EDI representative views your form, they verify that the PTAN, NPI, Practice Name, and Tax ID on the form match the information in our system.

If the information does not match or if one of the items listed below is missing, it is mailed back to you with an explanation:

- PTAN
- NPI
- Practice Name
- Tax ID (EIN)
- First and Last Name of individual requesting access

If all the information is correct, the EDI representative will forward the information to our Security department.

The Security department checks their system to see if the individual requesting access has an existing user ID or is setup with the user ID listed on the form.

If the individual is setup with the user ID listed on the form, request is completed promptly.

If the individual does not have a user ID listed on the form and security does not see a user ID in the system for the individual, the request is submitted to the Data Center for assignment of a user ID.

Once the Data Center assigns the user ID, security attaches the user ID to the individual and PTANs requested.

Security sends the completed request to EDI. EDI emails confirmation of the completed request to the contact on the form. If an email address was not provided on the form, EDI will call the contact on the form.

Note: CGS EDI has up to 20 business days from the date of receipt to complete a request.

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>. Select the line of business for your segment then choose the EDI icon to the left. In the section of bulleted links within the middle of the page, select the EDI ENROLLMENT PACKETS link.
- 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 <http://www.cgsmedicare.com>.
- 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.

Online Inquiry Form:

- The EDI CONTACT person should be the individual you have deemed authorized to receive information about the forms contents submitted to CGS.

- The Group Practice/Provider name and Group PTAN/NPI must match what is listed on file.
- In the EXISTING ID/PIN field please include the existing ID/PIN on those users whom an ID has already been established so that we may add access for the PTAN(s) requested. If this is a NEW user, please leave blank or indicate NEW in the EXISTING ID/PIN. If you are attempting to delete a user's access please indicate DELETE in this field.

ASCA Waiver Requirements

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;
- Claims for payment under a Medicare demonstration project that specifies claims be submitted on paper;
- Medicare Secondary Payer Claims when there is more than one primary payer and one or more of those payers made an "Obligated to accept as payment in Full" (OTAF) adjustment;
- Claims submitted by Medicare beneficiaries or Medicare Managed Care Plans;
- Dental Claims;
- Claims for services or supplies furnished outside of the U.S. by non-U.S. providers;
- Disruption in electricity or communication connections outside of a provider's control expected to last more than two business days.
- Claims from providers that submit fewer than 10 claims per month on average during a calendar year.

Providers are to self-assess to determine if they meet one or more of these situations and should not submit a waiver request when they meet one or more of these situations. Please note that some of these situations are temporary or apply only to certain claims, when the temporary situation expires or when billing other types of claims, providers must submit their claims or those other types of claims electronically, and in the HIPAA standard.

The Importance of PC-ACE Pro32 Updates and Your Practice

PC-ACE Pro32 is often used by our Providers in order to get their claims ready for transmission. Updates to the PC-ACE Pro32 software are available on a quarterly (3 month) basis. The updates to the software are incremental additions of various edits such as Health Care Common Procedure Coding (HCPCS), modifiers, and Diagnosis Codes as well as other changes. In addition, updates sometimes come through with changes to the way PC-ACE Pro32 compiles and compresses the information into its database indexes. But what does all this mean to your practice?

In an ideal situation, PC-ACE Pro32 would be updated by someone within your practice soon after these updates are made available on our website. If PC-ACE Pro32 was currently installed on their PC, Providers would go out to our website, select their line of business or go to <http://www.cgsmedicare.com/ohb/claims/edi/pro32/index.html> and click on the link that says PC-ACE Pro32 update. It that may look something like this:

■ PC-ACE Pro32 Software (v2.50.0.100 update)

From there the prompts are to be followed to install the update. Depending on your internet download speed and PC's hardware resources, the whole process may be complete in less than a minute. This minute of time to update your software may save you hours or days of work should your PC crash with an older version of the backup files.

Unfortunately Providers sometimes wait until the message comes up on their PC-ACE Pro32 software that tells them that their version of PC-ACE Pro32 is about to expire. By the time this message shows up, it is often almost 6 months past due for updates. The problem occurs if and when the computer that the PC-ACE Pro32 is installed on goes down. This is a problem even if you regularly backup your files and store them at a separate location from the crashed PC. This major problem occurs because even the backup files will have been created on versions of PC-ACE considered older and outdated.

In a nutshell, this means that your PC-ACE Pro32 restore will not work correctly and it's very likely all the information entered over the years will be lost indefinitely. You will end up spending some time retyping your Provider, Payer, and Patient information. This time away from Practice can be mitigated by simply downloading and installing the most recent updates quarterly. We strongly advise this since we cannot assist in retrieving your old files if you are too many versions behind on your backup file.

Performing system backups/restores

PC-ACE Pro32 provides complete database backup and restore features to protect your valuable system data. All claims, reference files, and system configuration settings can be backed up to either writeable CDROM or a standard Windows directory, file name PCACEPBK.ZIP. In the event of a system failure, resulting in the loss or compromise of PC-ACE Pro32 database files, a complete database restore operation can be performed from the most recent backup. It is strongly recommended that you supplement these backups with a copy of the actual software each time it is upgraded. By doing so, in the event a full restore is required, and you have not upgraded to the latest version on the CGS website, you would have the version that coincides with the lasted backup you performed.

You would first add the copy of PC-ACE Pro32 that goes with the latest backup you have, to regain the version lost. The most recent PC-ACE Pro32 backup can now be restored to recover your databases and configuration settings. It is then recommended that you upgrade to the latest version from the CGS website. You are prompted to perform a backup each time you exit the PC-ACE Pro32 program. You may also perform a backup from the "Backup/Restore" tab of the System Utilities form. This option can be accessed by clicking the "System Utilities" button from the PC-ACE Pro32 Main Toolbar.

Attention: The restore operation will overwrite your current database files with older data from the specified backup.

PC Print Version 4.3.0 Incompatible with Microsoft XP

PC Print software allows Medicare Part A providers to print the electronic remittance advices in a human readable format. Version 4.3.0 of PC Print, released in April 2014, is not compatible with Windows XP. Windows XP end of life was April 8, 2014. Part A providers using Windows XP should continue to use version 4.2.6 of PC Print until they are able to upgrade to a newer version of Windows. PC Print version 4.3.0 displays

the English descriptions for the claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs) and Group codes at the claim and line levels, as well as indicating the appropriate Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange (CAQH CORE) business scenario. PC Print version 4.2.6 displays the CARC, RARC and group codes, but the English descriptors and CAQH CORE business scenarios for these codes will not be displayed. Part A providers that have Windows XP will still need to refer to the Washington Publishing Company website to get the English descriptors for these codes and the CAQH CORE website to get the CORE Code Combination business scenarios. For background, see MLN Matters® Article # MM8479, "MREP and PC Print Updates for Operating Rules Phase III 360 Rule Compliance."

5010 Institutional and Professional Edits Spreadsheet

The 5010 Edit Spreadsheet is a resource tool for reading TA1/999/277CA rejections. We encourage our Providers and Trading Partners to use this tool for resolving errors. If you submit claims directly or use a clearinghouse/billing service to submit claim files, the 5010 Institutional and Professional Edit Spreadsheet will assist you with errors that are return on the reports.

This is a list of some of the information that is displayed on the spreadsheet.

- Edit Reference
- Segment or Element
- Description
- Disposition/Error Code
- Proposed 5010A1 Edits Part A and Part B (this will give you the resolutions to the problem) such as loops and segments.

Website for EDI Edit Spreadsheet

<http://www.cms.gov/Medicare/Billing/MFFS5010D0/Technical-Documentation.html>

Website for 5010 edits:

<http://www.cms.gov/Medicare/Billing/MFFS5010D0/Technical-Documentation.html>

Kentucky Part B Top 5010 Errors

	Edit Number	Business Edit Message	Resolution
1	X222.262.2310B. NM109.030	<p>CSCC A7: "Acknowledgement/Rejected for Invalid Information..."</p> <p>CSC 562: "Entity's National Provider Identifier (NPI)"</p> <p>EIC: 82 "Rendering Provider"</p> <p>This Claim is rejected for Invalid Information for a Rendering Provider's National Provider Identifier (NPI).</p>	<p>The rendering provider NPI was not found on the crosswalk.</p> <p>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.</p>
2	X222.087.2010AA. NM109.050	<p>"CSCC A8: "Acknowledgement / Rejected for relational field in error"</p> <p>CSC 496 "Submitter not approved for electronic claim submissions on behalf of this entity."</p> <p>EIC: 85 Billing Provider"</p> <p>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</p>	<p>The billing provider must be "associated" to the submitter (from a trading partner perspective) in 1000A.NM109.</p> <p>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</p>
3	X222.351.2400.SV101-2.020	<p>"CSCC A7: "Acknowledgement /Rejected for Invalid Information..."</p> <p>CSC 507: "HCPCS"</p> <p>This Claim is rejected for relational field Information within the HCPCS</p>	<p>When 2400.SV101-1 = "HC", 2400.SV101-2 must be a valid HCPCS Code on the date in 2400.DTP03 when DTP01 = "472".</p> <p>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.</p>
4	X222.121.2010BA. NM109.020	<p>"CSCC A7: "Acknowledgement /Rejected for Invalid Information..."</p> <p>CSC 164: "Entity's contract/member number"</p> <p>EIC: IL Subscriber"</p> <p>This Claim is rejected for Invalid Information for a Subscriber's contract/member number</p>	<p>The subscriber HICN is invalid. Verify the HICN is entered exactly as it appears on the beneficiary's red, white, and blue Medicare card.</p> <p>Medicare number can only be 10 to 11 characters only. Here are the valid formats: NNNNNNNNNA or NNNNNNNNNNAA or NNNNNNNNNAN. If the patient's Medicare number is not in these formats, your claim will reject.</p>
5	X222.094.2010AA. REF02.050	<p>"CSCC A8: "Acknowledgement / Rejected for relational field in error"</p> <p>CSC 562: "Entity's National Provider Identifier (NPI)"</p> <p>CSC 128: "Entity's tax id"</p> <p>EIC: 85 Billing Provider"</p> <p>This Claim is rejected for relational field Billing Provider's NPI (National Provider ID) and Tax ID</p>	<p>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.</p>

Kentucky Part B Top 5010 Errors (cont.)

6	X222.087.2010AA. NM109.030	<p>“CSCC A7: “Acknowledgement /Rejected for Invalid Information...”</p> <p>CSC 562: “Entity’s National Provider Identifier (NPI)”</p> <p>EIC: 85 Billing Provider”</p> <p>This Claim is rejected for Invalid Information in the Billing Provider’s NPI (National Provider ID)</p>	<p>2010AA.REF must be associated with the provider identified in 2010AA.NM109</p> <p>Billing Provider Identifier must be a valid NPI on the Crosswalk. Verify that the NPI and PTAN are linked together.</p>
7	X222.351.2400.SV101-3.010	<p>CSCC A7: “Acknowledgement /Rejected for Invalid Information...”</p> <p>CSC 453: “Procedure Code Modifier(s) for Service(s) Rendered”</p> <p>This Claim is rejected for relational field Information within the Procedure Code Modifier(s) for Service(s) Rendered</p>	<p>Procedure Modifier must be valid for the Service Date. (DTP01 = “472”)</p>
8	X222.351.2400.SV101-7.020	<p>“CSCC A8: “Acknowledgement / Rejected for relational field in error”</p> <p>CSC 306 Detailed description of service”</p> <p>This Claim is rejected for relational field Information within the Detailed description of service</p>	<p>Description must be present when Procedure Code requires a description/additional information.</p> <p>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</p>
9	X 222.125.2010BA. N403.020	<p>CSCC A7: “Acknowledgement /Rejected for Invalid Information...”</p> <p>CSC 500: “Entity’s Postal/Zip Code”</p> <p>EIC IL: Subscriber</p> <p>This Claim is rejected for Invalid Information for the Subscriber’s Postal/Zip Code</p>	<p>Subscriber Postal Zone or ZIP Code must be a valid US Postal Service Zip Code.</p>
10	X 222.480.2430. SVD03-2.020	<p>CSCC A7: “Acknowledgement /Rejected for Invalid Information...”</p> <p>CSC 507: “HCPCS”</p> <p>CSC 710: “Line Adjudication Information”</p> <p>This Claim is rejected for Invalid Information within the HCPCS and Line Adjudication Information</p>	<p>Valid CMS Proprietary HCPCS reference must be available for this edit.</p>

Ohio Part B Top 5010 Errors

	Edit Number	Business Edit Message	Resolution
1	X222.087.2010AA. NM109.050	<p>“CSCC A8: “Acknowledgement / Rejected for relational field in error”</p> <p>CSC 496 “Submitter not approved for electronic claim submissions on behalf of this entity.”</p> <p>EIC: 85 Billing Provider”</p> <p>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</p>	<p>The billing provider must be “associated” to the submitter (from a trading partner perspective) in 1000A.NM109.</p> <p>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</p>
2	X222.094.2010AA. REF02.050	<p>“CSCC A8: “Acknowledgement / Rejected for relational field in error”</p> <p>CSC 562: “Entity’s National Provider Identifier (NPI)”</p> <p>CSC 128: “Entity’s tax id”</p> <p>EIC: 85 Billing Provider”</p> <p>This Claim is rejected for relational field Billing Provider’s NPI (National Provider ID) and Tax ID</p>	<p>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.</p>
3	X222.087.2010AA. NM109.030	<p>“CSCC A7: “Acknowledgement /Rejected for Invalid Information...”</p> <p>CSC 562: “Entity’s National Provider Identifier (NPI)”</p> <p>EIC: 85 Billing Provider”</p> <p>This Claim is rejected for Invalid Information in the Billing Provider’s NPI (National Provider ID)</p>	<p>2010AA.REF must be associated with the provider identified in 2010AA.NM109</p> <p>Billing Provider Identifier must be a valid NPI on the Crosswalk. Verify that the NPI and PTAN are linked together.</p>
4	X222.121.2010BA. NM109.020	<p>“CSCC A7: “Acknowledgement /Rejected for Invalid Information...”</p> <p>CSC 164: “Entity’s contract/member number”</p> <p>EIC: IL Subscriber”</p> <p>This Claim is rejected for Invalid Information for a Subscriber’s contract/member number</p>	<p>The subscriber HICN is invalid. Verify the HICN is entered exactly as it appears on the beneficiary’s red, white, and blue Medicare card.</p> <p>Medicare number can only be 10 to 11 characters only. Here are the valid formats: NNNNNNNNNA or NNNNNNNNNNAA or NNNNNNNNNAN. If the patient’s Medicare number is not in these formats, your claim will reject.</p>
5	X222.262.2310B. NM109.030	<p>CSCC A7: “Acknowledgement/Rejected for Invalid Information...”</p> <p>CSC 562: “Entity’s National Provider Identifier (NPI)”</p> <p>EIC: 82 “Rendering Provider”</p> <p>This Claim is rejected for Invalid Information for a Rendering Provider’s National Provider Identifier (NPI).</p>	<p>The rendering provider NPI was not found on the crosswalk.</p> <p>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.</p>

Ohio Part B Top 5010 Errors (cont.)

6	X222.351.2400.SV101-2.020	<p>“CSCC A7: “”Acknowledgement /Rejected for Invalid Information...””</p> <p>CSC 507: “”HCPCS””</p> <p>This Claim is rejected for relational field Information within the HCPCS</p>	<p>When 2400.SV101-1 = “HC”, 2400.SV101-2 must be a valid HCPCS Code on the date in 2400.DTP03 when DTP01 = “472”.</p> <p>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.</p>
7	X222.351.2400.SV101-3.010	<p>CSCC A7: “Acknowledgement /Rejected for Invalid Information...”</p> <p>CSC 453: “Procedure Code Modifier(s) for Service(s) Rendered”</p> <p>This Claim is rejected for relational field Information within the Procedure Code Modifier(s) for Service(s) Rendered</p>	<p>Procedure Modifier must be valid for the Service Date. (DTP01 = “472”)</p>
8	X222.351.2400.SV101-7.020	<p>This Claim is rejected for relational field Information within the Detailed description of service</p>	<p>“CSCC A8: “”Acknowledgement / Rejected for relational field in error””</p> <p>CSC 306 Detailed description of service”</p> <p>This Claim is rejected for relational field Information within the Detailed description of service</p>
9	X222.157.2300.CLM05-3.020	<p>“CSCC A7: “”-Acknowledgement/Rejected for Invalid Information...””</p> <p>“CSC -535 – Claim frequency Code</p> <p>This Claim is rejected for Invalid Information within the Claim Frequency Code</p>	<p>Part B Medicare only accepts original claims.</p> <p>****CLM05-3 must be 1 for Medicare Part B claims only****</p>
10	X999.DUPE	<p>N/A</p> <p>Rejected due to duplicate ST/SE submission</p>	<p>Data in transaction set (between ST and SE a previously submitted transaction set.</p>