FALL 2026

EDI CONNECTION

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The EDI Connection Newsletter informs providers, clearinghouses, and software vendors about the benefits of using Medicare-supported HIPAA Electronic Data Interchange (EDI) transactions, EDI changes, and common EDI billing errors and resolutions.

Due November 30: DDE & PPTN Recertification

For security purposes, CGS must certify each Direct Data Entry (DDE) and Professional Provider Telecommunications Network (PPTN) user's system access annually.

The 2026 Annual DDE & PPTN Recertification process began on July 1.

Based on the completion rates below, we're offering a second extension to help users avoid deactivation. Please fax the Annual DDE PPTN Recertification Form (https://www.cgsmedicare.com/forms/annual_dde_pptn_recert_formre.pdf) before November 30.

Provider Type	Completion Rate
Home Health & Hospice	64%
Part A	61%
Part B	40%

NOTE: Once the termination process begins, a new application (DDE & PPTN Application/Reactivation) is required to restore access, and the normal 20 business days for processing applies.

Why Use EDI?

Electronic Data Interchange (EDI) is the process of using nationally established standards to exchange electronic information between business entities.

The benefits of using EDI include:

- **Eliminate paperwork**
  Staff can accomplish more in less time, and you save money for postage and paper claim forms.
- **Flexibility**
  Submit claims for multiple providers simultaneously and control claim frequency and volume.
- **Reduce claim errors**
  Less manual entry, EDI edits that validate information reported on electronic claims, and electronic billing reports help ensure correct claim payment without the need to request claim reopenings, adjustments, or appeals.
- **Faster processing**
  Medicare claims processing systems accept most electronic claims within 24 hours and the payment floor (i.e., mandatory waiting period for CGS to issue payment) is 13 days after the receipt date (electronic claims) vs. 26 days (paper claims).

EDI Application Status Tool

When you submit an EDI Application, please note and secure the tracking (reference) number documented in your Provider Authorization Form and confirmation email to:

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- Quickly check application status online.
  - HHH EDI Application Status Tool (https://www.cgsmedicare.com/medicare_dynamic/j15/hhh/edi_application/edi_application/status.aspx)
  - Part A EDI Application Status Tool (https://www.cgsmedicare.com/medicare_dynamic/j15/parta/edi_application/edi_application/status.aspx)
  - Part B EDI Application Status Tool (https://www.cgsmedicare.com/medicare_dynamic/j15/partb/edi_application/edi_application/status.aspx)
- View rejection reasons and required corrections.
- Access the most recent status information daily.
- Avoid unnecessary calls to Customer Service.

Keep the tracking number until your enrollment is complete. Continue to use the EDI Application Status Tool to stay informed and keep the enrollment process moving forward.

Reminder: AUC Program for Advanced Diagnostic Imaging Ended

The Appropriate Use Criteria (AUC) Program required:

- Practitioners who order advanced diagnostic imaging services to consult AUC using an electronic Clinical Decision Support Mechanism (CDSM) tool.
- Practitioners who provide the imaging services to report the AUC consultation information from the ordering practitioner on the claim for imaging services.

In the CY 2024 Physician Fee Schedule final rule, CMS finalized a pause to the AUC Program.

Consistent with the AUC Program pause, **effective January 1, 2024**, providers and clearinghouses should not report AUC data on Medicare claims for advanced diagnostic imaging services. Inappropriate use of the K3 segment may cause processing issues for crossover claims to other payers.

Reference: MM13485—Appropriate Use Criteria for Advanced Diagnostic Imaging: CY 2024 Update (https://www.cms.gov/files/document/mm13485-appropriate-use-criteria-advanced-diagnostic-imaging-cy-2024-update.pdf)

myCGS: Provider Administrator vs. Provider User

Please see User Roles for detailed descriptions. (https://www.cgsmedicare.com/mycgs/ssi/intro/user-roles.html)

myCGS: Account Recertification vs. Profile Verification

Read system messages carefully to ensure you complete the correct process:

- System message: "In order to maintain your access, you must complete the recertification process by MM.DD.CCYY. This process must be completed every 360 days."
  - Use the Account Recertification instructions (Provider Administrator). (https://www.cgsmedicare.com/mycgs/ssi/admin/recertification.html)
- System message: "In order to maintain your access, you must complete the profile verification process by MM.DD.CCYY. This process must be completed every 250 days."
  - Use the Profile Verification instructions (Provider Administrator & Provider User). (https://www.cgsmedicare.com/mycgs/ssi/myaccount/profile_verification.html)

Part A Top 10 Edits

	Edit Number	Business Edit Message	Resolution
1	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: NNNNNNNNA or NNNNNNNNAA or NNNNNNNNAN. 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."
2	X223.423.2400.LX01.030	This Claim is rejected for the Service line number greater than maximum allowable for payer.	Do not submit more than 449 service lines on a claim.
3	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.

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	Edit Number	Business Edit Message	Resolution
4	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"
5	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."
6	X223.345.2310E.N403.030	This Claim is rejected for Invalid Information within the Service Location's Postal/Zip Code. Verify Postal/Zip Codes for the Service Location on the USPS website prior to submitting claims	2310E.N403 must be a valid 9 digit zip code.
7	X223.150.2300.DTP03.050	CSCC A7: "Acknowledgement/Rejected for Invalid Information…" CSC 510: "Future date" CSC 188: "Statement from-through date""	2300.DTP03 must not be a future date.
8	X223.424.2400.SV202-7.025	This Claim is rejected for a relational field in error for Service(s) Rendered.	Not Otherwise Classified (NOC) procedure codes require a detailed description of the service. NOC drug codes require the name and dosage of the drug. Enter the description in the 2400 SV101-7
9	X223.143.2300.CLM05-1.020	This Claim is rejected for Invalid Information within the Type of bill for UB claim.	2300.CLM05-1 must be the 1st and 2nd positions of a valid Uniform Bill Type Code.
10	X223.284.2300.HI01-2.010	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 725: "NUBC Value Code(s)"	If 2300.HI01-1 is "BE" then 2300.HI01-2 must be a valid Value code on the receipt date and is within the codes effective and termination date.

Pary B Top 10 Edits

	Edit Number	Business Edit Message	Resolution
1	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.
2	X222.157.2300.CLM05-3.020	This Claim is rejected for Invalid Information within the Claim Frequency Code	Claim Frequency Code must be "1".
3	X222.262.2310B.NM109.030	This Claim is rejected for Invalid Information for a Rendering Provider's National Provider Identifier (NPI).	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	This Claim is rejected for Invalid Information for a Subscriber's contract/member number	If Medicare HICN: 2010BA.NM109 must be 10-11 positions formatted NNNNNNNNNA or NNNNNNNNNAA or NNNNNNNNNAN 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	X222.351.2400.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".
6	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
7	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.
8	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.
9	X222.125.2010BA.N403.020	The claim is rejected for invalid format of Subscriber's contract/member zip code.	2010BA.N403 must be a valid postal/zip Code when N404 equals US or blank.
10	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.

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