SPRING 2020

EDI CONNECTION

Contents

Changes are Coming to Electronic Data Interchange (EDI) Forms 1

CWF Eligibility Sunset 1

The New Qualified Medicare Beneficiary (QMB) myCGS Sub-Tab! 1

myCGS Availability 2

NEW: myCGS Appeal Option: 2nd Level Appeal 2

Tips to Avoid myCGS Registration Lock-Out 2

Provider Authorization Form Signature Page 2

Part A Top Ten Edits 2

Part B Top 10 Edits 3

Changes are Coming to Electronic Data Interchange (EDI) Forms

To ensure the CGS EDI department receives accurate information with form submittals, EDI forms will transition to a paperless environment. All EDI enrollment forms including the EDI Enrollment Agreement and the EDI application form will be required to be completed and submitted online.

The online application form process implementation date is May 1, 2020. After May 1, 2020, EDI will no longer accept forms via fax or mail. Any submissions received after the implementation date will be returned to the sender with instructions to resubmit the application online. The process for submitting a signature page remains the same.

Please continue to review Listserv communications for future updates.

CWF Eligibility Sunset

CMS will begin revoking access to Common Working File (CWF) eligibility transactions HIQA, HIQH, ELGA and ELGH effective February 1, 2020. Submitters that aggregate transactions for otherwise disparate providers (e.g., clearinghouses, billing services, software vendors, etc.) and have both HETS and CWF based eligibility access should use HETS exclusively. CMS will remove HIQA/HIQH/ELGA/ELGH access for these submitters by revoking role-based access for specific CMS RACF IDs. CMS will revoke access starting with high-volume aggregators. Aggregators that use both HETS and CWF based eligibility should assume they must use HETS only no later than February 1, 2020.

Reference: https://www.cms.gov/research-statistics-data-systems/hipaa-eligibility-transaction-system-hets-help-270271/cwf-eligibility-sunset

The New Qualified Medicare Beneficiary (QMB) myCGS Sub-Tab!

The Qualified Medicare Beneficiary (QMB) Program (https://www.cgsmedicare.com/partb/pubs/news/2017/09/cope4509.html) is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance and copays. Because of this, you may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing, as they have no legal obligation to pay.

To help you determine the QMB status of your patients, CMS recently updated the HIPAA Eligibility Transaction System (HETS) to allow you access to this information. CMS requires us to utilize HETS 270/271 transactions to provide eligibility information to you when inquiries are submitted through our secure online web portal, myCGS (https://www.cgsmedicare.com/partb/mycgs/index.html). As a result, myCGS has been enhanced to coincide with the HETS updates in order to allow you access to this important information.

The new QMB sub-tab is available to you under the ‘Eligibility’ tab. Please note that “$0” will display in the deductible, coinsurance, and copay sections for beneficiaries enrolled in the QMB program.

© 2020 Copyright, CGS Administrators, LLC.

CGS® A CELERIAN GROUP COMPANY

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

EDI CONNECTION

myCGS Availability

myCGS is available 24 hours a day, seven days a week. However, there are times where all access to certain functions will not be available. Below will advise which functions will be available during those certain times.

Claims Data	6:00 a.m. - 9:00 p.m. ET
Remittances	6:00 a.m. - 9:00 p.m. ET
Beneficiary Eligibility	24/7 except during established myCGS and CMS scheduled maintenance
Financial Data	6:00 a.m. - 9:00 p.m. ET

If scheduled myCGS maintenance is required, it will be performed during the times listed below:

Monday-Friday:	6:00 a.m. to 8:00 a.m. - ET
Saturday - Sunday:	You may be able to login to myCGS; however, access to individual functions may not be available.
Sunday:	5:00 p.m. - 10:00 p.m. ET

Unscheduled maintenance may happen in order to address any issues that may arise. myCGS will display all times that any maintenance that would be in progress.

NEW: myCGS Appeal Option: 2nd Level Appeal

Did you know myCGS now allows myCGS users the capability of submitting a Reconsideration, 2nd Level Appeal? What to know more visit the 2nd Level Appeal Job Aid at https://www.cgsmedicare.com/parta/pubs/news/2020/03/cope16538.html.

Tips to Avoid myCGS Registration Lock-Out

Are you continually locked out of myCGS Registration?

In an effort to ensure successful completion, follow the steps listed:

1. Contact the CGS EDI Help Desk (select your CGS line of business)
   - HH&H: 1.877.299.4500 (Option 2)
   - Part A: 1.866.590.6703 (Option 2)
   - Part B: 1.866.276.9558 (Option 2)
2. Provide PTAN, NPI, last 5 digits of the Tax ID Number

The EDI Customer Service Representative will provide the most recent Medicare payment amount received.

Tip: We've noticed an uptick in myCGS Registration calls due to locked out of registration. If an incorrect payment amount is entered up to 3 times, the user will be locked out indefinitely.

You are encouraged to contact EDI Help Desk for last payment.

Provider Authorization Form Signature Page

To submit and complete the setup process for the EDI Online Application please print, add the practice's Tax Identification Number, sign and fax the Provider Authorization form to the appropriate fax number at the bottom of the form. Applications will be returned if the Provider Authorization form is not received within seven days.

Part A Top Ten Edits

	Edit Number	Business Edit Message	Resolution
1	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.
2	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.""
3	X223.424.2400. SV202-2.020	This Claim is rejected for Invalid Information within the HCPCS.	"When 2400.SV202-1 = "HC," 2400.SV202-2 must be a valid HCPCS Code."
4	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.""

© 2020 Copyright, CGS Administrators, LLC.

	Edit Number	Business Edit Message	Resolution
5	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.
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	X223.486.2430. DTP03.030	This claim is rejected due to Other's Insured payment date is a future date.	2430.DTP03 must not be a future date.
8	X223.480.2430. CAS.030	This claim is rejected for line level adjustments being present when Medicare is the Primary Payer.	"“When Medicare is priamry remove the Other Payer Claim Adjustment Indicator (Loop 2330B, REF Segment) and resubmit.”"
9	X223.424.2400. SV202-2.030	This Claim is rejected for Invalid Information within the HIPPS Rate Code for services Rendered.	When 2400.SV202-1 = "HP", 2400.SV202-2 must be a valid HIPPS Code.
10	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

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	X222.351.2400. SV101-4.020	This Claim is rejected for relational field Information within the Procedure Code Modifier(s) for Service(s) Rendered.	2400.SV101-4 must be valid procedure modifier on the date in 2400.DTP03 when DTP01 = "472".
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	X999.DUPE	Rejected due to duplicate ST/SE submission.	The ST/SE (Batch number) is the same within the file. The Batch numbsers must be unique within each file submitted. Please correct and resubmit the file.
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	X222.351.2400. 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.
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.

© 2020 Copyright, CGS Administrators, LLC.