SPRING 2023

EDI CONNECTION

Contents

myCGS: Use the Eligibility Tab to Avoid Claim Errors

Before you submit a claim to Medicare, determine if your patient is eligible to receive the item(s)/service(s) provided. The myCGS Eligibility sub-tabs provide answers to important questions like these to help you avoid the most common billing errors:

- **Eligibility –** Is your patient eligible to receive services covered under the Medicare Part A, Part B or Part B immunosuppressive drug benefits?
- **Deductibles/Caps –** Has your patient met the annual Part B deductible, therapy cap or rehabilitation services limitation?
- **Preventive Services –** Does your patient qualify to receive the service based on a gender, age, frequency, or other limitation?
- **NEW! Medicare Advantage (formerly Plan Coverage) –** Did your patient enroll for coverage under a Medicare Advantage (MA) managed care plan that replaces Original Medicare (Part A and Part B)?
- **NEW! Prescription Drug Plan (formerly Plan Coverage) –** Did your patient enroll for coverage under a Part D prescription drug plan?
- **MSP –** Is your patient entitled to other insurance coverage that is primary to Medicare and requires you to submit a Medicare Secondary Payer claim?
- **Hospice/Home Health, Inpatient –** Did you provide services that overlap a hospice election, home health period of care, or an inpatient hospital or Skilled Nursing Facility stay covered under Medicare Part A?
  - **NEW!** Access the hospice election receipt and revocation dates under the Notices of Election (NOE) section.

Stop the guesswork and eliminate the need to submit multiple claims. Use the myCGS Eligibility tab today and every day to save your office time and money!

Reference the *myCGS User Manual* (https://www.cgsmedicare.com/mycgs/mycgs_user_manual_eligibility.html#eligibility_main) for additional information and step-by-step instructions.

myCGS: How to Add New Users

Individuals should never share User IDs and/or passwords to access myCGS. Each user must receive a unique User ID and password. Provider Administrators can follow these steps to add new users to an existing myCGS account:

- Select the **Admin** Tab.
- Select the **User Listing** sub-tab.
- Scroll to the bottom of the page and select “Add New User“.
- Complete the **Create New User** form and click “Submit“.

Please note:

- **Name –** Enter the user’s actual first and last name. Generic names (e.g., Front Desk, Account Coordinator, Billing Department, etc.) are not permitted.
- **Permissions –** If you select “Admin,“ the user will have full Provider Administrator access for the account. **We recommend you establish at least two Provider Administrators for each PTAN/NPI combination (i.e., persons responsible for maintaining your office/organization’s portal access).**

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The Provider Administrator can then share the "New User Created" screen and temporary password with the new user. Upon the first log in, the new user will receive a prompt to create a new password. Once the profile and security questions are complete, the user will receive an email that includes a 7-digit PIN to complete the setup.

Reference the *myCGS User Manual* (https://www.cgsmedicare.com/mycgs/ssi/admin/adding_users.html) for additional information and step-by-step instructions.

myCGS: Financial Forms

The myCGS portal allows you to access, complete and submit certain forms to CGS electronically. For example, the Financial Forms sub-tab includes these options:

- **CMS-838 Credit Balance** (available to Part A, home health and hospice providers only) **–** This form is used to monitor identification and recovery of credit balances owed to Medicare. A credit balance is an improper or excess payment made to a provider as the result of patient billing or claims processing errors. Each Part A, home health and hospice provider must submit this form within 30 days after the end of each calendar quarter.
- **E-Offset –** This form authorizes CGS to offset funds to satisfy a pending overpayment due. You may choose to submit an authorization each time you receive a demanded overpayment or a permanent authorization for all future demanded overpayments.

When you use myCGS Forms, you can:

- **Ensure your information is legible and received timely.** Don't worry about delivery delays or technical issues with fax transmissions.
- **Receive confirmation.** myCGS will send a message to your inbox to confirm receipt of the form.
- **Check status.** Once accepted, myCGS will also send a message with a submission ID you can use to check the status.

Reference the *myCGS User Manual* (https://www.cgsmedicare.com/mycgs/mycgs_user_manual_financial.html#financial_main) for additional information and step-by-step instructions.

myCGS: Part B Reopenings

The Part B Reopening process is used to correct minor errors and omissions identified on previously processed claims. For example, Part B providers may submit a Reopening request to cancel an entire claim or claim line item(s). To submit a Part B Reopening in myCGS:

- We recommend you reference your myCGS remittance advice to ensure the line items correspond with the claim information in myCGS.
- Access the specific claim on the Claims tab to ensure the correct information to process your request auto-populates on the form.
- Select "Request Reopening."
- Select the appropriate option from the drop-down fields (i.e., Type: Cancel Entire Claim or Cancel Line; Action: Cancel; Line: line-item number (if applicable)).
  - **Note:** If removing a claim line will result in a payment reduction, submit an Overpayment Recovery (OPR) request instead.
- Verify all required fields are complete and correct.
- Click "Add" to attach this request to the form.
- Click "Submit."

Part A Top 10 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 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.'"
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. SV201.020	A7: 455: "Acknowledgement /Rejected for Invalid Information…" 2400.SV201 must be a valid revenue code.	Revenue code must be valid.

	Edit Number	Business Edit Message	Resolution
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	X223.486.2430. 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	X223.284.2300. HI03-2.010	"CSCC A7: "'Acknowledgement/Rejected for Invalid Information…'" CSC 725: "NUBC Value Code(s)"	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.
9	X223.143.2300. CLM02.080	"This Claim is rejected due to the Claim being out of Balance within the Payer's payment information."	CLM02 must = the sum of all 2320 CAS amounts & all 2430 CAS amounts and the 2320 AMT02 (when AMT01=D) Payer Paid amount for each other payer occurrence.
10	X223.424.2400. SV202-7.025	CSCC A8: "Acknowledgement/Rejected for relational field in error" CSC 306 Detailed description of service.	2400.SV202-7 must be present. When 2400.SV202-2 contains a non-specific procedure 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	X222.157.2300. CLM05-3.020	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 535: "Claim Frequency Code."	Claim Frequency Code must be "1."
3	X222.262.2310B. NM109.030	CSC 535: "Claim Frequency Code"	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 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	X222.458.2420E. N403.020	"CSCC A7: 'Acknowledgement/Rejected for Invalid Information…' CSC 500: 'Entity's Postal/Zip Code' EIC: DK 'Ordering Physician'"	2420E.N403 must be a valid Zip Code.
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	"CSCC A8: 'Acknowledgement/Rejected for relational field in error' CSC 306 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.