



EDI CONNECTION

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ACTION REQUIRED: 2023 DDE PPTN Recertification

For security purposes, CGS is required to certify each DDE/PPTN user’s access annually. To ensure a smooth recertification process, and avoid any service interruptions, each provider with staff who access DDE/PPTN should:

- Complete the Annual DDE PPTN Recertification Form https://www.cgsmedicare.com/forms/annual_dde_pptn_recert_formRE.pdf
 - List all users
 - If you have more than 10 users, please submit additional forms
- Fax the completed form(s) to CGS:

Provider Type	Fax Number	Deadline
Home Health & Hospice	1.615.664.5947	June 30, 2023
Part A	Kentucky: 1.615.664.5943 Ohio: 1.615.664.5945	July 31, 2023
Part B	Kentucky: 1.615.664.5917 Ohio: 1.615.664.5927	August 31, 2023

If we don’t receive your recertification form timely, we must deactivate current users on or after August 31, 2023.

Reference: CMS IOM Publication 100-25, Appendix A, AC-2, page 3

What to Expect When You Call EDI

As of May 1, 2023, you must use your telephone keypad to authenticate certain elements before speaking with an EDI customer service representative. This includes the provider’s:

- National Provider Identifier (NPI)
- Provider Transaction Access Number (PTAN)
- Last 5 digits of the Tax Identification Number (TIN)

CSRs cannot authenticate the information verbally or release any provider or beneficiary-specific information. If you don’t complete the following steps, the CSR must transfer your call to the automated system.

Telephone Numbers

- J15 Home Health & Hospice – 1.877.299.4500
- J15 Part A – 1.866.590.6703
- J15 Part B – 1.866.276.9558

States (Part A or Part B only)

- Press “1” for KY.
- Press “2” for OH.
- Press “9” for a list of Call Center closures.

Main Menu

Press “2” for Electronic Data Interchange (EDI).



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NPI

Enter your 10-digit NPI followed by the “#” key.

PTAN

- Press “1” if your PTAN includes numbers only.
 - Enter your PTAN followed by the “#” key.
- Press “2” if your PTAN includes both numbers and alpha characters.
 - Enter your PTAN followed by the “#” key.
- Press “*#” for instructions on how to enter an alpha character (or see instructions below).
- Press “9#” to return to the previous menu.

Tax ID

Enter the last 5 digits of your tax ID.

Note: The NPI, PTAN, and last 5 digits of the tax ID you enter must be a valid combination.

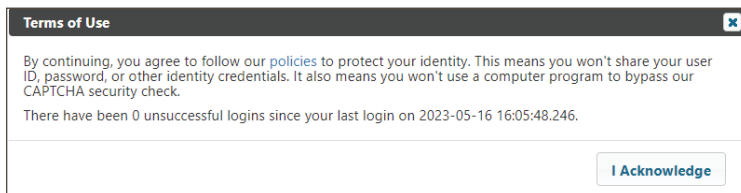
To Enter an Alpha Character

- Press the “*” key.
- Press the key that corresponds with the letter.
- Press the position of the letter on the key (e.g., “1,” “2,” or “3”).

Letter	Key	Letter	Key	Letter	Key	Letter	Key
A	*21	H	*42	O	*63	V	*83
B	*22	I	*43	P	*71	W	*91
C	*23	J	*51	Q	*11	X	*92
D	*31	K	*52	R	*72	Y	*93
E	*32	L	*53	S	*73	Z	*12
F	*33	M	*61	T	*81		
G	*41	N	*62	U	*82		

myCGS: Terms of Use Acknowledgment

To access the myCGS portal, you must first acknowledge the Terms of Use security banner pictured below:



What am I acknowledging?

- I understand and consent to the terms of use.
- This system is provided for Government-authorized use only.
- I will NOT share user IDs and passwords.
 - Each user, including new trainees, must have a unique User ID and password.
 - The Administrator must create/add a User ID that consists of

the user's first and last name. Do not use a physician's name if the physician doesn't actively use the portal.

- If an Administrator is no longer employed by a provider, don't allow others to use that User ID. If the provider doesn't have another Administrator, contact EDI to delete the Admin User's access.

Consequence

Per CMS guidelines, an EDI representative must delete access if there is reason to believe User IDs are shared.

Resource

To access all terms and conditions, select “Terms” in the lower-right corner of the myCGS Log-In page (https://www.onlineproviderservices.com/cgs_ops/).

myCGS: View an ADR

When a claim is selected for review by our Medical Review (MR) department staff, CGS sends the provider an Additional Documentation Request (ADR) letter. The ADR letter provides details about the review and includes a list of required/recommended medical record documentation to support that the services billed were medically necessary and meet Medicare coverage requirements. If you don't submit the requested documentation to CGS within 45 days, we must deny your claim.

Use the myCGS MR Dashboard under the “Medical Review” tab to quickly identify any MR ADRs sent to you and perform these functions:

- View claim details and the ADR letter
- Complete the ADR Response Form and attach the requested documentation
- Ask a general question about the ADR
- Submit an MR Reopening or other type of request (depending on the claim status)

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

Authorized Contact and Changing Provider Submitter ID Information

When you submit an EDI application (other than DDE/PPTN), CGS uses the information provided in the EDI Contact fields to send any related correspondence or communications, including but not limited to confirmations, rejections, and inquiries. To avoid delays with processing your paperwork, it is important to ensure the contact information, including name, phone number, address, and email, are current, legible, and valid.

As reminder, CGS does not accept hardcopy PDF applications (other than DDE/PPTN). However, you do need to print, input the tax identification number, and sign the Prior Authorization Form. Before you fax the signed form, please verify the contact information entered.

CGS does not limit who you deem the authorized official chosen as your company's contact. In addition, the contact may only



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change information if the provider's PTAN is the owner of the submitter ID number listed. Billing services and clearinghouses often use one submitter ID number for all their clients. **The provider's contact cannot make any changes, updates, or amendments to a submitter ID number owned by another provider or trading partner.**

How to Update Contact Information

If you own the submitter ID number, send a written request on your company's letterhead that includes the following information in the body of the letter:

- Line of Business
- Statement indicating what the change is for
- Submitter ID number (also include PTAN, if available)
- Name of approved software vendor and Network Service Vendor
- Group practice or name of the provider that owns the submitter ID number
- Contact name, email address, and phone number
- Address (If you need to change the address on file, please list both the old and new address.)
- Signature of the company's authorized official or contact currently listed

All requests are handled in the same manner as other applications and processed in the order in which they are received.

Part B ACE Smart Edits

In September 2019, CGS implemented Advance Communication Engine (ACE) Smart Edits. ACE returns pre-adjudicated claim messaging on your 277CA claim rejection reports and is a proactive strategy to help you submit claims correctly the first time.

Most claims that hit the CGS ACE pre-adjudication editing process are not forwarded to the claims processing system. If a claim receives a Smart Edit, review the information, decide if updates are needed or not, and resubmit it for processing.

Example of a Smart Edit from a 277CA claim rejection file:

```
A3>23>41**U*****SMARTEDIT PATTERN 3429 PROCEDURE
CODE 98941 IS A POSSIBLE DUPLICATE OF THE SAME
PROCEDURE CODE FOUND ON CLAIM ID LINE ID PERFORMED BY
THE SAME PROVIDER ON THE SAME DAY.~
```

```
A3>23>41**U*****SMARTEDIT INFO A POTENTIAL CODING
ERROR WAS IDENTIFIED WITH THIS CLAIM PLEASE SEE STC
2220D LOOP FOR SPECIFIC INFORMATION. IF YOU WISH TO
CONTINUE WITHOUT UPDATES, PLEASE RESUBMIT THE CLAIM IN
ITS CURRENT STATE TO BYPASS ADDITIONAL SMARTEDITING.~
```

If a clearinghouse or billing service submits your claims, please ensure they provide you a detailed 277CA claims report.

The 277CA Report CGS ACE Smart Edits Listing (<https://www.cgsmedicare.com/partb/pubs/news/2020/04/cope16935.html>) includes a list of Smart Edit messages and their descriptions.

Part A Top 10 Edits

Edit Number	Business Edit Message	Resolution	
1	X223.480.2430. CAS.030	This claim is rejected for line level adjustments being present when Medicare is the Primary Payer.	If 2000B.SBR01 = "P" then 2430.CAS must not be present.
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: NNNNNNNNNNA or NNNNNNNNNNAA or NNNNNNNNNNAN. 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	X223.116. 2010BA.N403.030	This Claim is rejected for containing Invalid Information within the Subscriber's Postal/Zip Code.	2010BA.N403 must be a valid postal/zip Code when N404 equals US or blank.
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.
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."



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Edit Number	Business Edit Message	Resolution	
7	X223.088. 2010AA.N403.030	This Claim is rejected for containing Invalid Information within the Billing Provider's Postal/Zip Code.	2010AA.N403 must be a valid 9 digit zip code.
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	This Claim is rejected for Invalid Information within the 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	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 NNNNNNNNNNA or NNNNNNNNNNAA or NNNNNNNNNNAN 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	X222.430.2420A. NM109.030	This Claim is rejected for Invalid Information within the Rendering Provider's National Provider Identifier (NPI).	2420A.NM109 must be a valid NPI on the Crosswalk when evaluated with 1000B.NM109, except when 2300.REF with REF01 = "P4" and REF02 = "82."
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.