

EDI CONNECTION

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Elimination of Outdated EDI Application Forms

In an effort to be consistent with newly changed submission practices including the elimination of direct dial-up submission, as well as minimize on errors with missing information,

CGS has updated the EDI application listed online at <http://www.cgsmedicare.com>.

The new application has changed slightly removing the direct dial-up option and inclusion of a TAX ID field which is mandatory for electronic remit (ERN/ERA) setup. Although CGS has been encouraging the usage of the new application it appears that many continue to use pre-printed forms which are outdated and often times illegible from being faxed or continuously copied and printed multiple times. We have accepted and processed these to the best of our ability.

Beginning November 1st 2014 Providers and Trading Partners should begin using the revised EDI Application in either hardcopy or electronic version to complete EDI enrollment setup. There will be a 45 day grace period to allow for your business to comply with transitioning to the new application before it is sent back in error for usage of outdated forms.

**Please follow the steps below to access the application and other enrollment forms:

1. Go to: <http://www.cgsmedicare.com/>
2. Select your line of business.
3. To the left hand side column, select ELECTRONIC DATA INTERCHANGE (EDI)
4. Under the EDI topic, select ENROLLMENT.

*The Enrollment Topic houses the paper and electronic versions of the EDI Application and other forms.

SFTP Port Change Effective February 27, 2015

The port configuration for SFTP connectivity is changing from 2021 effective on February 27, 2015 at 5:00 PM ET. You may begin testing your connectivity now.

You do not need to call EDI to schedule a test. Please see the **GPNet Communications Manual** http://www.cgsmedicare.com/pdf/gpnet_comm_manual.pdf for additional information concerning connectivity.

If you are currently using a Network Service Vendor (NSV) please contact them for assistance. Additional updates will be posted on this site.



Moving from Paper to Electronic Claim Submission?

Use these helpful Crosswalks to match your claims, field for field.

Professional Claim:

There are two ways to file Medicare claims to CGS – electronically or through a paper form created by the Centers for Medicare & Medicaid Services (CMS-1500). The required information is the same regardless of whether you file electronically or if you qualify for an exception to file paper claims. This document illustrates how each element on paper claims corresponds with the loops and segments for electronic claims.

Each individual loop on an electronic claim has a segment component where the data is entered. The loops and segments contain the readable information that provides the clearinghouse the identifying information for the claim that was filed. The loops on an electronic claim are organized by categories of information that match data elements on the CMS-1500 claim form.

CMS-1500/ Electronic Claim Crosswalk

http://www.cgsmedicare.com/pdf/5010_jobaid.pdf

The implementation of the ASC 837I v5010A2 presents substantial changes in the content of the data Institutional providers will submit with their claims. In order to help Institutional providers prepare for these changes, we have created a CMS-1450 Claim Form Crosswalk to ASC 837I v5010A2 Institutional Health Care Claim. This crosswalk will help institutional providers with correct claims submission during and after the transition to the ASC 837I v5010A2.

Institutional Claim: ASC 837I/Electronic Claim Crosswalk

<http://cgsmedicare.com/parta/pubs/news/2011/1111/cope17170.pdf>

Medicare Remit Easy Print (MREP) and PC-Print

The **MREP** software is used by **Part B** customers to view and print the compliant 835 (electronic remit). The most up-to-date version of MREP is 4.3 as of January 2015. The following link will take you to the MREP download page containing the link to the latest version.

<http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccessToDataApplication/MedicareRemitEasyPrint.html>

The **PC-Print** software is used by **Part A** customers. The most up-to-date version of PC-Print is 5.0.2 (not compatible with Windows XP). If you use Windows XP, you will need to download version 4.2.4.

- Go to the CGS website: <http://www.cgsmedicare.com/>
- Click on your Line of Business (Home Health & Hospice or KY & OH Part A).
- Click on EDI or Electronic Data Interchange on the left side of the page
- Click on Articles or Articles and Updates
- You will see the link ---
 - PC Print, v. 5.0.2 – Download Available

If you have time please, check out many other courses that may help improve your Medicare experience.


EDI System Status Log

The EDI System Status Log for CGS J15 is provided to assist you in determining if there are any system issues.

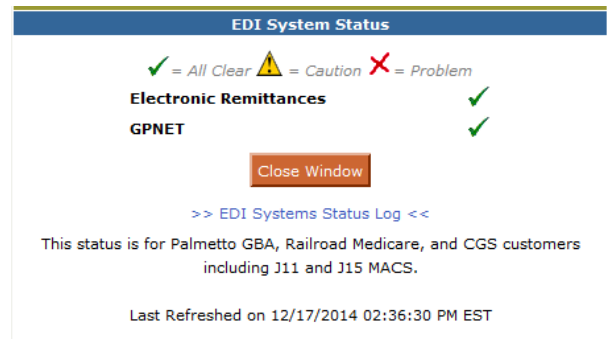
To view the status log:

1. Go to the CGS website: <http://www.cgsmedicare.com/>
2. Click on your Line of Business (Home Health & Hospice, KY & OH Part B, or KY & OH Part A).
3. Click on Quick Links to expand.

QUICK LINKS + | -
CLICK TO EXPAND/COLLAPSE

- **EDI System Status** 

4. Click on the EDI System Status link.



The screenshot shows a window titled "EDI System Status". At the top, there is a legend: a green checkmark for "All Clear", a yellow triangle for "Caution", and a red X for "Problem". Below this, the status for "Electronic Remittances" is shown as "All Clear" with a green checkmark. The status for "GPNET" is also shown as "All Clear" with a green checkmark. A "Close Window" button is visible. At the bottom, there is a navigation link ">> EDI Systems Status Log <<". A note states: "This status is for Palmetto GBA, Railroad Medicare, and CGS customers including J11 and J15 MACS." The last refresh time is "12/17/2014 02:36:30 PM EST".

The front page will show if the Electronic Remittances or GPNET are all clear, have a caution, or have a problem. If there is a caution or problem, a message will show as to what the issue is for each one. You may click on the >>EDI Systems Status Log<< link to view more information on open issues or scroll through resolved issues.

ICD-10 Testing

Acknowledgement Testing

Have you begun testing your software for ICD-10? Medicare is quickly approaching the ICD-10 Implementation Date. The MLN article <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1435.pdf> contains information concerning Acknowledgment and End-to-End Testing. Our EDI helpdesk is available to assist with your questions about ICD-10 testing.

FAQs—International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing

Physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing should review the following questions and answers before preparing claims for ICD-10 end-to-end testing to gain an understanding of the guidelines and requirements for successful testing. Read more...

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1435.pdf>

myCGS Password Requirements

myCGS enforces the following password policy.

Passwords are case sensitive and:

- Must be at least 8 characters long
- Must contain an uppercase letter
- Must contain a lowercase letter
- Must have at least one of the following special characters
 - @, #, or \$
- Must contain numbers (0-9) and letters (A-Z, a-z)
- Must start with a letter

- No leading portion of first or last names may occur
- Must be changed every 60 days
- Cannot contain spaces
- Must be different from the previous 13 passwords
- Must contain at least 4 different characters than
 - the previous password

For additional information please visit our website. http://www.cgsmedicare.com/pdf/mycgs_passwordquickrefguide.pdf

Direct Data Entry (DDE) IDs

Direct Data Entry provides immediate access to claims processing and beneficiary eligibility information for Medicare providers. Each person accessing the system must have their own unique ID assigned by our Security Department which can be used for multiple provider numbers. For security reasons you should not share your DDE or PPTN User ID. If the employee leaves the company the ID should not be reassigned to another individual within the company. It is the responsibility of the provider to notify the CGS EDI Help Desk if this situation occurs.

What is a Response Report?

Since the adoption and implementation of the 5010 version of the 837 transaction there has been many changes. One of the major changes was the method from which acceptance or rejection of claims is determined. Although there are many different levels of edits that claims go through, rejections on the 999 and 277CA levels are most common. Either of these types of rejections can impact your practice financially since they prevent claims from going into the adjudication system.

A 999 level rejection may cause the whole file or batch to reject. These are usually caused by something important missing or in the wrong place and are best solved by taking the issue to your software vendor. A 277CA level rejection is usually caused by something being invalid such as a HCPCS or Diagnosis code. A 277CA level rejection may cause one claim in error to reject, not the whole batch. They can usually be fixed by reviewing the error, replacing the incorrect data with valid data and resubmitting the claim.

It is important to check your response reports to ensure that there are no rejections on either the 999 or 277CA levels. This will give you the best perspective on whether your claims made it into the adjudication system correctly. Both the 999 and 277CA are automatically sent in their original ANSI format, which makes

for a challenging time to read and interpret. It is recommended that you obtain a response report (999, 277CA) reader program through your software vendor in order to have the capability to open and interpret your 999 and 277CA in a legible format.

From the MLN: "Important Information Concerning Medicare Outreach Efforts to Supplemental Payers Directing Their Payments to Incorrect Addresses" MLN Matters Article Released

MLN Matters Special Edition Article #SE1212, "**Important Information Concerning Medicare Outreach Efforts to Supplemental Payers Directing Their Payments to Incorrect Addresses** (<http://www.cms.gov/MLNMattersArticles/Downloads/SE1212.pdf>)," has been released and is now available in downloadable format. This article is designed to provide education on issues related to supplemental payers directing payment to incorrect addresses, and includes different scenarios to illustrate these issues and guidance providers can use to avoid them.

Requesting a Submitter ID number for ALL clients for existing Trading Partners

If you are an existing approved 5010 Trading Partner and would like to request **ONE Submitter ID number for all your clients**, please see the steps below.

Based on your specific condition:

- **Part A/HHH**

If you have been approved for Part A 5010 then you are automatically approved for HHH and vice versa. If you are a Part A Trading Partner and would like a separate submitter ID number for your Ohio-A (OHA) versus Kentucky-A (KYA) or Home Health & Hospice (HHH), please submit a letter of request on company letterhead indicating you are requesting to be assigned a separate submitter ID number for the segment line of business chosen. Please be specific in indicating if this submitter ID number should be assigned for claims (837 files), electronic remits (835 files), or both.

The request must also include the EDI contact information (name of person & email), name of Clearinghouse (which will go in owner name of EDI application once we assign a submitter number), the address of clearinghouse we have on file, and signed by an authorized official.

- **Part B**

If you are a Part B Trading Partner and would like a separate submitter ID number for your Ohio-B (OHB) versus Kentucky-B (KYB) clients, please submit a letter of request on company letterhead indicating you are requesting to be assigned a separate submitter ID number. Please be specific in indicating if this submitter ID number should be assigned for claims (837 files), electronic remits (835 files), or both. The request must also include the EDI contact information (name & email), name of Clearinghouse (which will go in owner name of application once we assign a submitter number), the address of clearinghouse we have on file, and signed by an authorized official.

Once you have been assigned a Submitter ID number you will receive confirmation via mail or email. If the confirmation is emailed, the first email will include your new Submitter ID number and confirmation statement. The second email will include your password to access the GPNet system.

You may then access the EDI Application located on our website <http://www.cgsmedicare.com/partb/edi/enrollment.html> and complete it in the same manner as you have done with others in the past. Please place the new Submitter ID number in the Submitter ID number. The Billing Service or Clearinghouse's name must be entered in the **OWNER NAME** field.

Part A COBC Issues

	Error Code	Error Message	Invalid Values	Resolution
1	H25375	'The Billing Provider Address must be a street address. Post Office Box or Lock Box addressed are to be sent in the Pay-to-Provider Address	2010AA N302 2010AA N301	The Billing Provider Address must be a street address
2	N22223	Claim does not meet selection criteria		The claim does not meet the selection criteria for crossover
3	H54241	Claim Adjustment Reason Code '18' can only be used with Claim Adjustment Group Codes 'OA'.	'2430 CAS01 2320 CAS01	Condition Code "18" can only be used with Claim Adjustment Group Code "OA" Other Adjustments 2430 CAS01 2320 CAS01
4	H51000	The Procedure Code '%a' is not a valid CPT or HCPCS Code for this Date of Service.	'01', '521', 'V2878', 'G5942', '93672', 'ROOM', '885', '54760', 'R B', 'G1962', '0125', 'SW', '3614', '87048', '82250', 'J2912', 'G9183', 'RVA41', 'RHA2D', '260 0', '99303', '90622', 'A0098', '82025', 'G5645', 2400 SV202	A valid Procedure Code for the Date of Service must be submitted.
5	H50002	'Invalid State/Province Code ('%a')	'XX', 'BC' 2010BA N402	Submit a valid State/Province Code in the 2010BA N402

Part B COBC Issues

	Error Code	Error Message	Invalid Values	Resolution
1	H51000	The Procedure Code '%a' is not a valid CPT or HCPCS Code for this Date of Service	'G0471', 'B7035', 'G8748', 'B8783', '98910', '3331X', '75949', '4177X', 'C8540', '92214', 'T1787', '97030', 'L0500', 'G8440', '90827', '9083Y', 'XXXXX', '99990', '99941', '8CC70', '73137', '9894A', '92110', 'G8370', 'C8730' 2400 SV101 2430 SVD03	Must submit a valid Procedure Code for the Date of Service
2	W25211	The '%a' is required when the entity is a person and the entity has a first name.	'2420E NM104 ('Ordering Provider First Name') 2420F NM104 ('Referring Provider First Name')	The First Name of the ordering or referring physician is required
3	H25375	'The Billing Provider Address must be a street address. Post Office Box or Lock Box addressed are to be sent in the Pay-to-Provider Address	'2010AA N301 2010AA N302	The Billing Provider Address must be a street address
4	H12034	Element repetition separator found in non-repeating element.	'2300 CLM01 2400 SV101 2400 NTE02 2300 NTE02	The element repetition separator is found in a non-repeating element
5	H54241	Claim Adjustment Reason Code '18' can only be used with Claim Adjustment Group Codes 'OA'.	'2430 CAS01	Condition Code "18" can only be used with Claim Adjustment Group Code "OA" Other Adjustments 2430 CAS01 2320 CAS01