EDI CONNECTION

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277CA Report CGS ACE Smart Edits Enhancements

CGS has successfully implemented several enhancements to the 277CA report, as part of our CGS Advance Communication Engine (ACE) Smart Edits.

CGS ACE Smart Edits is a process that returns pre-adjudicated claims information through claim acknowledgement transaction reports based on the Medicare 277CA. This system populates the STC*12 segment in the 2220D loop of the 277CA.

Most claims hitting the CGS ACE pre-adjudication editing process are not forwarded to the claims adjudication system. After reviewing these claims, you will decide if you should update or not update the claim then resubmit the claim for processing. Some claims may hit a CGS ACE Informational Smart Edit that returns important messaging for your practice while allowing the claim to forward to the claims processing system. We encourage you to review your 277CA report for these messages. To find out more about the enhancements and get a list of the active CGS ACE Smart Edits, read the following article:

https://www.cgsmedicare.com/partb/pubs/news/2020/04/cope16935.html

Google Authenticator: A New Way to Access myCGS!

Multi-factor Authentication (MFA) is the additional level of security myCGS requires before users can gain access to the portal. Instead of receiving your MFA code via text or email, you may now use the Google Authenticator app on your mobile devices! The app is available for download in the App Store (Apple) and Android Play Store (Android). For step by step instructions click the following link: https://www.cgsmedicare.com/partb/pubs/news/2020/10/cope19154.html

myCGS Enhancement: Part A Claims Practice Addresses

On June 1, 2019, Part A Outpatient Prospective Payment System (OPPS) hospital providers can use the myCGS Portal to confirm that the practice addresses submitted on their claims are an exact match to PECOS to help avoid/correct any Return to Provider (RTP) claims. For more information please visit https://cgsmedicare.com/parta/pubs/news/2019/06/cope12729.html.

myCGS Administrators: Recertification of Users

To ensure all myCGS users are compliant with updated Centers for Medicare & Medicaid Services (CMS) security requirements, account recertification is required to be completed by the Provider Administrator. This task must be completed every 90 days. A notification pop-up message will display upon login within 47 days of the date recertification is due. Failure to complete the process timely will result in an interruption of service, including deactivation. The user cannot access myCGS until the recertification is completed. This process applies to the Provider Administrator as well.

The Question often asked is…...*Where is the recertification button?*

To recertify an account: From the “Admin” tab; scroll to the bottom of the page and select the “Recertify Users” button.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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myCGS Profile Verification

Each myCGS user must complete a Profile Verification on each account per CMS
and CGS security guidelines every 250 days. Failure to complete this process can
result in interruption of service including deactivation. An email will be sent notifying the user. These steps must be followed by the myCGS user to complete the Profile Verification process:

- Log into the portal and complete the MFA process
- Once logged in, a pop-up box will state profile verification is required
- Click on the My Account Tab on the upper far-right side
- Review all information on the page to be sure it is correct
- Scroll down to the bottom and click submit
- Message will appear advising an email will be sent to the user
- User will automatically be logged out of the portal
- Close the myCGS log-in screen
- Open the email provided by myCGS and click on the verification link
- The user will be re-directed to the log-in page on myCGS
- Log back into the portal
- Profile has now been verified

myCGS Web Portal Registration

Looking for a one stop spot to access all beneficiary information such as Eligibility, Remittances, MBI numbers, view claims, as well as send Reopenings (PTB only), Redeterminations, and respond to ADR letters, then the myCGS Portal is it!! It is a quick and easy process to sign up. All providers need is their Group PTAN, NPI, Tax ID Number, demographic information and the most recent Medicare payment amount received. We ask that you review the myCGS Registration Checklist at https://www.cgsmedicare.com/partb/mycgs/mycgs_checklist.pdf for step by step guidance on registering for the myCGS portal. Please contact the EDI Helpdesk for the most recent payment amount. Once registered you will be issued a username and password to access the portal to login and use for your Medicare needs.

myCGS User ID Information

The Center of Medicare Medicaid Services (CMS) requires user authentication through user ID and password. This unique User ID and password is associated with a user's name, answers to security questions and email address. Therefore; It is against CMS guidelines to access the myCGS portal with a User ID that was not assigned to you. Every User must have their own user id and password. Considering this guideline; keep the following in mind:

- **Physician Does Not use:** myCGS User id should be assigned only to active users. If a physician is assigned an ID as stated above, no other user should be using the physician's user ID.

  Additional users can be added and assigned their own unique user ID (see myCGS User Manual, Admin Chapter-Adding New Users)
- **User has left the group:** If the Administrator is still active, deactivate the user. (see myCGS User Manual, Admin Chapter-Deleting a User)
- **Administrator No Longer with Group:** If there is another active Administrator under this group, have that active administrator deactivate that administrator that is leaving. If no other administrator -contact the EDI Help Desk to request deactivation.
- **Administrator will be leaving the Group:** If there is not another assigned administrator for the group, prior to leaving, have new administrator added.

If you have any questions, please contact us:

- EDI Help Desk
  - Part A: 1.866.590.6703 (Option 2)
  - Part B: 1.866.276.9558 (Option 2)
  - Home Health and Hospice: 1.877.299.4500 (Option 2)

Check Points for Filling Out the J15 DDE PPTN Application/Reactivation Form

- Choose the line of business (LOB), only select one (1) LOB and enter the Date
- Select the Action Requested
- Enter the Entity Name
- Choose the Type of Entity- if you select Individual Provider the provider Address must match our system
- Enter the EDI Contact Person name
- Enter the Phone and Fax numbers
- Select if the User is located outside the United States- If "Yes" you must attach a copy of your network connectivity diagram
- Enter the Address, City, State and Zip Code of the Entity or Group Practice/Provider
- Enter the E-mail Address (Note: E-mail is required and will be the primary method of communication)
- Enter the Group Practice/Provider Name, Group Provider Number (PTAN) and Group NPI
- Enter the User First Name, Middle Initial, Last Name and Existing ID, Enter "NA" or "New" if user is applying for a new RACF ID.
- Signature is required (no stamp or digital signature)

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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	X223.424.2400.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."
3	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.""
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	X223.143.2300.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) for each other payer occurrence."
7	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
8	X223.088.2010AA.N403.030	This claim is rejected for containing Invalid Information within the Billing Provider's Postal Zip Code	Verify a valid 9 digit zip code is listed in the N403 segment for Billing Provider in 2010AA.
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	X223.381.2330A.N403.030	This Claim is rejected for Invalid Information within the Other Insured's Postal/Zip Code.	2330A.N403 must be a valid postal/zip code when N404 equals US or blank.

Part B Top 10 Edits

	Edit Number	Business Edit Message	Resolution
1	X222.423.2410.LIN03.025	INVALID NATIONAL DRUG CODE (NDC)	This claim is rejected for having an NDC code that is not 11 digits
2	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.
3	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.
4	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."

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	Edit Number	Business Edit Message	Resolution
5	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."
6	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."
7	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"
8	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
9	X222.087.2010AA.NM108.020	This claim is rejected for missing information in the Identifier Qualifier's Billing Provider's NPI (National Provider ID)	This claim is rejected for missing information in the Identifier Qualifier's Billing Provider's NPI (National Provider ID)
10	X222.087.2010AA.NM109.030	This Claim is rejected for Invalid Information in the Billing Provider's NPI (National Provider ID)	The Billing Provider Identifier in the 2010AA.NM109 must be valid on the NPI Crosswalk.

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