WINTER 2022

# EDI CONNECTION

## Contents


myCGS Offers a Better Solution! ..... 1

Need Help Understanding the 277CA Rejection? ..... 1

Check Points for Filling Out the J15 DDE PPTN Application/Reactivation Form .... 2

System Requirements for myCGS ..... 2

myCGS Messaging ..... 2

Part A Top Ten Edits ..... 3

Part B Top 10 Edits ..... 3


## myCGS Offers a Better Solution!

Are you still using the phone or paper to meet your Medicare claim needs? myCGS is a FREE, online self-service application available to ALL J15 providers that offers a better solution! Use myCGS to:

1. Save calls to the Provider Contact Center (PCC) for more complex inquiries:
   - Obtain a beneficiary's Medicare Beneficiary Identifier (MBI)
   - Determine if a beneficiary is eligible to receive an item/service
   - Check a claim's status
   - View/print a remittance advice
2. Save paper, time, and money:
   - Submit claims and reopenings (Part B) or Credit Balance Reports (Part A/HH&H)
   - Respond to a Medical Review Additional Documentation Request (ADR)
   - Request prior authorization, immediate offset, or an appeal
   - Receive a confirmation and check the status of a submission/request submitted via the myCGS portal!

What are you waiting for? Register today (https://www.onlineproviderservices.com/cgs_ops/initCreateNewUser.do) and access the myCGS User Manual (https://www.cgsmedicare.com/mycgs/mycgs_user_manual.html) for step-by-step instructions!

## Need Help Understanding the 277CA Rejection?

### 277CA Edit Lookup Tool

The 277CA Edit Lookup Tool allows Trading Partners, billing services, providers, and clearinghouses to view easy-to-understand descriptions associated with the edit code (S) returned on the 277CA – Claim Acknowledgement for 5010A1 claims. The tool allows you to enter the edit codes and will return possible explanations for the cause of the edit.

Enter the edit information located in the STC segment or reported on your acknowledgement file into the **5010A1 277CA Edit Lookup Tool** and click Submit.

Example: **STC*A7:562:85**U*1983~**

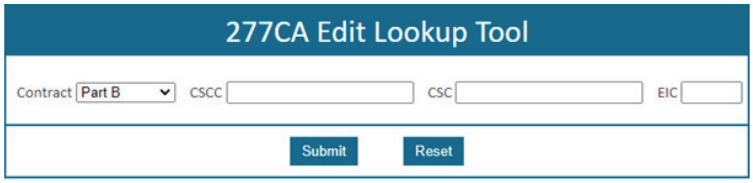
**A7** = CSCC (Claim Status Category Code)

**562** = CSC (Claim Status Codes)

**85** = EIC (Entity Identifier Code)

The results will be return below the search fields and will display all possibilities for the cause of the edit.

For additional instructions, please refer to 277CA EDI User Guide PDF.







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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

## 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 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)

## System Requirements for myCGS

To optimize usability of myCGS, we recommend that users verify their system adheres to the following requirements:

### Operating System

- Windows 10 (latest security patches)
- Mac OS X 11.x or above

### Supported Internet Browsers

- Microsoft Edge
- Google Chrome: Version 98.x and above

### Recommended Screen Resolution

1024x 768

### Additional Requirements

- Adobe Acrobat Reader Version DC or Adobe Acrobat Pro Version DC
- JavaScript enabled
- Compatibility view disabled
- Pop-up blocker disabled
- Use TLS 1.2 selected in browser settings

**Note:** Although myCGS may still be accessible without meeting these requirements, only the options above are supported. Failure to meet these requirements may adversely affect the functionality and layout of myCGS.

## myCGS Messaging

### Using the Inbox Folders and Filtering in the Messages Tab

You may access the messages, sent to the PTAN/NPI that you are registered under, by either selecting the Messages tab or Retrieve Messages displayed in the Message Bar.

#### Inbox Folders

In the Inbox Folders, myCGS defaults to display all messages delivered to your inbox. Each message is sorted to the appropriate folder for allowing quick access for review. These folders are:

- ADRs – Correspondence, Financial, Redeterminations
- Audit and Reimbursement – Customer Service, Medical Review, Reopenings
- Claim Inquiries – Education, Prior Auth, myCGS

To find a specific type of letter, select the specific folder.

**Note:** Messages will automatically be moved to ARCHIVED MESSAGES after 60 days. Messages will not be available after 365 days.

#### Inbox Filtering

Inbox Filtering allows you to search the inbox for a specific message or letter or filter the inbox by:

- Claim Number
- Date
- E-Letters
- Medicare ID
- Submission ID

Select Message Inbox. Under the drop down, select the filtering option. Enter the criteria, then click Filter button.

**NOTE:** Confirmation messages for Claim Inquiries are not available when filtered by MBI or Claim Number. However, they can be found in the Claim Inquires folder. Also, when in the ADR folder, you can filter those related to MR and unrelated MR; in addition to those related to the Prior Authorization program.

## Part A Top Ten 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 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." |
| 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 | X223.423.2400. LX01.030 | This Claim is rejected for the Service line number greater than maximum allowable for payer. | 2400.LX01 must be > 0 and <= 449 |
| 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 | X223.184.2300. HI01-2.065 | "This Claim is rejected for the Acknowledgement/ Rejected for Invalid Information… Principal diagnosis code" CSC 509: External Cause of Injury" | If 2300.HI01-1 = ABK, then 2300.HI01-2 must not begin with a "V," "W," "X," or "Y." |
| 8 | X223.088. 2010AA. N403.030 | This Claim is rejected for the Acknowledgement rejected for Invalid Information Billing provider zipcode. | 2010AA.N403 Billing provider zip code must be a valid 9 digit zip code |
| 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 | X223.143.2300. CLM05-3.020 | This claim is rejected for Type of bill for UB claim. | 2300.CLM05-1 must be the 1st and 2nd positions of a valid Uniform Bill Type 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 | X222.273.2310C. N403.020 | This Claim is rejected for Invalid Information for a Service Location's Postal/Zip. | 2310C.N403 must be a valid 9 digit Zip Code. |
| 3 | X222.262.2310B. NM109.030 | CSC 400: "Claim is out of Balance" | 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." |

| | Edit Number | Business Edit Message | Resolution |
|---|---|---|---|
| **5** | X222.430.2420A. NM109.030 | This Claim is rejected for Invalid Information within the Rendering Provider's National Provider Identifier (NPI) | Valid NPI Crosswalk must be available for this edit. Coach NPIs will not be present on the NPI xwalk, when REF02 = 82 the coach NPIs are excluded from this edit. |
| **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. SV103.020 | This Claim is rejected for Invalid Information submitted inconsistent with billing guidelines for the Unit or Basis for Measurement Code. | 2400.SV103 must be “MJ” when SV101-3, SV101-4, SV101-5, or SV101-6 is an anesthesia modifier (AA, AD, QK, QS, QX, QY or QZ). Otherwise, must be “UN.” |
| **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. |