EDI CONNECTION

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IVR Beneficiary Eligibility

To protect beneficiaries from Medicare fraud, Medicare Administrative Contractors (MACs) must disable beneficiary eligibility information from their Interactive Voice Response (IVR) systems by March 31, 2025.

CGS will disable IVR beneficiary eligibility information on **February 28, 2025, at 5 pm CT (6 pm ET)**.

You must check your patient's eligibility using:

- myCGS portal (https://cgsmedicare.com/mycgs/index.html)
- Billing agencies, clearinghouses, or software vendors
- HIPAA Eligibility Transaction System (HETS) (https://www.cms.gov/data-research/cms-information-technology/hipaa-eligibility-transaction-system)
- Direct Data Entry inquiry option 10 (Part A & HHH providers)
- Professional Provider Telecommunications Network (Part B providers)

As a reminder, Customer Service can't provide eligibility information and must refer callers to these options.

See the Checking Medicare Eligibility fact sheet (https://www.cms.gov/files/document/mln8816413-checking-medicare-eligibility.pdf) or CMS instruction (https://www.cms.gov/files/document/r12858otn.pdf) for more information.

myCGS: How Do I...?

The J15 A/B & HHH MAC portal, myCGS, offers a variety of online capabilities to serve the needs of our health care providers and staff. The myCGS User Manual provides step-by-step instructions for each. Access the links below to learn more.

- **Log In –** The URL to log in to myCGS recently changed. Please use the following URL and update any bookmarks or favorites: https://www.onlineproviderservices.com/cgs_ops/initLoginV2.do.
- **Account Recertification vs. Profile Verification –** Read system messages carefully to ensure you complete the appropriate process.
  - System message: "In order to maintain your access, you must complete the recertification process by MM.DD.YYYY. This process must be completed every 360 days."
    - See the "Account Recertification" instructions. https://www.cgsmedicare.com/mycgs/ssi/admin/recertification.html
  - System message: "In order to maintain your access, you must complete the profile verification process by MM.DD.YYYY. This process must be completed every 250 days."
    - See the "Profile Verification" instructions. https://www.cgsmedicare.com/mycgs/ssi/myaccount/profile_verification.html
- **Provider Administrator vs. Provider User –** Provider Administrators are responsible for managing your organization's myCGS account(s). CGS recommends at least two Provider Administrators for each PTAN/NPI combination to complete the tasks listed below. See the Admin tab for details. (https://www.cgsmedicare.com/mycgs/mycgs_user_manual_admin.html#admin_main)

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

- Approve or decline user requests to access provider accounts and myCGS functions
- Add or delete users and modify user access without a request
- Unlock Provider Administrator and Provider User IDs (due to not logging in at least once every 30 days or after three unsuccessful login attempts within 120 minutes)
- Complete the account recertification process every 360 days (to verify compliance with CMS security requirements and maintain all users' access)
- Choose whether your organization receives CGS correspondence via myCGS only or myCGS and US mail.

Provider Users should address any questions or concerns with their Provider Administrator before contacting CGS. If your Provider Administrator can't resolve an issue, please call the EDI Help Desk for assistance. You must enter a valid NPI, PTAN, and last 5 digits of your Tax ID to speak with a representative.

- **View an ADR –** CGS sends an Additional Documentation Request (ADR) letter when a claim is subject to medical review. Use the Medical Review tab to identify, respond, and perform other functions associated with such a request. https://www.cgsmedicare.com/mycgs/mycgs_user_manual_mr.html#mr_main

Part A Top 10 Edits

	Edit Number	Business Edit Message	Resolution
1	X223.423.2400.LX01.030	This Claim is rejected for the Service line number greater than maximum allowable for payer.	Do not submit more than 449 service lines on a claim.
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	X223.112.2010BA.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.
4	X223.143.2300.CLM05-1.020	A7: "Acknowledgement /Rejected for Invalid Information…" CSC 228: "Type of bill for UB claim"	2300.CLM05-1 must be the 1st and 2nd positions of a valid Uniform Bill Type Code.
5	X223.184.2300.HI01-2.065	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 254: "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".
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	X223.387.2330B.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."
8	X223.345.2310E.N403.030	This Claim is rejected for Invalid Information within the Service Location's Postal/Zip Code. Verify Postal/Zip Codes for the Service Location on the USPS website prior to submitting claims	2310E.N403 must be a valid 9 digit zip code.
9	X223.284.2300.HI04-2.010	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 725: "NUBC Value Code(s)"	If 2300.HI04-1 is "BE" then 2300.HI04-2 must be a valid Value code on the receipt date and is within the codes effective and termination date.
10	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

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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	This Claim is rejected for Invalid Information for a Subscriber's contract/member number. The 2010BA NM109 must be an MBI.
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 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	X222.305.2320. AMT.030	CSCC A6: "Acknowledgement/Rejected for Missing Information…" CSC 286: "Other payer's Explanation of Benefits/payment information"	If 2000B.SBR01 = "S" then one 2320 loop with an AMT segment with AMT01 = "D" must be present.
6	X222.087.2010AA. NM109.050	CSC 286: "Other payer's Explanation of Benefits/payment information"	2010AA.NM109 billing provider must be "associated" to the submitter (from a trading partner management perspective) in 1000A.NM109.
7	X222.226.2300. HI01-2.050	CSCC A7: "Acknowledgement/Rejected for Invalid Information…" CSC 254: "Principal diagnosis code"	This Claim is rejected for Invalid Information within the Primary diagnosis code
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.

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