



Summer 2012

IMPORTANT:

5010 Electronic Claim Submission

On March 15, 2012, the Centers for Medicare & Medicaid Services (CMS) announced that it will not initiate enforcement action until July 1, 2012, with respect to any HIPAA covered entity that is not in compliance with the Accredited Standards Committee X12 Version 5010, NCPDP Telecom D.0 (NCPDP D.0), and NCPDP Medicaid Subrogation 3.0 (NCPDP 3.0) standards. This means that non-compliant covered entities will not incur monetary fines until July 1, 2012.

On March 22, 2002, an additional Technical Direction Letter announced that to ensure that Medicare Fee-For-Service (FFS) will be fully compliant with all the Accredited Standards Committee X12 Version 5010, NCPDP Telecom D.0 (NCPDP D.0), and NCPDP Medicaid Subrogation 3.0 (NCPDP 3.0) standards, Medicare claims administration contractors shall immediately modify their systems to not reject any Part A or Part B transactions for failing to use Version 5010 until July 1, 2012. This means that submitters may continue to submit claims in Version 4010, although this is highly discouraged by your MAC, and we will do everything possible to assist you in becoming 5010 compliant.

CGS has already taken steps to identify and reach out to submitters who are not yet successfully submitting Version 5010. Medicare FFS will also be hosting additional National Provider

Calls (NPC). Once information for these calls is finalized, CGS will advise submitters of the details.

The goal of the additional 90 days of not initiating enforcement action is to ensure 100 percent of all submitters are compliant with Version 5010 by July 1, 2012.

Our website <http://www.cgsmedicare.com/> will continue to post notifications and tips toward successful compliance with Version 5010.

Contact Numbers for Jurisdiction 15 A/B MAC Contract

Home Health & Hospice Contact Information	
States: Colorado, Delaware, DC, Iowa, Kansas, Maryland, Missouri, Montana, Nebraska, North Dakota, South Dakota, Pennsylvania, Utah, Virginia, West Virginia, and Wyoming	
Electronic Data Interchange (EDI)	1.866.758.5666 8:00 a.m. – 4:30 p.m. (CT)
Fax number for EDI applications and forms (preferred method)	1.615.664.5947
Interactive Voice Response (IVR) System IVR User Guide	1.877.220.6289
Home Health Complex Inquiries	1.877.299.4500 8:00 a.m. – 4:30 p.m. (CT)
Hospice Complex Inquiries	1.866.539.5592 8:00 a.m. – 4:30 p.m. (CT)
Telecommunications Devices for the Deaf	1.866.854.1876

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Kentucky & Ohio Part A	
Electronic Data Interchange (EDI)	1.866.758.5666 8:00 a.m. – 4:30 p.m. (CT)
Fax number for EDI applications and forms (preferred method)	KY: 1.615.664.5943 OH: 1.615.664.5945
Interactive Voice Response (IVR) System IVR User Guide	1.866.289.6501
Provider Customer Service	1.866.590.6703 8:00 a.m. – 5:00 p.m. (ET)
Telecommunications Devices for the Deaf	1.855.294.9889

Kentucky Part B	
Electronic Data Interchange (EDI)	1.866.758.5666 8:00 a.m. – 4:30 p.m. (CT)
Fax number for EDI applications and forms (preferred method)	1.615.664.5917



Interactive Voice Response (IVR) System IVR User Guide	1.866.290.4036
Provider Customer Service	1.866.276.9558 8:00 a.m. – 5:00 p.m. (ET)

Ohio Part B	
Electronic Data Interchange (EDI)	1.866.758.5666 8:00 a.m. – 4:30 p.m. (CT)
Fax number for EDI applications and forms (preferred method)	1.615.664.5927
Interactive Voice Response (IVR) System IVR User Guide	1.866.290.4036
Provider Customer Service	1.866.276.9558 8:00 a.m. – 5:00 p.m. (ET)

Using Hyperterminal to Download 999 and 277CA Reports Into the PCace Pro32 Software

After logging into GPNet and at the Main Menu:

1. Choose Download and press **enter**
2. Choose Z for ZModem and press **enter**
3. You will be ask if you wish to download all files in the mailbox, type **N** to list all of the files in your mailbox.
4. Path to Download a 999 into PCace
5. Click **Transfer**
6. Click **Receive File**
7. Click **Browse**
8. Double-click the **(C) Drive**
9. Double-click **WINPACE**
10. Double -click **ANSI997**
11. For Professional, click once **ACK1500**
12. For Institutional, click once **Ackub92**
13. Click **OK**, then **Close**
14. Path to Download a 277CA into PCace
15. Click **Transfer**
16. Click **Receive File**
17. Click **Browse**
18. Double-click the **(C) Drive**
19. Double-click **WINPACE**
20. Double-click **ANSI277**
21. For Professional, click once **Stat1500**
22. For Institutional, click once **Statub92**
23. Click **OK**, then **Close**

You will then see the list of files in your mailbox and will need to choose the number corresponding with the file you would like to download.

When the file has been transferred to the appropriate folder you will receive the message "Transfer Completed Successfully."

Helpful Tips Concerning EDI Enrollment Application Set-Ups

- **5010 COMPLIANCE:** As of July 1st, 2012 you must be 5010 compliant. New setups for 4010 will be rejected
- **TESTING NEW SOFTWARE:** Providers, after your software vendor has completed testing you must notify CGS before you begin sending in 5010 production claims or receiving 5010 production electronic Remittance Notices. You may contact our EDI helpdesk at 1.866.758.5666.
- **SETUP TIMEFRAME:** CGS has 20 business days to complete an EDI application. You will receive a letter or email from CGS confirming its completion.
- Make sure all paperwork is complete, as you will be setup exactly as indicated on your forms. Also, fax paperwork only once. Duplicate faxes and submissions lengthen the setup processing time.
- **EFT APPLICATION CONFIRMATION:** To check the status of an **EFT** application, please contact Customer Service at:
 - See page 1 for Contact Numbers
 - **Hours of Operation:** 8:30 am - 4:30 pm CT, Monday – Friday

The Importance of Response Reports and Your Practice

Checking your claim response reports is one of the most important steps you can take to keep your cash flow running smoothly. I am sure we have all arrived home from a store to find out that we have paid too much for an item after thoroughly examining the receipt. Then you have to get back in your vehicle and drive back to the store, hours or sometimes days later and haggle with customer service to get things squared away. We all have friends or relatives who spend way too much time going over every portion of the receipt to make sure they did not pay a penny more for their items than they were supposed to. Response reports deserve this kind of attention and cannot be "hoped" into making it into the adjudication system to eventually be paid.

Your response reports have vital information about the status of your claims. Transmitting claims without thoroughly reviewing and understanding the response reports is nothing but a financial gamble for your practice. You need to evaluate for yourself whether or not you can afford such a gamble. You may hope that your claims go through and are paid, but cannot base your cash flow on hope right? Because we know that regardless of timely cash flow coming in, there will still be cash flow going out on a regular basis to pay the bills. If a claim or batch of claims rejects it **WILL NOT** get paid. It will not even make it into the adjudication system to be paid until is corrected and/or retransmitted.

Understanding your response reports is important to your practice. Especially with the implementation of ANSI 5010, response reports can require a few more steps to open, read, and interpret correctly. If you are using third party software, your vendor can often get you a 999 and 277ca reader to help you interpret the 5010 response reports correctly. The latest version of PCACE PRO32 can be used to read and the 999 and 277ca reports. Instructions can be found here: http://www.cgsmedicare.com/kyb/pubs/mb_J15/2012/01_2012/PDFs/CGS%20Pro32%20999%20277CA%20reports%20_3_.pdf. If for some reason you cannot figure out the rejection reason and your third party cannot help you, please give us a call at 1-866-758-5666 with some information about the transmission time frame and we will be more than happy to help you identify and correct the rejected claims(s).

Set yourself up with a reminder to check your response reports when you transmit your claims. In many practices, there is so much going on that downloading and reviewing response reports is just looked at as an unnecessary step in dealing with the Medicare Claims Process. If you have trouble remembering to review the response reports, set yourself up with a Microsoft Outlook reminder or other calendar reminder. Smartphones often have reminder functions that can be put to use for this as well. Not checking your response reports in a timely fashion may be money left on the table for your practice. Correcting and retransmitting claims only takes a few minutes and will pay off in dividends for your practice if you invest the time.

PCAce Pro32 Helpful Hints

How to update your PCAce Pro32 software to the 5010 version:

- Go into Reference File Maintenance
- Click **Codes/Misc**
- Click **Submitter**
- Click correct **Claim Type**
- Choose correct **LOB** and **Submitter ID**
- Click **View/Update**
- Click **Prepare**
- Right click on **ANSI Version (837)** and choose correct **5010 version**
- Click **Save**

Also remember after updating to the 5010 version to go to the Provider information in the Reference File Maintenance and change the Billing Provider address from PO Box to the street address and add the last 4 digits to the zip code. This also applies to the Service Facility address in Codes/Misc, Facility.

Remittance Advice Reruns

We get numerous requests for remittance advice reports. To better serve you, you can help us to be able to more efficiently research your remittance issues if you will have the following information readily available when you call our help desk:

- NPI number of the Pay-To Provider
- PTAN of the Pay-To Provider
- Check number
- Check Date
- Check amount

We understand that you may not always, due to circumstances, be able to provide all this information, but the more you can provide, the easier it is for us to research and to provide the correct remittance advice back to you.

Also, there will be times when it will not be possible for us to provide you with an electronic remittance file for your request. If the date you request is too old (over 60 days) or if the remit was not delivered originally due to unusual circumstances such as a setup issue that prevented the remittance from originally being created in the electronic format, it will only be possible to provide your remittance advice to you on paper. *When this happens, the remittance advice must be mailed to the Pay-To Provider address on file with CGS Provider Enrollment, even if the electronic file is normally picked up by a third party such as a clearinghouse or billing service.*

It is also important that you download your files in a timely fashion. Files will remain in your mailbox (or your third-party agent's mailbox) for fourteen (14) days from the original creation date, or until they are downloaded—whichever occurs first. If you have a file older than 14 days old reposted, it may not remain in your mailbox more than a day—because the **original** creation date is what the mailbox system uses to determine its aging for removing old files. If you request a file rerun, you should check regularly for that file to post to your mailbox and download it immediately when it does post.

HHH Providers: Change to Duplicate Remittance Advice Request Policy

Effective April 1, 2012, when a provider requests a copy of a remittance advice (electronic or paper) CGS will charge \$15.00 for each remittance advice requested. Requests will be completed within 45 business days of receipt. Requests must be submitted using the "Request for Duplicate Remittance Advice" form. Return this form and your check payable to "CGS Administrators, LLC" to the address provided on the form. For additional information, please refer to the "Change to Duplicate Remittance Advice Request Policy" article in the March 2012 HHH Medicare Bulletin at: http://www.cgsmedicare.com/hhh/pubs/mb_hhh/2012/03_2012/PDFs/HHH_2012_03.pdf

Top Errors for 5010 Jurisdiction 15 Part A

The chart below is the Top 5010 Errors for Part A and Home Health and Hospice:

Edit Description	999/277CA Rejection Description	Resolution
This claim is rejected for acknowledgement/rejected for Invalid information within the Revenue code for services rendered.	CSCC A7: "Acknowledgement /Rejected for Invalid Information..." CSC 455: "Revenue code for services rendered"	You must send a valid revenue code in 2430 SVD04. This is the line adjudication Information. This is Medicare Secondary (MSP) information.
This claims is rejected for the acknowledgement/rejected for; Invalid Information within the HCPCS	CSCC A7: "Acknowledgement /Rejected for Invalid Information..." CSC 507: "HCPCS"	The HCPSC (Health Care Financing Administration Common Procedural Coding System code must be a valid code on the date of service.
This claim is rejected for acknowledgement/rejected for Invalid Information submitted inconsistent with billing guidelines due to PR payer's additional/Secondary Identifier.	CSCC A7: "Acknowledgement /Rejected for Invalid Information..." CSC 732: "Information submitted inconsistent with billing guidelines." CSC 560: "Entity's Additional/Secondary Identifier." EIC: PR "Payer"	The 2010BB/ Other Payer loop should not include a REF segment.
Rejected due to a duplicate ST-Se submission		If you have previously submitted this file to CGS, please create a new file to submit to CGS. You must submit a new control number in ISA13, BHT03, ST and SE 02.
This claim is rejected for acknowledgement/rejected for relational field in error within the Billing Provider's National Provider Identifier (NPI) and Billing Provider's tax ID.	CSCC A8: "Acknowledgement/Rejected for relational field in error" CSC 562: "Entity's National Provider Identifier (NPI)" CSC 128: "Entity's tax id" EIC: 85 "Billing Provider"	The Tax Identification must match the NPI number of the billing provider.
This Claim is rejected for the acknowledgement/rejected for Invalid Information within the NCD Number.	CSCC A7: "Acknowledgement/Rejected for Invalid Information..." CSC 218: "NDC Number"	The National Drug code must be a valid code.
This claim is rejected for acknowledgement/rejected for relational field in error within the Billing Provider's National Provider Identifier (NPI).	CSCC A8: "Acknowledgement/Rejected for relational field in error." CSC 562: "Entity's National Provider Identifier (NPI)" EIC: 85 "Billing Provider"	The NPI number of the billing provider must be a valid number on the NPI crosswalk.
This claim is rejected for the acknowledgement/rejected for Invalid Information within the NUBC Value Code(s) and/or Amount(s).	CSCC A7: "Acknowledgement/Rejected for Invalid Information..." CSC 463: "NUBC Value Code(s) and/or Amount(s)"	The diagnosis code must be a valid diagnosis code for the date of service of the claim.
This claim is rejected for the acknowledgement/rejected for Invalid Information within the Claim is out of balance due to Line Item Charge Amount	CSCC A7: "Acknowledgement/Rejected for Invalid Information..." CSC 400: "Claim is out of balance: CSC 583: "Line Item Charge Amount" CSC 643: "Service Line Paid Amount"	The service line charge amount must equal the primary paid amount in the Line adjudication and the CAS adjustment amounts in the 2430. This information is located on the EOB from the primary payer.

Top Errors for 5010 Jurisdiction 15 Part B

The chart below is the Top 5010 Errors for Part B Kentucky and Ohio:

Edit Description	277CA Rejection Description	Resolution
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	CSCC A8: "Acknowledgement/Rejected for relational field in error" CSC 496: "Submitter not approved for electronic claim submissions on behalf of this entity." EIC: 85 "Billing Provider"	Please verify that the Billing Provider's Submitter ID has been approved to submit in the 5010 format for production with CGS.
This Claim is rejected for relational field Billing Provider's NPI (National Provider ID) and Tax ID	CSCC A8: "Acknowledgement/Rejected for relational field in error" CSC 562: "Entity's National Provider Identifier (NPI)" CSC 128: "Entity's tax id" EIC: 85 "Billing Provider"	Please verify that the tax ID and Billing Provider NPI matches what we have on file with Provider Enrollment at CGS.
This Claim is rejected for Invalid Information in the Billing Provider's NPI (National Provider ID)	CSCC A7: "Acknowledgement/Rejected for Invalid Information..." CSC 562: "Entity's National Provider Identifier (NPI)" EIC: 85 "Billing Provider"	Make sure to verify that the Billing Provider NPI is valid and on the Medicare Crosswalk for Payer ID 15102 and 15202. Then verify the Billing provider effective date is on or after the Date of service rendered in your file.
This Claim is rejected for Invalid Information for a Subscriber's contract/member number	CSCC A7: "Acknowledgement/Rejected for Invalid Information..." CSC 164: "Entity's contract/member number" EIC: IL "Subscriber"	Medicare number can only be 10 to 11 characters only. Here are the valid formats: NNNNNNNNNA or NNNNNNNNNA or NNNNNNNNNAN. If the patient's Medicare number is not in these formats. Your claim will reject on the 277CA.
This Claim is rejected for relational field Information within the Detailed description of service	CSCC A8: "Acknowledgement/Rejected for relational field in error" CSC 306: "Detailed description of service"	For NOC or non-specific procedure codes used, a description of the service rendered is required. This description must be sent on the Service Line (2400 SV101-7). See example below.
This Claim is rejected for relational field Information within the HCPCS	CSCC A7: "Acknowledgement/Rejected for Invalid Information..." CSC 507: "HCPCS"	Please verify that the HCPCS code is valid and active for the date of service. Some HCPCS codes are no longer valid or active for Medicare
This Claim is rejected for Invalid Information within the Claim Frequency Code	CSCC A7: "Acknowledgement/Rejected for Invalid Information..." CSC 535: "Claim Frequency Code"	Part B Medicare only accepts original claims. ****CLM05-3 must be 1 for Medicare Part B claims only****
This Claim is rejected for Missing Information for the Identifier Qualifier within the Referring Provider's National Provider Identifier (NPI)	CSCC A6: "Acknowledgement/Rejected for Missing Information..." CSC 745: "Identifier Qualifier" CSC 562: "Entity's National Provider Identifier (NPI)" EIC: DN "Referring Provider"	Make sure that you are sending the "XX" (Identifier Qualifier) when you have the referring provider name and NPI included on the claim submitted. Please contact your clearinghouse or software vendor to correct if the identifier is present. Note: When NM108 is present then NM109 is required or your claim will reject.
This Claim is rejected for Invalid Information within the Primary diagnosis code	CSCC A7: "Acknowledgement/Rejected for Invalid Information..." CSC 254: "Primary diagnosis code"	Please verify the Primary Diagnosis Code is valid for Ohio Part B. If not, please correct and resubmit the claim.
This Claim is rejected for Invalid Information within the Authorization/certification number	CSCC A7: "Acknowledgement/Rejected for Invalid Information..." CSC 252: "Authorization/certification number"	For Mammography related claims. Please be sure that the rendering provider's Mammography Certification Number is valid, active and in the correct format.
This Claim is rejected for relational field Information within the Procedure Code Modifier(s) for Service(s) Rendered	CSCC A7: "Acknowledgement/Rejected for Invalid Information..." CSC 453: "Procedure Code Modifier(s) for Service(s) Rendered"	Please verify the modifier(s) used is valid for the procedure code before submitting on your claim(s). If not, please correct and resubmit.

Tips Contacting the Electronic Data Interchange Department (EDI)

Our customer is our priority and we're listening to you! The support team within the EDI Department is available to assist with issues that may impact your office and we will also direct you to the proper department regarding non-related EDI items (e.g., EOB Denials). Our CGS website <http://www.cgsmedicare.com>, contains a variety of topics and a complete listing of resources for your convenience rather than directly speaking with a Representative.

If you require the assistance of an EDI Analyst, contact EDI Help Desk at 1.866.758.5666. Please have available the following to expedite your request:

- Name
- Contact Telephone Number
- Provider Transaction Access Number (PTAN)
- National Provider Identifier (NPI)

Important Note: Also, we appreciate the dedication to our clearinghouses and the services they provide to our customers daily. If you are a provider, that uses these services, please remember your clearinghouse is your first point of contact for EDI issues. Anything they cannot resolve for you should then be referred to the EDI Help Desk. On contact please provide one of the following pieces of information to one of our "EDI Analysts", so timely assistance might be provided:

- REF-D9 (clearinghouse stamp) - *for clearinghouses only*
- FILE ID=ISA-13 (of the file submitted) - *provider should be able to provide this to the EDI department, as provided by the clearinghouse. This will ensure that we are looking at the correct file and can provide accurate assistance.*

We understand our customer's needs and will continue to provide Confidence, Clarity and Caring Attitudes.

EDI Help Desk Available Hours:

Monday – Friday 8:00a to 5:30p (ET)

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- Then click on "Join the ListServ."



5010 Links and Job Aids

Standard Companion Guide Transaction Information:

Instructions related to the 837 Health Care Claim: Institutional Transaction based on ASC X12 Technical Report Type 3 (TR3), Version 005010A2

Kentucky and Ohio Part A:	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads//5010A2837ACG.pdf
Home Health & Hospice:	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads//5010A2837ACG.pdf

Instructions related to the 837 Health Care Claim: Professionals based on ASC X12 Technical Report Type 3 (TR3), version 005010A1

Ohio Part B:	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads//5010A2837ACG.pdf
Kentucky Part B:	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads//5010A1837BCG.pdf

ANSI V5010 Errata Testing Companion Guide Job Aids: The companion guide will assist in assuring that your claim files are processed correctly once testing has been completed.

Kentucky Part B:	http://www.cgsmedicare.com/kyb/claims/edi/pdf/5010_Companion.pdf
Ohio Part B:	http://www.cgsmedicare.com/ohb/claims/edi/pdf/5010_Companion.pdf
Kentucky and Ohio Part A:	http://www.cgsmedicare.com/kyb/claims/edi/pdf/5010_Companion.pdf

Electronic Media Claims (EMC) may be transmitted to CGS using various billing methods and communication software packages. The following link(s) list the Trading Partners (vendors, billing services, clearinghouses) who have tested their software with CGS and have been approved for 5010 claim submission.

Kentucky Part B:	http://www.cgsmedicare.com/kyb/claims/edi/5010trading_partners.html
Ohio Part B:	http://www.cgsmedicare.com/ohb/claims/edi/5010trading_partners.html
Kentucky and Ohio Part A:	http://www.cgsmedicare.com/parta/edi/5010Trading_Partners.html
Home Health & Hospice:	http://www.cgsmedicare.com/hhh/edi/5010trading_partners.html