EDI Xchange

Volume II Issue V | A newsletter for Part A EDI users from Highmark Medicare Services | August 2007

EDI Test Required by July 31 to Migrate to New EDI Front-End

The existing method for submitting Medicare Part A EDI (electronic data interchange) claims via the LAN, Frame Relay, WAN, and NDM connection methods will be eliminated effective August 31, 2007. The Stratus Telecommunication Server now functions as the new EDI Front-End Platform at Highmark Medicare Services. Stratus replaces the existing Part A EDI Front-End Platform, which includes the Highmark Medicare Services LAN and the Frame-Relay, Wide Area Network (WAN), and Network Data Mover (NDM) connection methods. Connectivity instructions are contained on pages 4 and 5.

During the first week of July 2007, we sent a letter to you containing your new Submitter ID and Logon ID. You must send a small test file (1 or 2 claims) to us to ensure you can connect to the new EDI Front-End Platform. Once you successfully connect with us, we will contact you within 3 business days to approve you for production billing using the new EDI Front-End Platform. **You must connect and send a small test (1 or 2 claims) no later than close of business July 31, 2007. Failure to do so may jeopardize your ability to bill electronic claims.**

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Pennsylvania Providers Must Migrate to a DDE Vendor by August 31

The existing LAN and Frame Relay/WAN connectivity for FISS Direct Data Entry (DDE) will be eliminated August 31, 2007. Virtually all Pennsylvania Part A providers access FISS/DDE to verify beneficiary eligibility, enter claims directly into the FISS Medicare processing system, verify claim status, and/or perform claims correction, so you must take immediate action to avoid billing and payment delays. (NOTE: Maryland/DC Part A FISS/DDE customers are not impacted because Maryland/DC Part A customers are already connecting to FISS for DDE via a Secure DDE Vendor. Therefore, Maryland/DC Part A customers do not need to change their DDE connectivity).

All Pennsylvania Part A customers accessing FISS for DDE (to verify beneficiary eligibility, enter claims directly into the FISS Medicare processing system, verify claim status, and/or perform claims correction) must contract with one of the Secure Third-Party DDE Vendors in order to continue using DDE. Please contact a Secure Third-Party DDE Vendor immediately to initiate the contract and setup arrangements. A list of Secure DDE Vendors is available on our internet website at: http://www.highmarkmedicareservices.com/parta/edi/ddevendor.html.

Many customers are migrating at once, so act now to avoid any interruption in your DDE capabilities. If you do not make this change prior to the August 31, 2007, deadline, you will not be able to enter claims in FISS, perform claim corrections, verify beneficiary eligibility, or check claim status. Ideally, you should migrate and be ready to use a Secure DDE Vendor for DDE when we approve you for production EDI billing using Stratus.

Act now, don't delay. For questions regarding this transition, please contact an EDI Analyst at 1-866-488-0546.

Medicare
In this Issue

EDI Xchange is published by Medicare EDI Services for EDI submitters, vendors, billing services and clearinghouses. This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins are available at no cost from our website at: http://www.highmarkmedicareservices.com

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Act now, don't delay. There are already EDI billers who have tested and migrated to the new EDI front-end, and many more EDI billers are submitting tests every day. Many customers are migrating at once, so act now to avoid any interruption with your electronic billing. YOU MUST CONNECT AND SEND A SMALL TEST (1 or 2 CLAIMS) NO LATER THAN CLOSE OF BUSINESS JULY 31, 2007. FAILURE TO DO SO MAY JEOPARDIZE YOUR ABILITY TO BILL ELECTRONIC CLAIMS. For questions regarding this transition, please contact an EDI Analyst at 1-866-488-0546.

TIPS FOR SENDING A SUCCESSFUL TEST

- When connecting for the first time, you will be prompted to set a customer-controlled password. This password must be exactly 8 characters in length, must contain both numbers and letters (any combination totaling 8), must be entered in lower case (no capital letters), cannot contain the Login ID (i.e., PRJ number) and must be changed periodically (every 30, 60, or 90 days).

- When sending a Test File, the Test/Production indicator located in ISA15 (of the X12N 837I) must equal T for test. Don't forget to change it back to P for production when sending a production file. If you send a test, but the Test/ Production indicator is not set to T, your file will reject and we will not know that you sent a test.

- The new Submitter ID must be reported in the ISA06 and GS02 of your EDI transactions. If the Submitter ID in the ISA06 and GS02 do no match, the file will be rejected.

- The Version Identification Number in either the GS08 or REF02 must be reported as a value of 004010X096A1 or your file will reject.

- EDI files transmitted to the new EDI Front-End Platform must be sent as a "streaming" X12N data file, or one continuous string. If you use a tilde (~) segment terminator do not use Carriage Return (CR) when creating the X12N data file.

(NOTE: For those very few customers who do not submit EDI claims, but do retrieve Electronic Remittance Advice (ERA), you do not need to send a test file. Please contact us to schedule a production date using the new platform.)

New EDI Submitter and Login ID Required for the New EDI Platform

A new EDI Submitter ID and Login ID was issued to you in July 2007. This new Submitter ID and Login ID, along with a customer-controlled password, is required to connect to your new EDI mailbox on the new EDI Front-End Platform.

Additionally, the new Submitter ID must be submitted in the X12N 837 Institutional Claim File and the X12N 276 Claim Status Inquiry Transactions you send to Highmark Medicare Services. The new Submitter ID must also be contained in any EDI transactions (X12N TA1, 997, 835, 277) that Highmark Medicare Services returns to you.

Here's some important information about your new Submitter ID, Logon ID, and customer-controlled password:

- The EDI Submitter ID is a seven-position, unique numeric value and must be reported in ISA06 and GS02. Medicare EDI Services assigned this number to you.
- The Login ID is a seven-position, unique alpha-numeric value, beginning with the standard value of PRJxxxx, where xxxx may contain a numeric or alpha numeric value. Medicare EDI Services assigned this number to you. This will also be your unique mailbox for all EDI transactions and functions.
- The customer-controlled password must be exactly 8 characters in length, must contain both numbers and letters (any combination totaling 8), must be entered in lower case (no capital letters), cannot contain the Login ID (i.e., PRJ number) and must be changed periodically (every 30, 60, or 90 days). The first time you log on to the new EDI Front-End Platform, you will be prompted to assign a password.

Attention Billing Services, Clearinghouses, and EDI Billers Using a Billing Service/Clearinghouse: Billing Services and Clearinghouses have been assigned a Submitter ID, and all providers currently billing via a Billing Service or Clearinghouse are linked to the Billing Service/Clearinghouse's newly-assigned Submitter ID. This streamlined approach enables Billing Services and Clearinghouses to submit/retrieve one file for all of their clients at the same time. For EDI reports and ERA, Billing Service and Clearinghouses must parse and distribute EDI Reports and ERA to its respective clients.

For those customers who also bill Pennsylvania Medicare Part B claims electronically, this is parallel to how you were already enrolled for EDI Part B billing. **Please make these changes to avoid a negative impact to your cash flow.**

New System Operation Hours for the New EDI Front-End Platform

The new EDI Front-end Platform is accessible 24 hours a day, 7 days a week. However, **our business day ends at 4 PM.** (This is a change from the 4:45 PM end of business day under the previous EDI Front-End Platform.) **EDI files submitted after 4 PM on any business day are not considered "received" until the next business day. EDI files submitted on a non-business day are not considered "received" until the next business day or as published.**

The new EDI Front-end Platform allows for multiple transmissions within one day by assigning a unique Interchange Control Number in ISA13 for each transmission. If you are not sure how to assign a unique submission number, please contact your vendor or in-house programmer for instructions.

NOTE: In the unlikely event that you wish to submit claims via modem, but the system is unable to receive claims due to scheduled system maintenance or an outage, you will receive a busy signal, an unanswered ringing, or a message "Host Unavailable." We do not anticipate that this will happen with any frequency. However, good system design mandates planning for every possibility.

EDI File Format Requirements for the New EDI Front-End Platform

There are a few file format requirements for electronic billing using the new EDI Front-End Platform. **Please make these changes to avoid negatively impacting your cash flow.**

- A new Submitter ID, Login ID, and customer-controlled password is required to connect to the new EDI Front-End Platform. The new Submitter ID must be reported in the ISA06 and GS02 of your EDI transactions. If the Submitter ID in the ISA06 and GS02 do no match, the file will be rejected.
- A separate transmission is required for each X12N 837I transaction. (i.e., only one ISA-IEA per transmission).
- Only one X12N transaction type (i.e., 837I or 276) can be sent in one transmission. To submit electronic claims and submit claim status inquiries, one transmission must be sent containing the 837I transaction and a separate transmission must be sent containing the 276 transaction.
- EDI files transmitted to the new EDI Front-End Platform must be sent as a "streaming" X12N data file, or one continuous string. This applies to both the X12N 837I and the X12N 276 transactions. Highmark Medicare Services will return the X12N TA1 Interchange Acknowledgment, X12N 997 Functional Acknowledgment, X12N 277 Claim Status Transaction, and the 835 Electronic Remittance Advice (ERA) to you as a "streaming" X12N data file. If you use a tilde (~) segment terminator do not use Carriage Return (CR) when creating the X12N data file.
- Zipped files will not be accepted for processing. Do not send a zipped file or it will be rejected.

New Requirements for Customers' Enrolling for Part A EDI, Submitting Tests, or Making Changes to Current Setup

If you are enrolling for Part A EDI, want to submit a test, or want to make changes to your current setup, you will need to enroll and test using Stratus, the new Part A EDI Front-End Platform. The Stratus Telecommunication Server now functions as the new Part A EDI Front-End Platform at Highmark Medicare Services. Stratus replaced the existing Part A EDI Front-End Platform, which included the Highmark Medicare Services LAN and the Frame-Relay, Wide Area Network (WAN), and the Network Data Mover (NDM) connection methods. The old method of submitting Medicare Part A EDI claims via the LAN, Frame Relay, WAN, and NDM connection methods will be eliminated effective August 31, 2007.

This requirement will save customers and the Medicare program time and money by eliminating additional time and steps needed to enroll, test, or make changes using the old Part A EDI Front-End Platform and then having to repeat the process to migrate to Stratus, the new Part A EDI Front-End Platform.

Important information about the EDI transition and test requirements to migrate to the new EDI front-end platform can be found on the front page. Stratus connectivity instructions are contained on pages 4 and 5. Important information about the FISS DDE transition (for PA Part A customers only) can be found on the front page. For questions regarding this transition, please contact an EDI Analyst at 1-866-488-0546.

Connecting to the New EDI Platform

Dial-up via a Modem

You can now connect to the Stratus Telecommunication Server, the new EDI Front-End Platform, and transmit your electronic transactions using our 56K modem line. The 56K modem line is also equipped with downspeed capability, so even if your modem isn't capable of achieving 56K, you can still communicate with our system. Analog or digital modem lines can be used to connect to the Medicare telecommunication server. DSL, Cable modem, and Voice-Over Internet Protocol (VOIP) connections **cannot** be used to connect to the Medicare telecommunication server. The 56K modem line for electronic transmissions is:

(717) 214-7376

A Communications software program, such as HyperTerminal or Procom Plus, for dial-up modem submissions is required for dial-up customers--including PC-ACE customers. (These are only examples of possible communication software programs. Medicare does not recommend or endorse any particular product.) If you do not currently possess communication software, you will need to acquire a software program. The cost and support of any communications package is the responsibility of the submitter.

Technically speaking, the modem transmission is based on American Standard Code for Information Interchange (ASCII)/Asynchronous Transmission (TTY or TTY-Compatible). You may utilize a modem that incorporates Microcom Networking Protocol (MNP) error correction capabilities, or you may utilize a non-MNP modem if Z-Modem Data Integrity Protocol is incorporated. The communication line set up between the computer and modem requires the following for asynchronous transmission:

- **2-Two start bits.** (Signals that a frame is starting and enables the receiving device to synchronize itself with the message.)
- **1-One stop bit.** (Signals the end of the data frame.)
- **8-Eight data bits.** (Consists of a group of eight bits when character data is being transmitted.)
- **N-No parity.** (Transmission error detection.)
- **Full duplex** should be implemented to allow data to be sent in both directions at the same time.

* It is required to have **X-ON/X-OFF flow control** implemented on remote sites. This implementation should occur between remote Data Terminal Equipment (DTE) and Data Communications Equipment (DCE).

Attention WinFTP Users: WinFTP is an FTP software program for transferring data that Highmark Medicare Services has provided in the past to submitters. This program is currently used to send or receive files to and from the Highmark Medicare Services LAN. With the migration to the new EDI Platform, this program is no longer required and will not be provided. Submitters using the new dial-up modem connectivity option may choose from a vast array of communications packages offered in the consumer marketplace. HyperTerminal and ProComm Plus are just two examples of communication software programs that are available commercially. Submitters using an alternative connection method that permits the use of FTP may choose from a vast array of FTP programs offered in the consumer marketplace. The cost and support of any Communication or FTP program is the responsibility of the submitter.

Transmission Bulletin Board Menu for the New EDI Platform

The following information describes how to log onto the new EDI Platform, which is known as the Stratus Telecommunication Server. Please refer to these instructions for connecting to the new EDI Platform, which is now available. The Login ID depicted in this example is for example purposes only; your Submitter ID and Login ID were mailed to you during the first week of July 2007.

Login Screen with Login Prompt:

```
Welcome to Direct Access Services
Electronic Mail Claims Network

LOGIN:  prj0000 (Press Enter)
```

Login Screen with Password Prompt:

```
Welcome to Direct Access Services
Electronic Mail Claims Network

PASSWORD:    (Press Enter)
```

IMPORTANT: Passwords must be entered in lower case and MUST be eight characters long. Passwords must contain numbers and letters, but no special characters or the Login ID. Passwords should be changed every 30, 60 or 90 days.

Security Message on the Transmission Bulletin Board:

When you dial-in to Medicare to submit and/or retrieve electronic transactions, you will receive the following message after you login using your Login ID and password, but before you make a menu selection:

> *"This system is for the use of authorized users only. This system may be monitored to ensure proper operation, to verify authorized use and security procedures, and similar purposes. Your use of this system constitutes consent to such monitoring. Unauthorized attempts to change or copy information, to defeat or circumvent security features, or to utilize this system for other than its intended purposes are prohibited and may result in disciplinary and/or legal action."*

Transmission Bulletin Board Menu

After you connect to the new EDI Platform, a user-friendly menu is displayed to access your mailbox and conduct EDI transactions. Please use the following instructions to navigate the new Bulletin Board Menu, which is now available.

To Submit/Retrieve the Following Transactions/Miscellaneous Options:	Select the Following:
X12N 837I Claim Transaction	S
X12N 276 Claim Status Inquiry Transaction	S
X12N TA1 Interchange Acknowledgment	G
X12N 997 Functional Acknowledgment	G
IG Edit Report	A
Accept/Return-to-Provider (RTP) Report (Pennsylvania Part A Only)	A
X12N 277 Claim Status Response	X277
X12N 835 ERA Transaction	R
ERA Out-of-Balance Report	A
ERA Forced Balance Report	A
Change Your Customer-Controlled Password (Every 30, 60, or 90 Days)	C
View Help Information	H
Logoff	L

```
Welcome to Direct Access Services
Electronic Mail Claims Network

Please select one of the following:
S)ubmit Claims Data
G)et Confirmation
A)cquire MCS Edit Report
R)etrieve Reconciliation
C)hange Password
H)elp
L)ogoff

Enter Letter of Selection=>
```

EDI Reports Based on the New EDI Platform

The new EDI Platform brings some changes to the existing EDI reports. Under the new EDI Platform, the following reports are now generated for EDI billers:

- TA1 Interchange Acknowledgment (replaces the existing Results Report when a TA1 error is detected)
- X12N 997 Functional Acknowledgment
- IG Edit Report
- Accept/Return-to-Provider (RTP) (for Pennsylvania Part A only)
- X12N 835 Electronic Remittance Advice (ERA) (for those providers who are enrolled for ERA)
- Out of Balance and Forced Balance Reports (when an out-of-balance or forced balance ERA is detected)

All EDI Reports and ERA are only available for retrieval for five business days, so it is important for you to retrieve your EDI Reports and ERA in a timely manner. The EDI Report and ERA can be reset for you as many times as needed during those five days. However, **once the five days expire, the EDI reports and ERA are no longer available and cannot be reset or recreated for you.**

To retrieve the EDI Reports and ERA from the new EDI Front-End Platform, use the menu option associated to the respective EDI Report/ERA. Please refer to the *"Transmission Bulletin Board Menu"* section of the ***Transmission Bulletin Board Menu for the New EDI Platform article*** on Page 5 for details.

Results Report

To streamline the EDI reports, the Results Report has been eliminated with the new EDI Platform.

X12N TA1 Interchange Acknowledgement

The X12N TA1 Interchange Acknowledgement will be generated **if** an interchange control structure error is identified. For Pennsylvania and Maryland Part A customers, the TA1 will be generated for you immediately and remain available for five business days. The TA1 replaces the existing Results Report.

Please read the Using the TA1 Interchange Acknowledgment article on Pages 8-9 of this newsletter for detailed information.

X12N 997 Functional Acknowledgement

The X12N 997 Functional Acknowledgement is still generated for you at the same frequency you were already accustomed. For Pennsylvania Part A customers, the 997 is generated approximately one hour after transmitting your file and remains available for five business days. For Maryland Part A customers, the IG Edit Report is available the next business day and remains available for five business days.

The 997 verifies that the transmission was received and indicates whether the transmission was accepted or rejected, test or production.

- If the transmission is accepted, the file has successfully passed the initial edits. Your file is forwarded for secondary editing and the IG Edit Report is created for you.
- If the transmission is rejected, the errors must be corrected and the entire claim file must be retransmitted. The claims are not forwarded for secondary editing, but the IG Edit Report is generated. Your claims are not processed in FISS.

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IG Edit Report

The MEDATRAN Implementation Guide (IG) Edit Report is still generated for you at the same frequency you were already accustomed. For Pennsylvania Part A customers, the IG Edit Report is generated approximately one hour after transmitting your file and remains available for five business days. For Maryland Part A customers, the IG Edit Report is available the next business day and remains available for five business days.

The IG Edit Report indicates whether your claims have been accepted or rejected for processing consideration.

- If the file/batch/claim is accepted, the file/batch/claim has successfully passed the secondary edits. The file/batch/claims that are accepted are forwarded to the FISS Medicare processing system for processing and payment consideration.
- If the file/batch/claim is rejected, the file/batch/claim errors must be corrected and resubmitted. Any file/batch/claims that are rejected are not forwarded to the FISS Medicare processing system for processing or payment consideration.

Accept/Return to Provider (RTP) Report (Pennsylvania Part A Only)

The Accept/Return-to-Provider (RTP) Report continues to be generated for Pennsylvania Part A only at the same frequency you are already accustomed. However, **this report will only be available electronically for EDI billers; it will no longer be available in hardcopy for electronic billers.** For Pennsylvania Part A customers, the Accept/RTP Report will be generated on a daily basis and remain available for five business days.

X12N 835 Electronic Remittance Advice (ERA)

The X12N 835 Electronic Remittance Advice (ERA) continues to be generated for you at the same frequency you were already accustomed. For Pennsylvania Part A customers, the ERA is generated on a daily basis and remains available for five business days. For Maryland Part A customers, the ERA is generated on a weekly basis and remains available for five business days. If no claims finalize on a particular day/week, then the ERA is not created for you that day/week.

The ERA indicates how your Medicare Part A claims were adjudicated.

Out-Of-Balance Report and Forced Balance Report

Both the Out-Of-Balance Report and Forced Balance Report continues to be generated for you in conjunction with the X12N 835 version 4010.A1 Electronic Remittance Advice (ERA). However, these reports are provided to you **ONLY** when an **actual** out-of-balance or forced balance is detected. For Pennsylvania Part A customers, the Out-Of-Balance Report/Forced Balance Reports is available on a daily basis in conjunction with an Out-of-Balance or Forced Balance ERA and remains available for five business days. For Maryland Part A customers, the Out-Of-Balance Report/Forced Balance Reports is available on a weekly basis in conjunction with an Out-of-Balance or Forced Balance ERA and remains available for five business days.

Using the X12N TA1 Interchange Acknowledgment

The X12N TA1 Interchange Acknowledgement, which will replace the existing Results Report, will be generated **if** an interchange control structure error is identified. For Pennsylvania and Maryland Part A customers, the TA1 is generated for you immediately and remains available for five business days. The TA1 replaces the existing Results Report.

If the interchange control structure (header/trailer) of an X12N 837 or 276 transaction is not correct, the transmission will be rejected. The rejection is indicated in Segment TA1 Data Element 04 with an "R," which indicates the file was rejected. An example of a TA1 Interchange Acknowledgment rejection is displayed below.

```
ISA*00*          *00*          *27*00865          *ZZ*9999999
      *070420*1358*U*00401*704205810*0*P*:
TA1*000000659*070420*1346*R*023  <= The "R" indicates a rejection.
IEA*1*704205810
```

If a TA1 rejection is generated, your file is rejected, and it is not forwarded for additional editing or to the Medicare processing system for processing or payment consideration. A list of potential TA1 rejections is charted below.

TA1 Error	Requirement
No Action. The period in the file name is replaced with an 'E' character.	The file data must start with the string the following string: ISA
TA105 - 022: Invalid Control Structure	Each input file must contain one and only one ISA – IEA X12 groups.
TA105 - 004: Invalid Segment Separator TA105 - 026: Invalid Element Separator TA105 - 027: Invalid Composite Separator	The ISA element, composite, and segment separators will be validated as follows: ■ The X12 Element separator must be an Asterisk (*). ■ The X12 Segment separator must be a Tilde (~). ■ The composite separator can be any character except for the following: Period, Dash, Space, 0 through 9, A through Z, and a through z. ■ The Segment Separator in the ISA in position 106. ■ The Composite Separator in the ISA in position 105. ■ The Element Separators in the ISA are in positions: 4, 7, 18, 21, 32, 35, 51, 54, 70, 77, 82, 84, 90, 100, 102, and 104.
TA105 - 004: Invalid Segment Separator TA105 - 026: Invalid Element Separator TA105 - 027: Invalid Composite Separator	The segment, element, and composite separators must be all be unique from one another. For example, the segment separator must be unique from the element and composite separators, the element separator must be unique from the segment and composite separators, and the composite separator must be unique from the segment and element separators.
TA105 - 026: Invalid Element Separator	The element separator must be the same character in the fixed positions of the ISA segment. The ISA fixed element separator positions are: 4, 7, 18, 21, 32, 35, 51, 54, 70, 77, 82, 84, 90, 100, 102, and 104.

Chart Continued on Page 9

A list of potential TA1 rejections continued from Page 8 is charted below.

TA1 Error	Requirement
TA105 - 004: Invalid Segment Separator TA105 - 026: Invalid Element Separator TA105 - 027: Invalid Composite Separator	No elements within the ISA can contain a segment, element, or composite separator character.
TA105 – 005: Invalid Interchange Sender Qualifier	The ISA05 Interchange Sender ID Qualifier must equal: 01, 02, 03, 04, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36,37, AM, NR, SN, or ZZ.
TA105 - 006: Invalid Interchange Sender	The ISA06 must be an <u>exact</u> match of an existing Submitter ID. For example, an exact match means that 12345 will <u>not</u> match 0012345.
TA105 – 007: Invalid Interchange Receiver Qualifier	The ISA05 Interchange Receiver ID Qualifier must equal: 01, 14, 20, 27, 28, 29, 30, 33, or ZZ.
TA105 - 009: Unknown Receiver ID	The ISA08 must equal either 00363 for Pennsylvania Part A or 00366 for MD/DC Part A. The two leading zeros are significant and must be included or a rejection will occur.
TA105 - 010: Invalid Authorization Information Qualifier	The ISA01 Authorization Information Qualifier must equal “00” or “03.”
TA105 – 016: Invalid Interchange Standards Identifier	The ISA11 Interchange Control Standards Identifier must equal “U.”
TA105 – 017: Invalid Interchange Version ID Value	The ISA12 Interchange Control Version must equal “00401.”
TA105 – 019: Invalid Acknowledgement Request Value	The ISA14 Acknowledgement Requested must equal “0” or “1.”
TA105 - 020: Invalid Test Indicator	The ISA15 Usage Indicator must contain a ‘T’ or ‘P’ indicating whether the file is a Test or Production File.
TA105 – 024: Invalid Interchange Content	The GS01 Functional Group ID must be the same in all GS segments within the ISA-IEA envelope. Valid GS01 values are: HC, HR, and FA. The ST01 must correspond to the GS01 as follows: **<u>ST01</u>** **<u>GS01</u>** 837 HC 276 HR 997 FA
TA105 - 006: Invalid Interchange Sender	The GS02 element in all GS segments in an 837 or 276 file must equal the ISA06 element.
TA105 – 024: Invalid Interchange Content	At least one GS segment must be present in the file.
TA105 - 022: Invalid Control Structure	There must be at least one ST Segment, and the ST01 must equal 837, 276, or 997.
TA105 - 023: Premature End of File	The X12N file must end with an IEA segment.
TA105 – 001: Interchange Numbers Don’t Match	The IEA02 Interchange Control Number must equal the ISA13 Interchange Control Number.

File Naming Convention for EDI Reports

The new EDI Front-End Platform incorporates a unique file naming convention for EDI reports and ERA that is specific to the Submitter ID (which was assigned to you in July 2007), which ensures that your specific reports are distributed to your secure, unique mailbox. Each file name specifies your current contract, your EDI Submitter ID, a Julian Date/Time, a "retrieval" indicator, and the file extension.

NOTE: The new file naming convention will eliminate the need for you to "rename" your files under the new EDI Front-End Platform.

Below are examples of the new file naming convention as well as an explanation of the file name structure:

Example of a Report File Name Waiting for Retrieval	Example of a Report File Name That Has Already Been Retrieved
CC_XXXXXXX_JJJHHMMSS.XXX	CC_XXXXXXX_JJJHHMMSSsXXX

Element	Element Description
CC	Represents the contract ID: PA or MD.
XXXXXXX	Represents your unique EDI Submitter ID Number.
JJJHHMMSS	Represents the Julian Date and Time that the report or rile was placed into your mailbox.
. (a period)	Represents a "retrieval indicator," which depicts that the report or file is awaiting retrieval. After retrieving the report or file, the period will change to an "s" to indicate the report or file has already been sent (retrieved). This feature prevents you from accidentally "retrieving" the same report or file again. (If you happen to need a file again after it's already been retrieved, contact the EDI Helpdesk and request the report or file to be reset.)
XXX	Represents the type of report or file to be retrieved.

Report/File Type	File Name For PA/MD EDI Billers	Menu Option
X12N TAI Interchange Acknowledgment	**PA and MD**: PRJ_*Y_SSSJJJ.HH* (*SSSJJJ.HH* same as input file)	G
X12N 997 Functional Acknowledgment	**PA:** PA_*XXXXXXX_JJJHHMMSS*.997 **MD:** MD_*XXXXXXX_JJJHHMMSS*.997	G
IG Edit Report	**PA:** PA_*XXXXXXX_JJJHHMMSS*.IGR **MD:** MD_*XXXXXXX_JJJHHMMSS*.IGR	A
Accept/RTP (PA Part A Only)	**PA:** PA_*XXXXXXX_JJJHHMMSS*.ARJ **MD:** Not Applicable ***The ARJ extension will change**. **See Page 11**	A
X12N 835 ERA	**PA:** PA_*XXXXXXX_JJJHHMMSS*.835 **MD:** MD_*XXXXXXX_JJJHHMMSS*.835	R
ERA Out-Of-Balance Report	**PA:** PA_*XXXXXXX_JJJHHMMSS*.OOB **MD:** MD_*XXXXXXX_JJJHHMMSS*.OOB	A
ERA Forced Balance Report	**PA:** PA_*XXXXXXX_JJJHHMMSS*.FBA **MD:** MD_*XXXXXXX_JJJHHMMSS*.FBA	A
X12N 277 Claim Status Response	**PA:** PA_*XXXXXXX_JJJHHMMSS*.277 **MD:** MD_*XXXXXXX_JJJHHMMSS*.277	X277

PC-ACE Pro32 Users Only:
How to Enter Your New Submitter ID and Transmit a Test File.

By now, you should have received your new Submitter and Logon IDs in the mail to transition your electronic billing to the new EDI Front-End Platform. To send electronic claims created using the PC-ACE Pro32 software program to the new platform, please follow the instructions below to incorporate your new Submitter and Logon IDs into the PC-ACE Pro32 software program.

- Log into the PC-ACE Pro32 software program.
- Click on the "Reference File Maintenance" Icon.
- Click on the "Code/Misc" Tab.
- Click on the "Submitter" Tab.
- Click on and highlight your office ID.
- Click "View/Update."
- Replace the number located in the "ID" field with the new Submitter ID you received in the transition letter from Medicare EDI Services.
- Replace the number located in the "EIN" field with the new Submitter ID you received in the transition letter from Medicare EDI Services. *Note: Do not enter your Tax ID number in the EIN field.
- Click on the "Prepare" tab.
- Replace the "P" in the "Submission Status" field with a "T" for test.
- Click "Save."

*Note: After testing is successfully completed, you will need to follow the above steps to change the "submission status" back to "P" for production.

You are now ready to send the required test. Enter and process one or two claims and prepare a file for transmission. Connect to Highmark Medicare Services using your communication software package. Please remember to use the new transmission telephone number (717-214-7376) and your new logon ID. From the bulletin board menu:

- Type "S" to send a file and "Y"
- Click "Transfer"
- Click "Send File"
- Click "Browse"
- Locate your TRANS.DAT file created by PC-ACE. You will need to navigate to the directory where the file is saved (ie. C:\WINPCACE)
- Click on the "TRANS.DAT" file
- Click "Send"

Your test file is now being transmitted.

To retrieve a report from the bulletin board menu:

- Type "G" for Get Confirmation (997 report), "A" for acquire MCS Edit Report, or "R" for Retrieve Reconciliation (ERA) and "Y". Your report is now being retrieved.

*Note: Confirmation and edit reports can be opened and viewed with any program that can read a text file (ie. Notepad or Word). The ERA should be viewed in PC-Print.

If you have any questions or require assistance, please contact an EDI Analyst at 1-888-488-0546, option 2.

File Naming Convention for EDI Reports, continued from Page 10

* The ARJ extension for the Accept/RTP (PA Part A Only) File Name PA_XXXXXXX_JJJHHMMSS.ARJ will change to RTP extension effective October 1, 2007, because the current file attempts to only open in WINZIP. In the interim, please follow these instructions to open the file:

- Right click on the File Name
- Click on Rename
- Change file extension to .txt

If you have any questions or require assistance, please contact an EDI Analyst at 1-888-488-0546, option 2.

Attention PC-ACE Customers Using PrintLink

Effective immediately, Highmark Medicare Services no longer supports the PrintLink feature in PC-ACE Pro32, which allows a claim file from another software program to be imported into PC-ACE Pro32 and mapped into the proper X12N format for transmission to Medicare. This means we no longer provide support for new or existing PrintLink mapping (.map) files. Although we no longer support PrintLink, the following alternatives are available:

- Contact SDI, the PC-ACE Pro32 software vendor, for the creation or support of mapping files to use with PC-ACE Pro32. This service can be provided, for a fee, directly from the vendor to the submitter. For Print Image Import Mapping Services from SDI, please visit the following website for information and instructions: http://www.system-designs.com/plink.htm. If you have any questions after reviewing SDI's website, you may contact SDI at either 904-260-9220 or the SDI Help Desk at 904-482-0631.
- PC-ACE Pro32 can accept a HIPAA-compliant ANSI X12N claim file. If your other billing system is able to create a valid X12N claim file, it can be imported into PC-ACE Pro32.
- Enter claims directly into PC-ACE Pro32.
- Select another HIPAA-compliant billing software program or contract with a billing service or clearinghouse.

PC-ACE Pro32 is a low-cost software program available to Medicare Part A providers. The purpose of the software program is to enable Medicare Part A providers to submit Medicare Part A claims electronically. The PrintLink feature is outside the general purpose of the low-cost software program.

Who to Call for Help

For assistance, please use the following information to reach the appropriate contact.

Call your **Software/Hardware Vendor** ***for the following:***

- Communication software to connect to the new EDI Front-End Platform
- Communication software assistance if modem does not dial or connect with Highmark Medicare Services
- File Transfer Protocol (FTP) software
- Assistance with error messages in software billing program
- Questions on reports generated by software program (Pre- or post-billing reports)

Call Medicare EDI Services at 1-866-488-0546, option 2 ***for the following:***

- Enroll as EDI biller
- Enroll for Electronic Remittance Advice
- Transmission protocol and bulletin board access information
- X12N Implementation Guide Questions
- Reset EDI reports or questions about EDI reports generated by Highmark Medicare Services
    - X12N TA1 Interchange Acknowledgment
    - X12N 997 Functional Acknowledgment
    - IG Edit Report
    - Accept/RTP Report (PA Part A Only)
    - X12N 835 Electronic Remittance Advice (ERA)
    - Out-Of-Balance and Forced Balance Reports
- PC-ACE and PC-Print Software Support (excluding PrintLink support)

Summary of Major Changes Due to New EDI Front-End Platform

- A new Submitter ID, Login ID, and customer-controlled password is required to connect to the new EDI Front-End Platform. Billing Services and Clearinghouses will be assigned a Submitter ID, and all providers currently billing via a Billing Service or Clearinghouse will be linked to the Billing Service/Clearinghouse's newly-assigned Submitter ID. Medicare EDI Services will assign this number to you.
- A separate transmission is required for each X12N 837I transaction. (i.e., only one ISA-IEA per transmission).
- Only one X12N transaction type (i.e., 837I or 276) can be sent in one transmission. To submit electronic claims and submit claim status inquiries, one transmission must be sent containing the 837I transaction and a separate transmission must be sent containing the 276 transaction.
- EDI files transmitted to the new EDI Front-End Platform must be sent as a "streaming" X12N data file, or one continuous string. This applies to both the X12N 837I and the X12N 276 transactions. Highmark Medicare Services will return the X12N TA1 Interchange Acknowledgment, X12N 997 Functional Acknowledgment, X12N 277 Claim Status Transaction, and the 835 Electronic Remittance Advice (ERA) to you as a "streaming" X12N data file.
- The new Submitter ID must be reported in the ISA06 **and** GS02 of your EDI transactions. If the Submitter ID in the ISA06 **and** GS02 do no match, the file will be rejected.
- Communication software for dial-up modem submissions is required for dial-up customers, including PC-ACE customers. If you do not currently possess communication software, you will need to acquire a software program. The cost and support of any communications package is the responsibility of the submitter.
- The WinFTP software program that Highmark Medicare Services has distributed in the past is no longer provided or supported.
- Zipped files are not accepted for processing. Do not send a zipped file or it will be rejected.
- The PC-ACE Pro32 and PC-Print Medicare billing/ERA printing software programs are still offered. However, communication software is required in order to dial-up and connect to the new EDI Front-End Platform. Additionally, the PrintLink mapping feature within the PC-ACE software program is no longer supported, effective immediately.
- **EDI Reports and ERA are only available for retrieval for five business days.** This means that you need to develop a daily routine for retrieving all EDI reports and ERA in a timely manner to ensure you retrieve the reports and ERA before they are no longer available. Once the five business days expire, you will not be able to retrieve your reports or ERA.
- EDI Report Changes:
  - The Results Report will be eliminated. The Results Report will be replaced by a TA1 Interchange Acknowledgment if an interchange control structure error is identified.
  - The existing 997 Functional Acknowledgment will continue to be provided at the same frequency it is today.
  - The IG Edit Report will continue to be provided and it will include two reports: Accept Report and Reject Report. **For Pennsylvania Part A customers**, the IG Edit Report **will include a new** "Accept" report in addition to the current "Reject" report. **For Maryland Part A customers,** the IG Edit Report **will only contain** the "Accept" and "Reject" reports in the future; the other sections within the current IG Edit Report will no longer be provided.
  - The Accept/Return-to-Provider (RTP) Reports (for Pennsylvania Part A only) will continue to be provided; however, this report will **only be available electronically** for EDI billers. The Accept/RTP Report will no longer be available in hardcopy for electronic billers.
  - The ERA will continue to be provided, and the Out-of-Balance and Forced Balance Reports will continue to be provided to you in conjunction with an ERA. However, Out-of-Balance and Forced Balance Reports **will only be reported when an actual out-of-balance or forced balance ERA is detected.**

NEWS BYTES

ASCA Enforcement Reviews

Beginning October 1, 2007, CMS will require Medicare contractors to conduct Administrative Simplification Compliance Act (ASCA) reviews annually of at least 20 percent of providers submitting CMS 1500 paper claims who were not already reviewed in the past two years and found to have fewer than ten Full Time Equivalent (FTEs) employees employed by the practice. ASCA reviews are already being conducted on a quarterly basis. This revision establishes a percentage of reviews to be completed each year.

For more information regarding this upcoming change, please read the MLN Matters article at:
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5586.pdf

Addenda Record for EFT

An addenda record will be sent in the future along with Medicare claim payment when an Automated Clearinghouse (ACH) format is used to transmit an Electronic Funds Transfer (EFT) payment to a financial institution (if the remittance advice is separately transmitted to a provider). This will assist with reconciliation of the payment and the information that explains the payment. The EFT format will be the National Automated Clearinghouse Association (NACHA) format CCP - Cash Concentration/Disbursement plus Addenda (CCD+) (ACH) as mentioned in the X12N 835 version 004010A1 implementation guide.

For more information regarding this upcoming change, please read the MLN Matters article at:
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5586.pdf

PC-ACE Pro32 Version 1.85 Upgrade Available via Internet Download

PC-ACE Pro32 is a Medicare software product that offers the ability to prepare Medicare Part A HIPAA compliant electronic claim files. To provide the most up-to-date information within PC-ACE Pro32, the product is updated quarterly. The last upgrade was released July 30, 2007. This upgrade includes the PC-ACE Pro 32 Version 1.85 Download. To streamline the distribution process, the PC-ACE Pro32 software program is available via an internet download. This internet download is available free of charge for all new and existing PC-ACE Pro32 customers.

As of September 5, 2006, there is a quarterly $25 shipping and handling fee for all PC-ACE Pro32 requests via CD-ROM. This fee will be billed at $100 annually, covering the initial shipping and handling of the CD-ROM and the shipping and handling for any additional upgrades issued within the next year. To save time and money for you and the Medicare program, we strongly encourage you to download this program when enrolling or upgrading. If you are interested in more information about PC-ACE Pro32 or would like to enroll to begin using this product, please visit our website at:
http://www.highmarkmedicareservices.com/parta/edi/pcace32.html.

The PC-ACE Pro32 Release Newletter can be viewed on our website at:
http://www.highmarkmedicareservices.com/parta/edi/qtrly-pcace-newsletters.html

If you have questions or require additional assistance, please contact an EDI Analyst at 1-866-488-0546, option 2.

New Requirements for EDI submitters

Effective October 1, 2007, the National Provider Identifier (NPI) will be required to enroll for Electronic Data Interchange (EDI). This is being implemented to further support efforts by the Centers for Medicare & Medicaid Services (CMS) to have all providers obtain their NPI(s) as soon as possible. Medicare is monitoring claims to determine the level of NPI reporting. This is being done to determine when it will be reasonable for Medicare to begin rejecting claims that lack an NPI for billing, pay-to or rendering providers.

For more information, please see the MLNMatters article located at:
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5637.pdf

NPI Changes for the ERA and SPR

Effective October 1, 2007, submitted NPIs will be cross-walked to the Medicare legacy number(s) for processing. Medicare's internal provider files will continue to be based upon records established in relation to the legacy identifiers. The cross-walk may result in:

Scenario I	Single NPI	Cross-walked to	Single Medicare legacy number
Scenario II	Multiple NPIs	Cross-walked to	Single Medicare legacy number
Scenario III	Single NPI	Cross-walked to	Multiple Medicare legacy numbers

CMS will adjudicate Medicare Fee-for-Service claims based upon a unique NPI/Legacy combination for Scenarios II and III, but the remittance advice, both electronic and paper, and any output using PC Print will have only NPI as the primary provider identification. The Taxpayer Identification Number (TIN) will be used as the secondary identifier for the Payee. The NPI regulation permits continued use of TIN for tax purposes if the implementation guide allows it.

The Companion Documents and Flat Files for Part A will be updated to reflect these changes and the updated documents will be posted on the CMS website at: http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage

The following three scenarios refer to Medicare reporting of NPIs in remittance advice processes.

Note: Current requirements concerning the reporting of provider names and addresses still apply.

Scenario I - Single NPI cross-walked to single legacy number:

- **Electronic Remittance Advice (ERA) -**
  Under this scenario, Medicare will report the NPI at the Payee level as the Payee Primary ID, and the TIN, Employer Identification Number (EIN), or Social Security Number (SSN) in the REF Segment as the Payee Additional ID. Medicare will report any relevant Rendering Provider NPI at the Claim Level if it is different from the Payee NPI. Contractors, as appropriate, will also report relevant Rendering NPI(s) at the Service Line Level if different from the Claim Level Rendering Provider NPI. Under this scenario, there will be one remittance advice and one check/Electronic Funds Transfer (EFT) issued per NPI.

- **Standard Paper Remittance (SPR) -**
  Medicare will insert the appropriate Payee NPI at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See Note above.

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Scenario II - Multiple NPIs cross-walked to Single Medicare legacy number:

- **ERA -**
  Under this scenario, Medicare will report the NPI at the Payee Level as the Payee Primary ID, and the TIN, EIN/SSN in the REF Segment as Payee Additional ID. Then Medicare will add any relevant Rendering Provider NPI at the Claim Level if it is different from the Payee NPI. Contractors, as appropriate, will add any relevant Rendering NPI(s) at the Service Line Level if it is different from the Claim Level Rendering Provider NPI. Under this scenario, adjudication will be based on the unique combination of NPI/legacy number, and there will be multiple remittance advices and checks/ EFTs based on that unique combination.

- **SPR -**
  Medicare will insert the appropriate NPI number at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See Note on Page 15 of this article.

Scenario III - Single NPI cross-walked to Multiple Medicare legacy numbers:

- **ERA -**
  Under this scenario, Medicare will report the NPI at the Payee Level as the Payee Primary ID, and the TIN, EIN/SSN in the REF Segment as Payee Additional ID. Then, Medicare will add any relevant Rendering Provider NPI at the Claim Level if it is different from the Payee NPI. Contractors, as appropriate, will add relevant Rendering NPI(s) at the Service Line Level if it is different from the Claim Level Rendering Provider NPI. Under this scenario, adjudication will be based on the unique combination of NPI/legacy number, and there will be multiple remittance advices and checks/EFTs based on that unique combination.

- **SPR -**
  Insert the appropriate NPI number at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See Note on Page 15 of this article.

For All Three Scenarios - the Medicare Remit Easy Print (MREP) software program will be handled as follows:

- **PC Print Software -**
  Medicare will show the Payee NPI at the header level and add the relevant Rendering Provider NPI at the claim level if different from the Payee NPI.

For additional information regarding how Medicare will return the NPI in the ERA and SPR, please read the MLN Matters article on the CMS website at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf.

NPI: A Closer Look

The Centers for Medicare and Medicaid Services (CMS) is implementing the National Provider Identification (NPI) number in separate stages. The current stage, which started October 2, 2006, allows claims to be submitted with a legacy number only, an NPI only, or both an NPI and legacy number. If you are not already reporting your NPI, please send a small volume of claims using your NPI. If the claims are not rejected, we strongly encourage you to increase your NPI claim volume. If your claims are rejected, we encourage you to report both your legacy number and NPI on claims until the end of the NPI contingency. This will assist in creating a cross-walk between your legacy number and your NPI in preparation for the end of the NPI contingency, when only your NPI will be reported. It will also help prevent possible claim rejections if there is an issue with the NPI reported. For details of this contingency plan, see the MLN Matters article on the CMS website at:
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf

If you are reporting the correct NPI, but Medicare does not have it on file, it could be due to information you used when you enrolled for your NPI. There are five items that could cause you to have issues with your NPI:

- Errors in Employer Identification Number (EIN)
- Invalid or incomplete data within the 'Other Provider Identifiers' section of the NPPES online application
- Reporting an incomplete identifier
- Having more than the allowable number of legacy numbers
- Listing legacy numbers that do not belong to the applicant

CMS recommends that National Plan and Enumeration System (NPPES) data be validated and that providers make sure the key elements listed above are correct. To validate the data while enrolling for an NPI, you may go to the NPPES website at https://nppes.cms.hhs.gov to view and make changes to the data. If an EIN error is on the Medicare provider enrollment, then you must submit a CMS-855 Form to Highmark Medicare Services. For more details on handling NPI errors, please read the MLN Matters article on the CMS website at:
http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf

Reporting Individual and/or Group NPIs

Healthcare provider organizations that currently have a group Medicare legacy identifier must obtain an NPI for the group. Individual healthcare providers, including those within a group, who currently have an individual Medicare legacy identifier, must obtain an NPI for themselves. There are situations where both the group's and the individual doctor's NPIs are reported on a claim. Medicare business requirements for submitting claims for a group and its members has not changed. The number used to submit claims has changed from using a legacy number, such as a PIN, to using an NPI.

For example:

- If a group is billing for services performed by a rendering physician(s) within their group and the group is to receive Medicare reimbursement; the group NPI should be reported at the Claim Level and the individual rendering physician's NPI should be reported on the Service Line Level for each service provided by the rendering physician.

- If an individual physician provided all the services and the individual is to receive Medicare reimbursement; the individual physician's NPI should be reported at the Claim Level. There is no need to report the individual physician's NPI on the Service Line Level(s).

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Once you receive your NPI(s), you should share your NPI(s) with other providers with whom you do business, and with health plans that request your NPI(s). Under current regulation, providers who are covered entities under HIPAA must share their NPIs with any entities that need them for billing purposes; including those who need their NPI for designation of ordering or referring physician.

For more information on how to use the NPI correctly on Part B claims, please read the MLN Matters article on the CMS website at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf

Reporting the NPI in the X12N 837 Institutional Claim

- **Reporting The NPI Only:** When submitting X12N 837 Institutional EDI claims with the NPI only, use the Identification Code Qualifier XX in NM108 and enter the NPI in NM109.

Loop	Segment/Data Element	Data Element Description
2010AA	NM109	Billing Provider NPI ID
2010AB	NM109	Pay to Provider NPI ID
2310A	NM109	Attending Physician NPI ID
2310B	NM109	Operating Physician NPI ID
2310C	NM109	Other Provider NPI ID
2310E	NM109	Service Facility NPI ID
2420A	NM109	Attending Physician NPI ID
2420B	NM109	Operating Physician NPI ID
2420C	NM109	Other Provider ID

- **Reporting Both The NPI And Legacy Number:** When submitting X12N 837 Institutional EDI claims with the NPI and the legacy number, use the Identification Code Qualifier XX in NM108 and enter the NPI in NM109. Continue to submit your Medicare provider number in the REF 02 segment with the appropriate qualifier. Use the 1C qualifier for reporting the Medicare provider number and the 1G qualifier for the Medicare UPIN. Please see the chart on Page 19.

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NPI: A Closer Look., continued from Page 18

Loop	Segment/Data Element	Data Element Description
2010AA	NM109 REF02	Billing Provider NPI ID Billing Provider Medicare ID
2010AB	NM109 REF02	Pay to Provider NPI ID Pay to Provider Medicare ID
2310A	NM109 REF02	Attending Physician NPI ID Attending Physician Medicare ID
2310B	NM109 REF02	Operating Physician NPI ID Operating Physician Medicare ID
2310C	NM109 REF02	Other Provider NPI ID Other Provider Medicare ID
2310E	NM109 REF02	Service Facility NPI ID Service Facility Medicare ID
2420A	NM109 REF02	Attending Physician NPI ID Attending Physician Medicare ID
2420B	NM109 REF02	Operating Physician NPI ID Operating Provider Medicare ID
2420C	NM109 REF02	Other Provider ID Other Provider Medicare ID

EDI Inbound Reject Codes

Highmark Medicare Services uses the MEDATRAN Claims Translator. Below is a list of EDI Inbound Reject Codes you may receive:

Edit Number	Loop	Edit Description
99	2010AA	The NPI/Legacy combination does not match the NPI crosswalk.
99	2010AB	The NPI/Legacy combination does not match the NPI crosswalk.
99	2310A,B,C	The NPI/Legacy combination does not match the NPI crosswalk.
99	2420A	The NPI/Legacy combination does not match the NPI crosswalk

Some Medicare FIs and A/B MACs have developed front-end reason codes that will return claims to the providers when the NPI and Legacy combination submitted does not match the NPI crosswalk. If a reject or RTP (Return to Provider) is received, providers are encouraged to verify that their NPI/Legacy combination is valid in NPPES first at https://nppes.cms.hhs.gov/.

The following is a listing of Front-end Processing Reason Codes:

Code	Description
32000	This claim has been rejected because the intermediary has no record of the Medicare provider number submitted.
32102	The claim contains an NPI but the first digit of the NPI is not equal to "1", "2", "3","4" or the 10th digit of the NPI does not follow the check digit validation routine. Please verify billing and, if appropriate, correct. **Online providers – press PF9 to store the claim. **Other providers – return to the intermediary.
32103	NPI/OSCAR pair on the claim is not present in the Medicare NPI Crosswalk File. This edit applies to the NPI associated with the OSCAR number. Please verify provider billing number and, if appropriate, please correct either NPPES or your CMS-855 information. Please verify all of your information in NPPES. You should validate that the NPI/OSCAR pair you are using on the claim reflects the OSCAR number that you reported to NPPES. You may view/ correct your NPPES information by going to https://nppes.cms.hhs.gov. If your NPPES information is correct, and you have included all Medicare legacy identifiers (OSCARS) in NPPES, but you are still experiencing problems with your claims that contain a valid NPI, you may need to submit a Medicare enrollment application (i.e. – the CMS 855). Please contact your contractor prior to submitting a CMS-855 form.
32104	The NPI and the legacy (OSCAR) number are present on the claim and the NPI is present in the Crosswalk File, but the associated legacy (OSCAR) number in the Crosswalk file does not match the legacy (OSCAR) number on the claim. Please verify billing number and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other Providers – Return to the intermediary.
32105	The NPI is present in the Crosswalk File but the NPI corresponds to more than one legacy (OSCAR) number. Enter the OSCAR number associated with the NPI submitted. Please verify billing number and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.
32107	The NPI for the attending physician on the claim is not present in the Crosswalk File. Please verify billing number and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.
32108	The attending physician's NPI and UPIN are present on the claim and the attending physician's NPI is present in the Crosswalk File, but the attending physician's UPIN in the Crosswalk File does not match the attending physician's UPIN on the claim. Please verify the UPIN and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.
32109	The operating physician's NPI on the claim is not present in the Crosswalk File. Please verify billing number and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.
32110	The operating physician's NPI and UPIN are present on the claim and the operating physician's NPI is present in the Crosswalk File, but the operating physician's UPIN in the Crosswalk File does not match the operating physician's UPIN on the claim. Please verify the UPIN and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.
32111	The other physician NPI on the claim is not present in the Crosswalk File. Please verify the billing number and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.
32112	The other physician's NPI and UPIN are present on the claim and the other physician's NPI is present in the Crosswalk File, but the other physician's UPIN in the Crosswalk File does not match the other physician's UPIN on the claim. Please verify the UPIN and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.
32113	The taxonomy code entered is invalid. Or, a taxonomy code is required when the NPI is present in the Crosswalk File and the NPI corresponds to more than one legacy (OSCAR) number. Please verify the billing number and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.

Who Needs An NPI?

Medicare is transitioning from the provider identifiers it currently uses in HIPAA standard transactions to the new National Provider Identifier, or NPI. Current identifiers, which are now referred to collectively as legacy identifiers or legacy numbers, could include:

- Online Survey Certification and Reporting (OSCAR) system numbers;
- National Supplier Clearinghouse (NSC) numbers;
- Provider Identification Numbers (PINs); and
- Unique Physician Identification Numbers (UPINs) used by Medicare. **Note:** Under the Medicare Fee-for Services (FFS) Contingency Plan, UPINs and surrogate UPINs may still be used to identify ordering and referring providers and suppliers until further notice. However, this contingency plan does not affect CMS' discontinuance of assigning UPINs effective June 29, 2007, or any plans to disable the UPIN "look-up" functionality as of September 30, 2007. For details on the discontinuance of the UPIN Registry, see the MLN Matters article on the CMS website at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5584.pdf

NPIs are for healthcare providers and suppliers covered under HIPAA. All HIPAA covered healthcare providers who would either bill Medicare; render care to Medicare beneficiaries; order durable medical equipment, supplies, or services for beneficiaries; refer beneficiaries for other health care services; act as an attending physician when a beneficiary is hospitalized; prescribe covered retail prescription drugs for beneficiaries; operate on beneficiaries; or could otherwise be identified on a claim submitted to Medicare for payment must obtain an NPI.

This applies whether providers are individuals (such as physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) or organizations (such as hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, managed care organizations, suppliers of durable medical equipment, pharmacies, etc.), each must obtain an NPI for use to identify themselves in HIPAA standard transactions. The NPI will not change and will remain with the provider regardless of job or location changes. Providers and Suppliers may now apply for their NPI on the National Plan and Enumeration System (NPPES) website at:
https://nppes.cms.hhs.gov on the CMS website. To request a paper application, call 1-800-465-3203.

For additional NPI information and updates, visit the CMS NPI website at:
http://www.cms.hhs.gov/NationalProvIdentStand/