ELECTRONIC DATA INTERCHANGE (EDI)

Electronic claim submission
For medical and behavioral health care providers

Together, all the way.

Cigna®

OVERVIEW

Welcome

We want to help you make the most of your time, and provide the tools you need to help lower your administrative costs.

When you submit claims electronically, it's faster, more accurate, and less expensive than submitting claims by paper.

This course will provide you with the information you need to submit health care provider and facility claims electronically to Cigna.

What's inside?

- Required information to submit an electronic claim
- Submitting coordination of benefit information
- Understanding corrected claims
- How to get started

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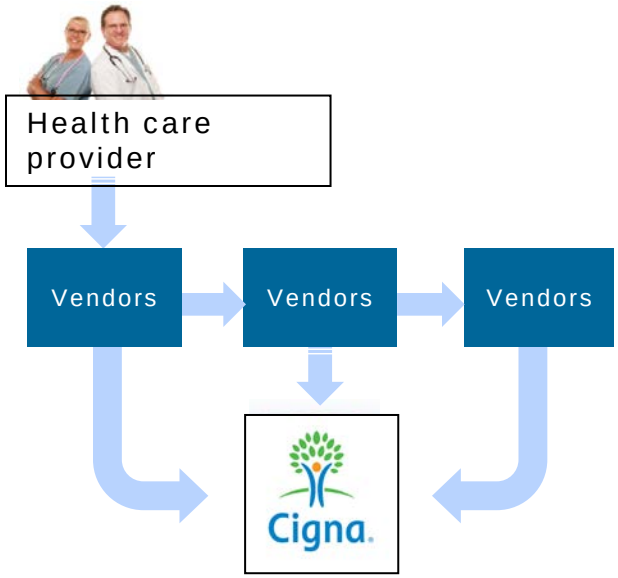
WHAT IS ELECTRONIC DATA INTERCHANGE (EDI)?

EDI is the electronic exchange of health care information between health care providers and facilities, payers, and vendors.

Patient information is transferred between health care providers and payers in a standardized and secure way.

Research* has shown that health care providers who use EDI transactions can save time and money through:

- Improving claim accuracy, while decreasing the chance of transcription errors or missing data
- Reducing paperwork, and eliminating printing and mailing expenses
- Eliminating the need to submit claims to multiple locations
- Utilizing one user ID and password to access and interact with multiple health plans



* Source: Council for Affordable Quality Healthcare (CAQH) 2016 Efficiency Index®

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EDI TRANSACTION TYPES AND PAYER IDS

Electronic claim submission allows you to submit claims quickly, track claims received, and save time on resubmissions.

You can submit various claim types through your clearinghouse, practice management system, or EDI vendor, including:

- Professional
- Institutional
- Dental (including encounters and predeterminations)
- Coordination of benefit (COB) – secondary, tertiary, etc.
- Corrected

Use Cigna payer ID 62308

for submitting medical, behavioral* dental, and Arizona Medicare Advantage HMO electronic claims.

Primary and secondary claims

You can submit both primary and COB claims electronically to Cigna.

You don't have to submit Medicare Part A and B coordination of benefits agreement (COBA) claims to Cigna This is because the Medicare explanation of benefit (EOB) or electronic remittance advice (ERA) will show that those claims are forwarded to Cigna as the secondary payer. Please note that the CMS Medicare Crossover process does not forward claims to Cigna that were 100% paid by Medicare or 100% denied by Medicare.

* Including employee assistance program.

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HOW TO SUCCESSFULLY SUBMIT AN ELECTRONIC CLAIM

Information needed

Patient's ID number Can be submitted with or without the suffix (e.g., U12345678 or U1234567801)	**Date of service, or admission and discharge dates**
Patient's date of birth	**Diagnosis codes** (e.g., ICD-10 and DRG)
Patient's first and last name	**Standard code sets** (e.g. CPT-4, revenue codes, HCPCS, NDC, and CDT) and description of procedure
Patient's address	**Charge amount for each procedure**
If the patient is not the subscriber: **Subscriber's name, ID number, and date of birth** *Note that if the patient ID includes a suffix, the patient is considered the subscriber for the claim submission.*	**The street address of the billing provider** *Note that when submitting the billing address:* • It must be a street address • The ZIP code must be nine digits • PO boxes can be submitted in the "Pay to Provider" field only
Name, Taxpayer Identification Number (TIN), and National Provider Identifier* (NPI) of the billing provider	**Place of service**
Name and NPI for the: • Rendering provider • Attending physician • Referring physician	**Prior authorization number** If the service required prior authorization

* If enrolled in electronic funds transfer (EFT) with a payment bulking preference of NPI, the submitted billing provider NPI will be used to bulk or group your payments and remittance advices. To learn more, access the EDI Electronic Payment and Remittance Advice eCourse by logging in to the Cigna for Health Care Professionals website (CignaforHCP.com) > Resources > eCourses.

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SUBMITTING COORDINATION OF BENEFITS CLAIMS

You can submit COB claims electronically, eliminating the need to attach primary explanation of payments (EOPs).

To submit COB claims electronically, you'll need to enter information from the primary payer ERA or EOP into the electronic claim. Be sure to include:

- Updated subscriber information to reference the subscriber of the COB payer. Enter the subscriber from the primary payer in the Other Subscriber Information fields.
- Payer paid, total non-covered, and remaining patient liability amounts from the primary payer at both the claim and service line levels, if available.
- Claim adjustment reason codes (may require converting the primary payer's EOP into the standard coding used in an ERA).
- Adjudicated procedure codes (may be different than the submitted procedure codes).
- Primary payer's claim adjudication date.

It's easiest to submit COB claims electronically if you receive ERAs, and your practice management system or accounts receivable system is able to automatically populate information from the ERAs* into the electronic COB claims.

Cigna already receives COB claims directly from Medicare. If the Medicare ERA contains an MA18 remark code, the claim has been automatically forwarded to Cigna, and there is no need to send a COB claim to us.

* To learn more about ERA, access the Electronic Payment and Remittance eCourse by logging in to CignaforHCP.com > Resources > eCourses.

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ADDITIONAL CLAIM SUBMISSION TIPS

Attachments

- If we receive a claim that requires supporting documentation, we will request the documentation from you.
- If you check a claim's status on CignaforHCP.com, and see that supporting documentation is required for a pended claim, you may upload the requested documents there.
- You can upload attachments for your pended claims as a registered user of CignaforHCP.com. Log in the website, and perform a claim search to find your pended claim.
- To send supporting documentation when the claim is submitted, indicate in the PWK (claim supplemental information) segment of Loop 2300 of the electronic claim that the documentation will be sent through another channel.
- The indicators on the electronic claim include the delivery method (PWK02) for sending the attachment (e.g., fax or mail), as well as the description code (PWK01) for the type of attachment (e.g., physician report or operative notes).
- You can also mail supporting documentation to the Cigna address on the back of the patient's ID card.

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ADDITIONAL CLAIM SUBMISSION TIPS (CONT.)

Anesthesia and National Drug Codes

Anesthesia

- Claims should be reported with minutes in the SV104 segment of Loop 2400 on professional claims.
- The surgical code related to anesthesiology services can be included, and additional anesthesia units can be reported for additional complexity beyond normal obstetric services.

National Drug Codes (NDCs)

- Drugs provided as part of a service should be reported in the LIN segment of Loop 2410 on institutional claims.
- Compound drugs should have a HCPCS code tied to a NDC. The association number must be included to link together the compound drug ingredients.

Information related to attachments, anesthesia, and NDCs should not be placed in the NTE (claim note) segment of the electronic claim. We will not recognize the information if it's included in the NTE segment. If you have trouble completing the information, your vendor can help.

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CORRECTED CLAIMS MADE EASY

What is a corrected claim?

This is a claim that was originally submitted with incorrect or missing information, and is resubmitted with the correct or updated information.

How to submit a corrected claim

You can submit a corrected clam electronically by completing the claim information, and updating the claim frequency code* with:

7 = Replacement
(replacement of a prior claim)

8 = Void
(void or cancellation of a prior claim)

*** The claim frequency code allows us to recognize the electronic submission as a corrected claim, instead of as a duplicate claim submission.**

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CLAIM ACKNOWLEDGMENTS AND TIMELY SUBMISSION

A primary benefit of submitting claims electronically is the timely notification of whether your claims have been accepted or rejected.

- **Your vendor does the initial data integrity validation** to improve claim accuracy. This is to make certain all required fields are complete, and that only active codes are being submitted.
- When we receive the claim, **we will complete the data integrity validation**, and confirm the patient is a Cigna customer with active coverage.

  We will also validate that the submitted codes are consistent with the age and gender of the patient. A claim acceptance at this point can serve as proof of timely filing.

It's best to submit claims as soon as possible.

If you're unable to file a claim right away, we will consider:

- Participating health care provider claims that were submitted three months (90 days) after the date of service, or
- Non-participating health care provider or patient claims submitted six months (180 days) after the date of service

If services are provided on consecutive days, such as for a hospital confinement, the limit will be counted from the last date of service.

If a claim is not accepted, the claim acknowledgment will indicate if the patient does not have Cigna coverage, or if there is a data error within the claim.

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HOW TO GET STARTED SUBMITTING CLAIMS ELECTRONICALLY

EDI offers flexibility in working with vendors of your choice.

Submitting claims electronically can be done with minimal cost and time.

All you need are a computer and Internet access. Then, simply choose how you want to connect with Cigna.

- You can use one user ID and password to work with multiple payers, including Cigna.
- For the latest information on our EDI vendors and the transactions they support, visit How to Submit Claims to Cigna.

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WORKING WITH VENDORS TO SUBMIT CLAIMS

How does this work?

1. Your vendor converts your claim information into the ANSI X12 format.
2. Cigna then transmits claim status information to your vendor in the ANSI X12 format.
3. Your vendor reformats the information into a readable format.
4. How the claim and claim acknowledgment information are displayed can vary by vendor.

If you have questions:

- About **claims submitted through your EDI vendor**, contact your vendor directly.
- About **Cigna claim processing**, call:
  - Medical and behavioral PPO* and OAP** claims – 1.800.88Cigna (1.800.882.4462)
  - All other behavioral claims – 1.800.926.2273
  - Dental claims – 1.800.Cigna24 (1.800.244.6224)

* Preferred provider organization
** Open Access Plus

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Congratulations.

You've completed the Electronic Data Interchange (EDI) Electronic Claim Submission eCourse.

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Today.

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