ELECTRONIC DATA INTERCHANGE (EDI)

ELECTRONIC CLAIM SUBMISSION
for medical and behavioral health care professionals

What's Inside?

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

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WELCOME

At Cigna, we want to help you make the most of your time and provide the tools to help lower your administrative costs.

Using electronic claim submission is faster, provides more accurate claim payment, and is less expensive than submitting paper claims.

This course will provide you with information about submitting health care professional and facility claims electronically to Cigna.

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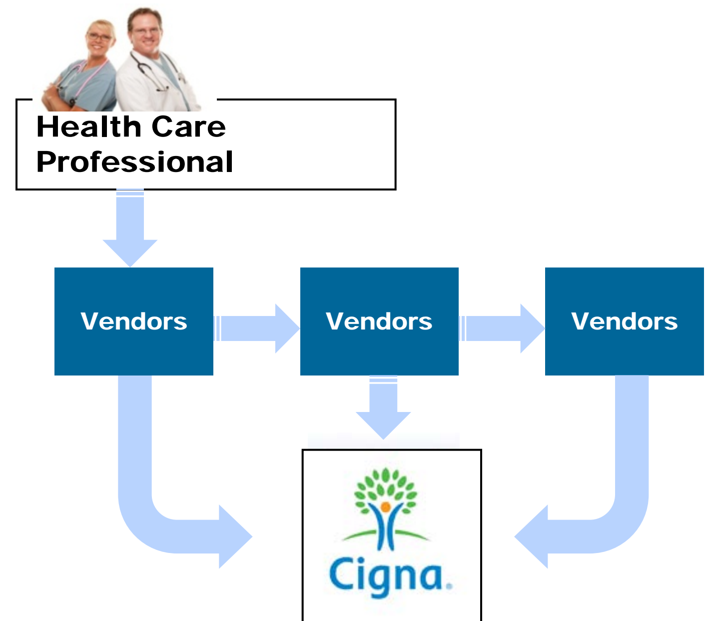
WHAT IS EDI?

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

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

Research* has shown that health care professionals 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: Milliman, "Electronic Transaction Savings Opportunities for Physician Practices," 2006.

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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 benefits (secondary, tertiary, etc.)
- Corrected claims

Use these Cigna payer IDs for submitting electronic claims

- **62308** for Medical (including GWH-Cigna and Payer Solutions network),
  Behavioral (including employee assistance program),
  Dental, and Arizona Medicare Advantage HMO
- **59225** for Starbridge Beech Street

Both primary and secondary (COB) claims can be submitted electronically to Cigna.

You don't have to submit Medicare Part A and B coordination of benefits agreement (COBA) claims to Cigna, as the Medicare explanation of benefit (EOB) or electronic remittance advice (ERA) will show that those claims are forwarded to Cigna as the secondary payer.

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INFORMATION NEEDED TO SUCCESSFULLY SUBMIT AN ELECTRONIC CLAIM

Patient's ID number (Can be submitted with or without the suffix, e.g., U12345678 or U12345678**01**)	Date of service, or admit and discharge dates
Patient's date of birth	Diagnosis codes (ICD-9, ICD-10, DRG)
Patient's first and last name	Standard code sets (e.g. CPT-4, Revenue Code, HCPCS, NDC, 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: If the patient ID includes a suffix, the patient is considered the subscriber for claim submission.	The street address of the billing provider. Note: When submitting the billing address: • It must be a street address • The ZIP code must be nine digits • P.O. 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 are required	Place of service
Name and NPI are required for the: - Rendering provider - Attending physician - Referring physician	Prior authorization number, if service required prior authorization

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

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SUBMITTING COORDINATION OF BENEFITS CLAIMS

Coordination of benefits (COB) claims (secondary, tertiary, etc.) can also be submitted electronically, eliminating the need to copy primary explanation of payments (EOPs).

To submit COB claims electronically, you'll need to enter information from the primary payer electronic remittance advice (ERA) or EOP into the electronic claim:

- Subscriber Information must be updated to reference the subscriber of the COB payer. The subscriber from the primary payer should be entered in the "Other Subscriber Information" fields.
- Payer Paid, Total Non-Covered and Remaining Patient Liability amounts from primary payer at both the claim and service line level, if available
- Claim Adjustment Reason Codes (may require converting the primary payer's EOP into the standard coding used in an ERA)
- Adjudicated Procedure Code (may be different than Submitted Procedure Code)
- Primary payer's Claim Adjudication Date

Electronic COB submission is easiest if you receive ERA and your practice management or account receivable system is able to automatically populate information from the ERA into the electronic COB claim.

To learn more about ERA, access the Electronic Payment and Remittance eCourse on the Cigna for Health Care Professionals website (CignaforHCP.com) > Resources > eCourses.

Cigna already receives secondary 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 Cigna.

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ADDITIONAL CLAIM SUBMISSION TIPS

Attachments

- Claims should be submitted electronically.
- If we receive a claim that requires supporting documentation, we request the additional documentation.
- If you wish 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, mail), as well as the description code (PWK01) for the type of attachment (e.g., physician report, operative notes).
- Supporting documentation can be mailed to the Cigna address on the back of the patient's ID card.

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 Code (NDC) Numbers

- 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 tied to a NDC. The association number must be included to link together the compound drug ingredients.

Information related to attachments, anesthesia, and NDC numbers 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

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

Corrected claims can be submitted electronically by completing the claim information and updating the Claim Frequency Code with:

7 = Replacement (replacement of prior claim)

8 = Void (void/cancellation of prior claim)

The Claim Frequency Code allows us to recognize the electronic submission as a corrected claim, instead of 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.

1. Initial validation is done by your vendor to improve claim accuracy. The data integrity validation makes certain all required fields are complete and that only active codes are being submitted.
2. Upon receipt of the claim, we will complete data integrity validation and confirm the patient is a customer of Cigna with active coverage. We also validate that the codes submitted 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 professional claims submitted three months [90 days] after the date of service, or
- Non-participating health care professional 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.
- You do not have to purchase additional software to work with Cigna.
- You can connect directly to Cigna using the Post-n-Track® web service, or through an EDI vendor.
  - The Post-n-Track web service is free to health care professionals in the Cigna network. To enroll, contact Post-n-Track at 860.257.2030, or visit Post-n-Track.com/Cigna.
  - For the latest information on our EDI vendors and the transactions they support, visit Cigna/EDIvendors.com.

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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 is displayed can vary by vendor.

For questions about claims submitted through your EDI vendor, contact your vendor directly. For questions 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)

Companion Guides, providing detailed information regarding our required data guidelines, are available from vendors who directly contract with Cigna to submit electronic claims.

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

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