Claim submission tips: Individual & Family Plans

For Health Care Providers

March 2024

Codes to use

When submitting claims for your patients with Cigna Healthcare Individual & Family Plan coverage, it's important to report their current health status and document their encounter for medical care using several different code types.

- International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
- Current Procedural Terminology (CPT®)
- CPT Category II (CPT II)
- Healthcare Common Procedure Coding System (HCPCS)

Tips for success

When submitting a claim:

- Report all diagnoses related to your patient's current health care status at the time of service.
- Report conditions to the greatest level of specificity and laterality, when appropriate.
- Consider all comorbid conditions related to the assessed chronic condition(s) that are appropriate for the current visit.
- Utilize additional ICD-10-CM codes to describe specific stages, terminology, and status codes (e.g., chronic kidney disease stage 3, diastolic congestive heart failure, Z-codes).
- Ensure timely claims submission.
- Verify your patient's eligibility for Cigna Healthcare coverage at the time of service.

When providing source documentation support:

- Ensure that the provider's authorized signature, credentials, and date are on the progress note within 180 days from the date of service.
- Be sure diagnostic statements are consistent between the progress note and the claim form (e.g., if the progress note identifies E11.9 – Type 1 diabetes mellitus without complications, the claim form should not identify a conflicting diagnosis, such as diabetes mellitus with complications).
- Documentation should accurately reflect services rendered.

