ELECTRONIC DATA INTERCHANGE

Electronic claim submission

to help you successfully submit electronic claims

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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 claims electronically to Evernorth.

What we will cover in this tutorial

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

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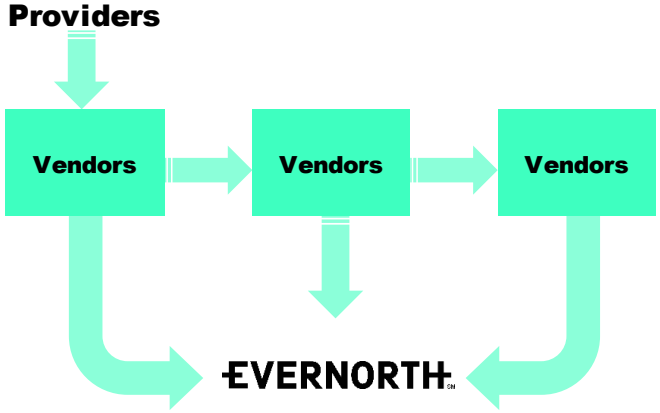
What is electronic data interchange?

Electronic data interchange (EDI) is the electronic exchange of health care information between providers and facilities, payers, and vendors.

With EDI, patient information is transferred between providers and payers in a standard and secure way.

Research* shows that health care providers who use EDI transactions can save time and money by:

- 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



Evernorth's payer ID is 62308

**Source: Council for Affordable Quality Healthcare (CAQH), "2020 U.S. Healthcare Efficiency Index®", 2021*

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EDI transaction types and payer IDs

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

+ Professional
+ Institutional
+ Coordination of benefit (COB) – secondary, tertiary, etc.
+ Corrected

Use Evernorth payer ID 62308

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

Including employee assistance program (EAP) claims

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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 U1234567***01***)

Patient's date of birth

Patient's first and last name

Patient's address

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 the claim submission.

Name, Taxpayer Identification Number (TIN), and National Provider Identifier* (NPI) of the billing provider

Name and NPI for the:
+ Rendering provider
+ Attending physician
+ Referring physician

Date of service, or admission and discharge dates

Diagnosis codes (e.g., ICD-10 and DRG)

Standard code sets (e.g. CPT-4, revenue codes, HCPCS, NDC, and CDT) and description of procedure

Charge amount for each procedure

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

Place of service

Prior authorization number
If the service requires 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.*

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Submitting coordination of benefits claims

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.

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

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.

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

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Corrected claims made easy

What is a corrected claim?

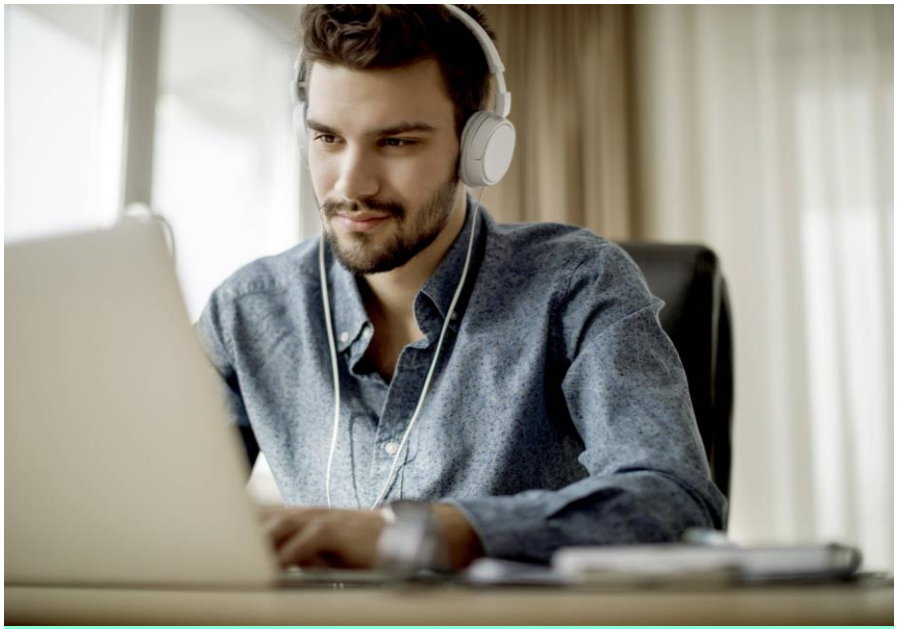
This is a claim that was originally submitted with incorrect or missing information, and is resubmitted with the correct or updated information.

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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Additional claim submission tips

Attachments and supporting documentation

+ If we receive a claim that requires supporting documentation, we will request the documentation from you.
+ If you check a claim's status on Provider.Evernorth.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 Provider.Evernorth.com. Log-in to 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 address on the back of the patient's ID card.

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Claim acknowledgements 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 an Evernorth or Cigna customer with active coverage.
+ We will also validate that the submitted codes are consistent with the age 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 provider claims that were submitted three months (90 days) after the date of service, or
+ Non-participating 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 Evernorth or Cigna coverage, or if there is a data error within the claim.

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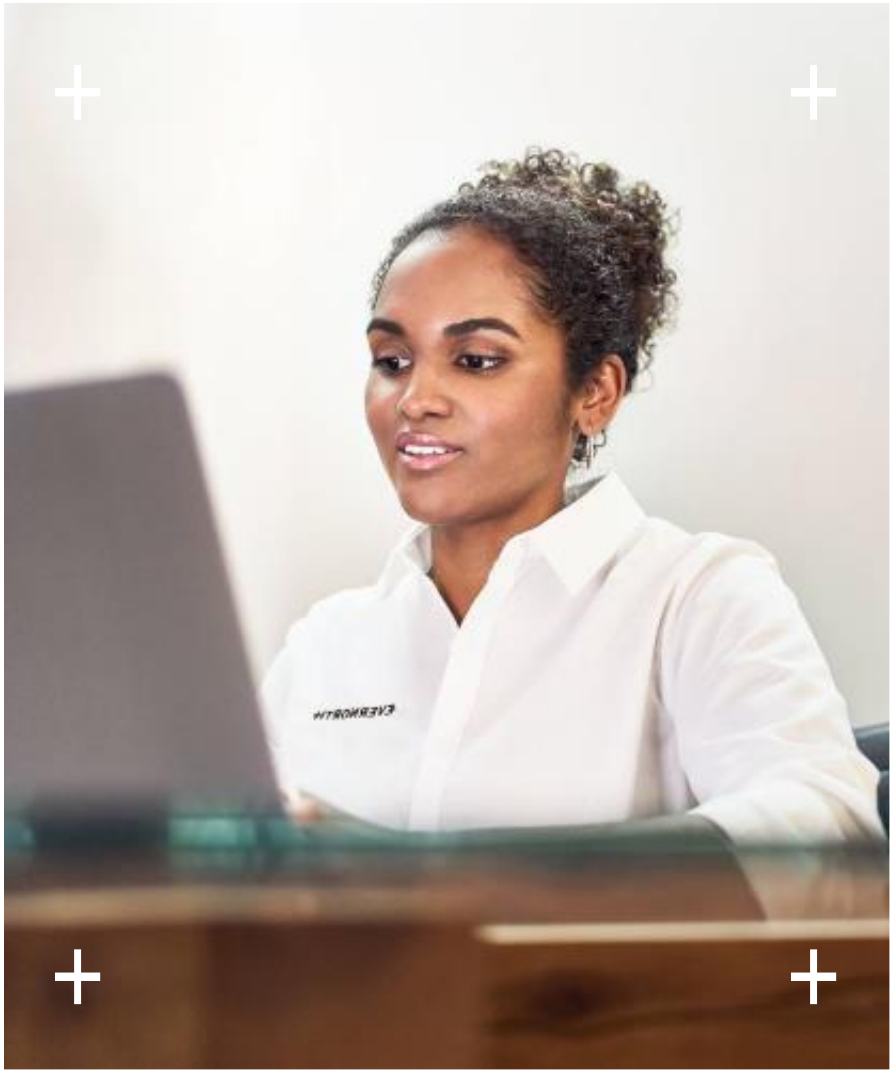
How to get started

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 Evernorth.

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



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Working with vendors

How does this work?

1. Your vendor converts your claim information into the ANSI X12 format.
2. We then transmit claim status information to your vendor in the ANSI X12 format.
3. Your vendor reformats the information into a readable format.
4. The display of claim and claim acknowledgment information can vary by vendor.

If you have questions:

About **claims submitted through your EDI vendor**, contact your vendor directly.

For claim processing, call:

+ Evernorth behavioral claims – 1.800.926.2273
+ Cigna Medical and Behavioral PPO* and OAP** claims – 1.800.88Cigna (1.800.882.4462)
+ Dental claims – 1.800.Cigna24 (1.800.244.6224)

* *Preferred provider organization*
** *Open Access Plus*

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CONGRATULATIONS!

You have completed the Electronic Data Interchange Electronic Claim Submission tutorial.

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