HIPAA 5010 Implementation

FAQs for Health Care Professionals

Released March 23, 2012

Key Messages

In January 2009, the Department of Health and Human Services published the final rule containing the requirements for the health care industry to upgrade electronic data interchange transactions to HIPAA version 5010 by January 1, 2012. The new rules apply across the health care industry to health plans, physicians, hospitals, and other health care professionals, and employer group health plans and vendors that currently use HIPAA version 4010 to transmit data.

Version 5010 replaces the current version of the X12 standard that the above mentioned entities must use when conducting electronic transactions, including:

- o Claims (professional, institutional and dental) – 837
- o Claims status inquiries and responses – 276/277
- o Payment remittance to health care professionals – 835
- o Eligibility inquiries and responses – 270/271
- o Precertification requests and responses – 278
- o Enrollment and disenrollment in a health plan – 834
- o Coordination of Benefits and premium payments – 820

Cigna is currently accepting and sending 5010 transactions in support of 5010 compliance and is committed to helping physicians and hospitals successfully migrate to 5010. When the transition to 5010 is complete, we expect that health care professionals and customers will benefit from even quicker and more accurate claim processing on Cigna's new gateway.

Questions and Answers about HIPAA 5010

General Questions

1. **What do I need to do to become 5010 compliant?**
    You should work directly with your trading partner to determine what is needed to become 5010 compliant. Trading partners are working with Cigna to ensure all files are 5010 compliant.

2. **Why is it important for me to work directly with my trading partner?**
    Trading partners are upgrading their systems to be able to handle 5010 transactions. It is important for you to understand your trading partner's requirements, because the trading partner may have built compliance checks or other helpful capabilities into their process.

3. **Am I required to update my computer software?**
    Required software updates are based on your software or system. You should contact your trading partner to verify if any updates are needed.

4. **Is a national provider identifier (NPI) required to submit 5010 transactions?**
   Yes. A NPI is required when submitting 5010 transactions.

5. **Will Cigna audit my current address and contract files?**
   No. You should review and update your "Billing Provider" and "Pay to Provider" name and address information as needed to avoid claim rejections, delays, or processing errors, especially if you have changed how you submit claims.

6. **Has Cigna provided 5010 companion guides?**
   Cigna provided clearinghouses with technical companion guides for each trading partner. Your trading partner should use the information provided in that guide to produce a less technical document for you or your software vendor to use.

   The following companion guides were distributed in April 2011:
   o   837 Institutional – inbound
   o   837 Professional – inbound
   o   837 Dental – inbound
   o   837 Institutional – outbound (Alliance)
   o   837 Professional – outbound (Alliance)
   o   835

   The following companion guides were distributed in May 2011:
   o   834
   o   820

   The following companion guides were distributed in June 2011:
   o   277 RFAI
   o   277 PEND
   o   276/277 Batch and interactive
   o   278 Request/response batch and interactive
   o   270/271 Batch and interactive
   o   837 Institutional – outbound (redirects)
   o   837 Professional – outbound (redirects)

7. **What compliance level does Cigna validate on incoming transactions?**
   Cigna currently validates compliance Levels 1 through 4:
   o   Level 1 – Valid segments, segment order, element attributes, verifying that numeric data elements have a numeric value, validation of X12 syntax and compliance with X12 rules
   o   Level 2 – HIPAA implementation guide specific requirements like repeat counts, used vs. unused codes, elements and segments, and required or intra-segment situational data elements
   o   Level 3 – Balancing: balanced field totals, record or segment counts, financial balancing of claims and balancing of summary fields
   o   Level 4 – Specific inter-segment situations described in the HIPAA implementation guides (i.e. if A occurs then B must be present)

8. **What compliance level does Cigna validate on outgoing transactions?**
   Transactions sent from Cigna's gateway are first validated for compliance Levels 1 through 4.
   o   Level 1 – Valid segments, segment order, element attributes, verifying that numeric data elements have a numeric value, validation of X12 syntax and compliance with X12 rules
   o   Level 2 – HIPAA implementation guide specific requirements like repeat counts, used vs. unused codes, elements and segments, and required or intra-segment situational data elements
   o   Level 3 – Balancing: balanced field totals, record or segment counts, financial balancing of claims and balancing of summary fields
   o   Level 4 – Specific inter-segment situations described in the HIPAA implementation guides (i.e. if A occurs then B must be present)

   Cigna runs reports for Level 5 compliance to identify future improvement opportunities.
   o   Level 5 – Code set testing: valid implementation guide specific code set values; accepted code set values are international classification of diseases, ninth edition, clinical modification (ICD–9CM), volumes one through three, health care financing administration common procedure coding system (HCPCS) except for level three or local codes and current procedural terminology,

fourth edition (CPT-4)

9. **What's been the response to industry-wide challenges with meeting migration deadlines?**
    Recognizing the challenges facing the industry, CMS issued updated guidance in March 2012 announcing an additional 90-day discretionary enforcement period for penalties – an extension that was welcomed by the entire industry. The 90-day discretionary period began on January 1, 2012 and ends on June 30, 2012. This extension has allowed for continued resolution of issues in the end-to-end process.

10. **Are materials available about Cigna's 5010 plans and readiness?**
    Yes. You can find more information on the 5010 page on Cigna.com (Cigna.com > Health Care Professionals > Resources for Health Care Professionals > Doing Business with Cigna > 5010 Transaction Standards).

    These FAQs are also available on the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Communication > HIPAA 5010/ICD-10 Updates > 5010 Implementation FAQs).

11. **Will any standard transactions remain on version 4010?**
    No standard transactions will remain on version 4010 after all trading partners have migrated. However, other formats may exist for employers and other entities not subject to the regulation, who submit enrollment and payroll deduction information, similar to the information contained in the 834 and 820 transactions.

12. **Who can I contact with 5010 inquiries?**
    Our eService Leads can assist you with HIPAA 5010 inquiries. Please contact the eService Lead for your region:

    o   West – Elizabeth Beto: Elizabeth.Beto@cigna.com
    o   Southeast – Justine Durant: Justine.Durant@cigna.com
    o   Northeast – Vera Papalko: Veronica.Papalko@cigna.com
    o   National contracts – Ana Isabella: Ana.Isabella@cigna.com

Electronic Claim (837) and Claim Acknowledgments (999 and 277CA)

1. **Who should I contact to determine what has changed and which fields are required on an 837 claim submission?**
    Cigna provided all trading partners with our technical guides (companion guides). You should work with your trading partner to determine what has changed.

2. **Will Cigna accept a PO Box in the "Billing Provider" field for 5010?**
    No. With the 5010 changes, a PO Box can be submitted in the "Pay to Provider" field only. You must submit a street address in the "Billing Provider" field. In order to avoid claim rejection and delays, submit any demographic or billing ID (TIN or NPI) changes following standard processes.

3. **Will Cigna utilize 999 and 277CA transactions?**
    Yes, Cigna will utilize the 999 and 277CA with any trading partner that can accept them.

4. **Will Cigna be supporting a 277X213 [277 request for additional information (RFAI)]?**
    Cigna will implement the 277RFAI in 2012 to any trading partner that can accept them. Additional communications will announce when this transaction becomes available.

5. **Will Cigna support unique member IDs for dependents?**
    Yes. Cigna has unique IDs for dependents.

6. **Will Cigna provide a TA1 – Interchange Acknowledgment?**
    Yes, Cigna will provide this information when a TA1 is requested on the submission.

7. **Can the service location still be submitted in the "Service Facility" field under 5010?**
    Yes, if it is different than the "Billing Provider". The "Service Facility" NPI should only be submitted if the service facility is not a subpart of the organization.

8. **Will Cigna audit my current address and contract files?**
    No. You should review and update your "Billing Provider" and "Pay to Provider" name and address information as needed to avoid claim rejections, delays, or processing errors, especially if you have changed how you submit claims.

9. **Will paper claims be affected by the 5010 changes?**
    Yes. Claims sent to Cigna's mail room are scanned and become electronic claims. Cigna's mail room will be migrating to Cigna's new 5010 gateway and will follow the same process as electronic claims. The actual timing for the mail room migration is under review.

10. **Is there a limit to the number of lines that can be submitted on a claim?**
    Yes. Claims with more than 700 claim lines should be split into more than one claim.

11. **What date of service should be submitted on a dental predetermination claim?**
    A date of service should not be submitted on a predetermination claim. If a date of service is submitted at the claim level, it will not be considered a predetermination claim.

12. **Will Cigna reject claims if the billing or service facility ZIP code contains all 0's for the last four digits?**
    No. Cigna will send a warning on the 277CA that the ZIP code received is not a valid ZIP code, but will not reject the claim.

13. **Will Cigna require the license number be submitted on the dental claim?**
    No. The national provider identifier (NPI) and the billing provider tax ID are required. If you would like to continue to send your license number, Cigna will not reject the claim.

14. **What does a claim status of A3/21 mean?**
    This is a claim rejection for missing or invalid information that prevented Cigna from being able to accept or process the claim.
    - A3 – Acknowledgement/returned as unprocessable claim. The claim/encounter has been rejected and has not been entered into the adjudication system
    - 21 – Missing or invalid information

    In most instances, Cigna will provide an additional status code identifying the missing or invalid information.

    If an additional status code is not provided, the claim was rejected for a workgroup for electronic data interchange (WEDI) strategic national implementation process (SNIP) Level 1 or 2 error. An additional error is not identified because an equivalent claim status code is not available for the error. Please work with your trading partner to review the error on the 999 Acknowledgment.
    - Level 1 – compliance checks for valid segments, segment order, element attributes, verifying that numeric data elements have a numeric value, validation of X12 syntax and compliance with X12 rules
    - Level 2 – compliance checks for HIPAA implementation guide specific requirements like repeat counts, used vs. unused codes, elements and segments, and required or intra-segment situational data elements

15. **How should newborn 837 be filed?**
    Subscriber information should be submitted with the following:
    o The policyholder's Cigna ID number without the suffix (for example, U1234567801 should be submitted as U12345678)
    o The policyholder's first name
    o The policyholder's date of birth

    Patient information should be submitted with the following:
    o The first name or "Newborn", "Baby Boy", "Baby Girl", or "Twin A", etc.
    o The newborn's date of birth

16. **What payer ID should be used when submitting claims to Cigna?**
    For medical and dental customers, use the payer ID on the patient's ID card. If the ID card does not

contain a payer ID, use 62308.

For behavioral HMO claims use SX071; for behavioral PPO claims use 62308.

For Arizona Medicare Advantage claims use payer ID 86033.

Cigna will proceed with moving to a single payer ID in the second quarter of 2012.

17. **How should I submit a rendering address on dental claims (837D)?**
The dental claim has a new "Service Facility Address" field that must be used to submit the address where services were rendered.

18. **If I see a claim rejection reason that was not seen under 4010, was the claim rejected correctly?**
There are some common, but valid rejections that may occur under HIPAA version 5010. View the list of these rejections and the actions you should take to resolve them for more details.

19. **I received a communication saying I should use a single payer ID of 62308. Why is Cigna accepting old payer IDs?**
While we continue our transition to a single payer ID, Cigna's trading partners have agreed to accept old Cigna payer IDs to help improve the service experience.

For medical and dental customers, use the payer ID on the patient's ID card. If the ID card does not contain a payer ID, use 62308.

For behavioral HMO claims, use SX071. For behavioral PPO claims, use 62308.

For Arizona Medicare Advantage claims use payer ID 86033.

Cigna will proceed with moving to a single payer ID in the second quarter of 2012.

20. **If I use an old payer ID, do I need to submit the claim in version 4010?**
No. You should continue to send 5010 claims. Your trading partner and Cigna will ensure timely and accurate processing of the claims.

21. **How long will Cigna's trading partners accept claims with old payer IDs?**
You should expect to see a transition to one single Cigna payer ID (62308) in the coming months. You will receive notification about the transition to one single Cigna payer ID through your trading partner.

Electronic Remittance Advice (ERA) – 835

1. **Who can I contact to determine which fields are changing on the 835 remittance advice?**
Cigna has provided all trading partners with our technical guides (companion guides). You should work with your trading partner to determine what is changing.

2. **Will Cigna be able to provide 5010 835 test files from 4010 837 data to health care professionals or groups?**
Cigna is not testing directly with health care professionals or groups. Cigna is testing with our connected trading partners. You should work directly with your trading partner to make certain they are prepared to accept 5010 information.

3. **Will Cigna support unique member IDs for dependents?**
Yes. Cigna has unique IDs for dependents.

4. **Will Cigna require a TA1 – Interchange Acknowledgment?**
Yes, Cigna will request a TA1 acknowledging receipt of the 835.

5. **Will Cigna send 835s for Medicare Advantage HMO patients?**
Yes. Cigna is implementing the 835 for Medicare Advantage HMO patients, although the date the 835 is available through your trading partner may be later than the date 835s are available for other Cigna

products.

A separate enrollment is not needed to receive 835 for Cigna Medicare Advantage HMO patients. Cigna will automatically enroll any health care professionals already receiving 835s for Cigna's other products.

6. **Why is "80705" returned in the REF payer ID of the 835?**
"80705" is returned on the 835 to help you identify 835s for patients on the GWH-Cigna network.

Eligibility and Benefits (270/271)

1. **Who can I contact to determine what is changing and which fields are required on a 270/271 benefits and eligibility submission?**
Cigna will require the fields mandated by the 5010 Technical Report (TR3).

Cigna has provided all trading partners with our technical guides (companion guides). You should work with your trading partner to determine what is changing.

2. **Is Cigna currently able to accept and send 270/271 eligibility transactions?**
Yes. Cigna currently conducts the 270/271 eligibility, coverage and benefit inquiry transaction with many trading partners. Cigna is CORE Phase I certified.

3. **What kind of information does Cigna have available for the 270/271 eligibility transactions?**
For details on the type of information Cigna returns on the 271, please access the eCourse on the Cigna for Health Care Professionals website (CignaforHCP.com > Education and Help > EDI Eligibility and Benefits.

4. **Will Cigna support 270 alternate name searches detailed in the TR3?**
Yes. Cigna will support the alternate member search options. If Cigna is unable to make a unique match based on the search options entered, an AAA segment will be returned to request additional search criteria.

5. **Will Cigna support unique member IDs for dependents?**
Yes. Cigna has unique IDs for dependents.

6. **Will Cigna provide a TA1 – Interchange Acknowledgment?**
Yes, Cigna will provide this information when a TA1 is requested on the submission.

Claim Status Inquiries (276/277)

1. **Who can I contact to determine what is changing and which fields are required on a 276/277 claim status submission?**
Cigna will require the fields mandated by the 5010 Technical Report (TR3).

Cigna has provided all trading partners with our technical guides (companion guides). You should work with your trading partner to determine what is changing.

2. **Will Cigna support unique member IDs for dependents?**
Yes. Cigna has unique IDs for dependents.

3. **Will Cigna provide a TA1 – Interchange Acknowledgment?**
Yes, Cigna will provide this information when a TA1 is requested on the submission.

Client Benefit Enrollment and Maintenance (834)

1. **What 834 clients of Cigna are affected by this 5010 change?**
Any client that is a covered entity (health plan, health care professional, or clearinghouse) is affected by this change.

2. **How should a Cigna client or designated third party administrator start the process for EDI 834?**
To connect with Cigna and start sending 834 transactions, the client should contact their Eligibility Account Specialist or Implementation Manager.

3. **Who can the client or designated third party administrator work with at Cigna to help them with the 834 file format?**
They should contact their Eligibility Account Specialist.