Companion guide

ASC X12N 837I (005010X223A2)

Health Care Claim Institutional 837I

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cigna healthcare

Preface

The Cigna Healthcare® Companion Guide supplements the Health Insurance Portability and Accountability Act (HIPAA) ASC X12N 837I (005010X223A2) Implementation Guide for Institutional Health Care Claims.

Disclosure statement

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1. Introduction

1.1 Scope

This companion guide has been designed to describe to Cigna Healthcare trading partners the format and data content of the 837 Institutional Health Care Claim transaction in the electronic data interchange (EDI) environment.

1.2 Overview

This companion guide will replace, in total, the previous Cigna Healthcare Companion Guide for the 837 Institutional Health Care Claim transaction. This companion guide has been written to assist you in designing and implementing institutional claim transactions to meet Cigna Healthcare processing standards. The Cigna Healthcare Companion Guide identifies key data elements from the transaction that we request you provide to us. The recommendations made are to enable you to more effectively submit institutional claim transactions to Cigna Healthcare.

1.3 References

This document is a companion to the ASC X12N Implementation Guide (005010X223A2) Health Care Claim: 837 Institutional.

2. Getting started

2.1 Working with Cigna Healthcare

Cigna Healthcare trading partners must have an active trading partner agreement. If a third party has been elected to perform electronic transactions, additional trading partner information may be required for setup.

Cigna Healthcare offers multiple connectivity options, as noted in Section 4 below, for exchanging EDI transactions through a consolidated gateway managed by Cigna Healthcare.

Trading partners who have an active trading partner agreement are given IDs and a URL to access the Cigna Healthcare technical assessment tool.

If you have additional questions, please email your Cigna Healthcare Trading Partner Management representative.

2.2 Trading partner registration

All trading partners who wish to submit health care claims to Cigna Healthcare via the ASC X12 837I (Version 005010X223A2) transaction must complete three technical assessments to provide Cigna Healthcare with their contact information, desired connectivity method, and transaction-specific information. After completing the assessments, Cigna Healthcare will work with each trading partner to establish connectivity. Upon successful connectivity testing, each trading partner can then begin system testing.

2.3 System availability and downtime

The 837I transaction is available 24 hours a day, 7 days a week. However, to allow for maintenance, 837I transactions may be unavailable on the first and third Sunday of the month from 6:00–10:00 p.m. ET. Batch files are queued for processing after the release window completes.

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3. Testing with the payer

EDI controls

Cigna Healthcare will utilize, when necessary and appropriate, both the TA1 – Interchange Acknowledgement and 999 – Functional Acknowledgement responses.

X12 transaction processing

- X12 transactions will be verified as originating from a Cigna Healthcare-recognized trading partner (authenticated) and checked for access to submit the specific X12 transaction (authorization). Failure of "authorization test" will generate a TA1 and/or 999 response back to the trading partner.
- X12 transactions will be checked for proper X12 structure via "envelope test validation." This ensures the transaction request is complete and formatted properly. Failures of envelope tests can generate TA1 or 999 responses back to the trading partner.
- X12 data elements that are mapped to the Cigna Healthcare copybook will be checked for validity through a defined set of "exception processing tests." If an exception occurs, the appropriate 999 response is sent back to the trading partner.

Special test processing

If the ISA15 (usage indicator) is set to T (test data), then the X12 request ISA10, GS04, and GS05 date and time elements are returned in the X12 response. This allows for regression test tools to validate expected date/time responses in those fields. If the ISA15 (usage indicator) is set to P (production data), then the date and time fields are populated with the current date and time.

3.1 X12 transaction authorization tests

The following table defines the "authorization tests" to be processed on receipt of each X12 Health Care Claim: 837 Institutional.

The authorization tests run in the order shown. Upon detection of an error, the appropriate TA1 or 999 response is sent. Multiple errors are not processed in the TA1 response since this can lead to faulty error reporting. In the 999 error response, multiple errors may be sent with the exception of GS01 and GS08 errors. If both GS01 and GS08 errors are present, only the GS01 error will be sent since only one AK905 segment is allowed.

HIPAA element	Authorization tests	TA1 response		999 response
		TA105		AK905
N/A	Clearinghouse source cannot be identified	013		N/A
ISA05/ ISA06	Unknown clearinghouse (unknown ISA05/ISA06 combination)	006		N/A
ISA07/ ISA08	Unknown payer (unknown ISA07/ISA08 combination)	008		N/A
ISA14	Acknowledgement requested	019		N/A
GS01	Unsupported transaction set in group	N/A		1
GS02	Unknown originator ID value	N/A		1
	Missing originator ID value	N/A		1
GS03	Unknown recipient LOB value	N/A		1
	Missing recipient LOB value	N/A		1
GS08	Unsupported version of implementation guide	N/A		2

3.2 X12 transaction envelope test validation

The following table defines the "envelope tests" to be processed on receipt of each X12 837I request. The envelope tests run in the order shown. Upon detection of an error, the appropriate TA1 or 999 response is sent. Multiple errors are not processed since this can lead to faulty error reporting.

HIPAA element	Envelope tests	TA1 response		999 response	
		TA105		IK502	AK905
IEA segment	Control number in IEA02 does not match control number in ISA13.	001		N/A	N/A
IEA segment	Functional group count in IEA01 does not match actual functional groups counted.	021		N/A	N/A
GE segment	Group control number in GE02 does not match group control number in GS06.	N/A		N/A	4
ST segments	Transaction sets included count in GE01 does not match actual transaction sets counted.	N/A		N/A	5
ST segments	Transaction set control number in ST02 does not match transaction set control number in SE02.	N/A		3	N/A
SE segment	Number of included segments count in SE01 does not match actual segment count.	N/A		4	N/A

3.3 X12 transaction exception processing

This section will be completed in coordination with Cigna Healthcare system testing.

4. Connectivity with the payer / communications

4.1 System availability

The 837I transaction is available 24 hours a day, 7 days a week. However, to allow for maintenance, 837I transactions may be unavailable on the first and third Sunday of the month from 6:00–10:00 p.m. ET. Batch files are queued for processing after the release window completes.

4.2 Process flows

Cigna Healthcare trading partners must have an active trading partner agreement. If a third party has been elected to perform electronic transactions, additional trading partner information may be required for setup.

Trading partners who have an active trading partner agreement are given IDs, passwords, and a URL to access the Cigna Healthcare technical assessment tool. Trading partners will complete a minimum of three technical assessments to provide Cigna Healthcare with their contact information, desired connectivity method, and transaction-specific information. Trading partners should submit transactions according to current guidelines. Any questions regarding transmissions must be submitted to Cigna Healthcare EDI Customer Service.

Cigna Healthcare offers the following transmission methods for securely exchanging batch transactions using the Cigna Healthcare gateway:

- SFTP/SSH-2 (PGP encryption optional)
- FTP/s SSL (PGP encryption optional)
- AS2
- VPN

- HTTP/HTTPS
- Connect:Direct (NDM)

Please note: These are Cigna Healthcare standard offerings. If these methods cannot be applied, contact your Cigna Healthcare Trading Partner Management representative to schedule a meeting.

After establishing a transmission method, each trading partner must successfully complete testing. Information on this phase is provided in the next section of this companion guide.

4.2.1 Trading partner testing

Before submitting production inbound files, trading partners should complete testing for each X12 transaction type they plan to use with Cigna Healthcare.

Trading partners should test by submitting inbound X12 files and receiving validation from Cigna Healthcare that the data in the file processes as expected. Trading partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional, and mutually defined components of the transaction.

4.2.2 Roles and responsibilities

Trading partner:

- Provide Cigna Healthcare with accurate contact information.
- Complete the technical assessments. This information will be used to set up the trading partner in the system.
- Coordinate testing with Cigna Healthcare for the communication option selected.

Cigna Healthcare:

- Contact your trading partner regarding any connectivity set-up/testing (by Cigna Healthcare Trading Partner Management team).
- Communicate to trading partner the actual production date.
- Install changes based upon the pre-established Cigna Healthcare production release procedures.

Cigna Healthcare business area/application technical support:

- Complete data testing, as needed.

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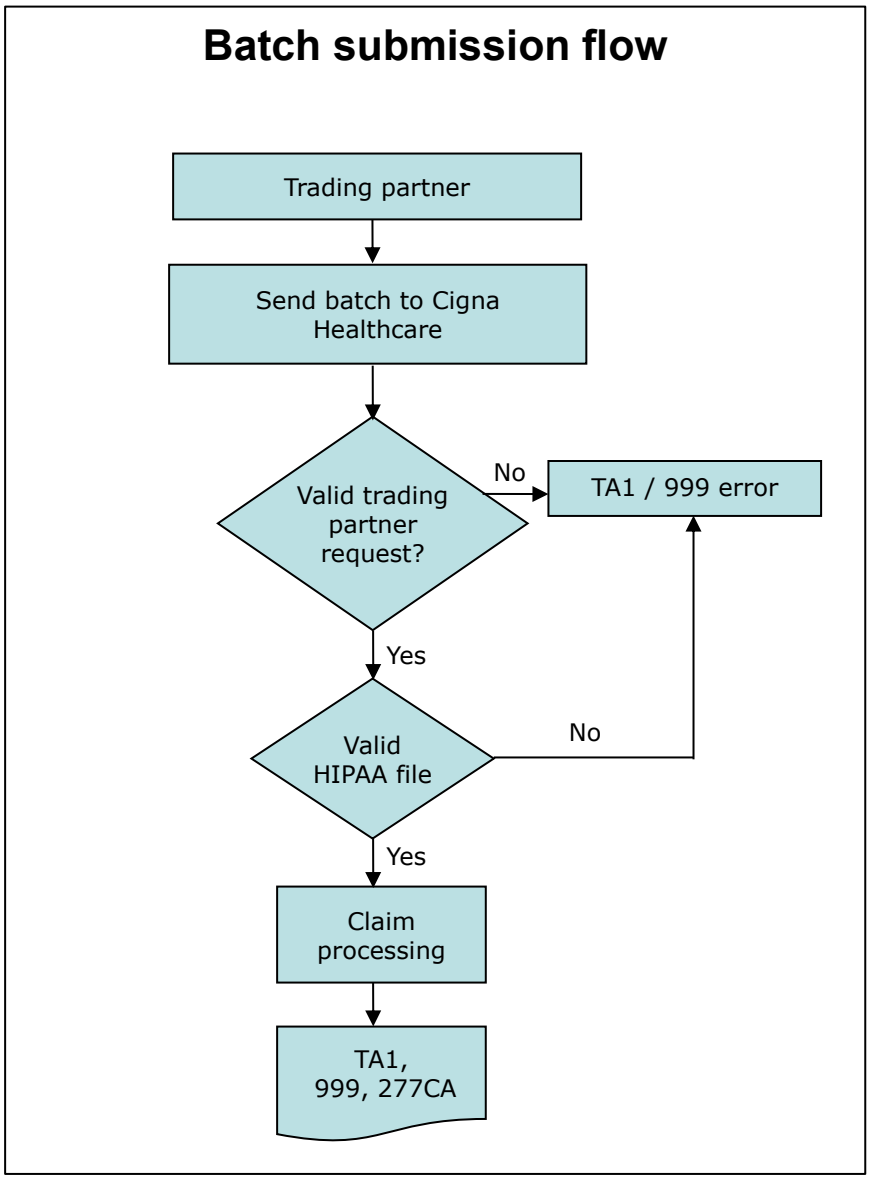

4.3 Transmission administrative procedures

Cigna Healthcare will respond to 837 transmissions with the 999 response, the 277CA 5010 (Cigna Healthcare August 2011 system release), and 277PEND/277RFAI 5010 (Cigna Healthcare October 2011 system release), when needed. A TA1 error response is dependent on information submitted within the inbound ISA field. If the value within the ISA14 element is a '0' then no TA1 error will be generated, even if the interchange is rejected. If the value within the ISA14 element is a '1' then a TA1 error will be generated.

Trading partners should expect to receive the 999 response within four hours and the 277CA within 24 hours of Cigna Healthcare receiving the 837 transaction. The trading partner 277CA default preference will be immediate and a trading partner can expect to receive a 277CA for each submitted claim. A trading partner can request setup of a batch process for the 277CA if preferred.

The naming convention for inbound 837 files needs to follow these guidelines:

- Entire file name must be less than 256 bytes.
- Must contain a file extension (e.g., .txt, .dat, .pgp).

- No special characters.
- Can contain underscores '_' and dashes '-'.
- Can only contain two nodes including the file extension. Nodes are separated by a period '.'.

Examples of valid inbound file names:

- Fileabc.txt
- 837_Inst_ccyymmdd.dat
- TPA-834Enrollment.pgp

Examples of invalid file names:

- Fileabc (no file extension)
- 837_Inst_%ccyymmdd (contains a special character)
- TPA.834.Enrollment.pgp (contains more than two nodes)
- **Filename.txt.pgp** (contains more than two nodes)

In reference to the invalid file name in **BOLD**, some PGP software packages append a file extension of .pgp to the file it is encrypting even if the file already has an extension. If your PGP encryption software does this, please ensure the file being sent to the Cigna Healthcare gateway only contains two nodes.

4.3.1 Retransmission procedure

Retransmission of 837 claims must use a new file name and new document control numbers (DCNs) to avoid rejection for duplicate submission.

4.4 Communication protocol specifications

Communication protocol specifications are not required for batch processing.

5. Contact information

5.1 EDI customer service

Most questions can be answered by referencing this companion guide. If you have additional questions related to the Cigna Healthcare 837I transaction or to report 5010 status/issues, email your Cigna Healthcare Trading Partner Management representative.

5.2 EDI technical assistance

If you have technical questions related to the Cigna Healthcare 837I transaction, call the Customer Support Center at **800.810.3388**.

5.3 Provider service phone number

If you have contracting, provider service, or credentialing questions, call 800.88Cigna (**800.882.4462**).

5.4 Applicable websites/email

For information about Cigna Healthcare policies, coverage positions, and claim edits, access the Cigna Healthcare website at Cigna.com > For Providers.

6. Control segments/envelopes

6.1 ISA – IEA (837I)

This section describes the use of the interchange control segments ISA and IEA. These segments mark the beginning and ending of an interchange. The ISA segment has a fixed length and all the elements within this segment must be populated. This segment includes a description of the expected sender and receiver codes and delimiters. The first element delimiter in the ISA segment is an asterisk (*), which will be used as the delimiter throughout the transaction. The final character in the ISA segment is a tilde (~), which will be used as the delimiter for each segment in the transaction.

The ">" (greater than) or "<" (less than) characters should not be used as the segment, element, repetition separator (ISA11), or component element separator (ISA16) delimiters as this will cause an application failure and a delay in the processing of the file.

Segment ID	Element ID	Name	Code	Definition of code / notes
ISA		Interchange control header segment		
	ISA01	Authorization information qualifier	'00'	No authorization information present.
	ISA02	Authorization information	10 'spaces'	Authorization information.
	ISA03	Security information qualifier	'00'	No security information present.
	ISA04	Security information	10 'spaces'	No security information present. **Note:** Value should always be 'spaces'.
	ISA05	Interchange ID qualifier of sender	'ZZ'	Mutually defined.
	ISA06	Interchange sender ID	<Sender ID>	Interchange sender ID for trading partner.
	ISA07	Interchange ID qualifier of receiver	'01' '20' '27' '28' '30' 'ZZ'	U.S. federal Taxpayer Identification Number.
	ISA08	Interchange receiver ID	'623080000'	Interchange receiver ID for Cigna Healthcare.
	ISA09	Interchange date	Format: YYMMDD	Date of the interchange. See note for ISA15.
	ISA10	Interchange time	Format: HHMM	Time of the interchange. See note for ISA15.
	ISA11	Repetition separator	'^'	Repetition separator is a delimiter used to separate repeated occurrences of simple data element or composite data structure.

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Segment ID	Element ID	Name	Code	Definition of code / notes
	ISA12	Interchange control version number	'00501'	Standards approved for publication by ASC X12 Procedures Review Board through October 2003.
	ISA13	Interchange control number	<Interchange control number>	Control number used by the interchange sender; must be identical to the associated interchange trailer IEA02.
	ISA14	Acknowledgement requested	'0' '1'	0: No acknowledgement requested. 1: Acknowledgement requested.
	ISA15	Usage indicator; code to indicate whether data enclosed by this interchange envelope is test or production information	'T' 'P'	'T': Test data **Note:** Date and time fields in ISA09, ISA10, GS04, and GS05 are returned in the X12 response. 'P': Production data **Note**: Date and time fields are populated with current date and time.
	ISA16	Component element separator	**:**	Component element separator is a delimiter and not a data element.
IEA		Interchange control trailer segment		
	IEA01	Number of included functional groups	<Number of included functional groups>	Cigna Healthcare functional group count.
	IEA02	Interchange control number	<Interchange control number>	Cigna Healthcare interchange control number.

6.2 GS – GE (837I)

This section describes the functional group control segments GS and GE. These segments identify the application sender and receiver codes. The GS control segment indicates the beginning of a functional group and the GE control segment indicates the ending of a functional group. These control segments describe how Cigna Healthcare expects a trading partner to send functional groups and how Cigna Healthcare will send functional groups back to the clearinghouse.

Segment ID	Element ID	Name	Code	Definition of code / notes
GS		Functional group header		
	GS01	Functional identifier code	'HC'	Health Care Claim: 837 Institutional.
	GS02	Application sender's code	<Sender code>	Code identifying party sending transmission; codes agreed to by trading partners.
	GS03	Application receiver's code	'623080000'	Code identifying party receiving transmission.
	GS04	Date	Format: CCYYMMDD	Date of functional group creation.
	GS05	Time	Format: HHMM	Creation time.
	GS06	Group control number	<Group control number>	Assigned number originated by sender; control number must be equal to the same data element in group trailer GE02.
	GS07	Responsible agency code	'X'	Accredited Standards Committee X12; value should always be 'X'.
	GS08	Version / release / industry identifier code	'005010X223A2'	Health Care Claim: 837I Implementation Guide originally published in May 2006 as "005010X223" and now includes the addenda published in June 2010 as "005010X223A2."
GE		Functional group trailer		
	GE01	Number of transaction sets included	<Number of transaction sets included>	Number of transactions included.
	GE02	Group control number	<Group control number>	Group control number must be identical to the same data element in functional group header GS06.

6.3 ST – SE (837I)

This section indicates the beginning and the ending of a transaction set and provides the count of the transmitted segments including the beginning (ST) and ending (SE) segments. These segments also provide a transaction set control number, which must be identical in each segment.

Segment ID	Element ID	Name	Code	Definition of code / notes
ST		Transaction set header		
	ST01	Transaction set identifier code	'837'	Health Care Claim: 837 Institutional.
	ST02	Transaction set control number	<Transaction set control number>	Transaction set control number assigned by sending party. The transaction set control numbers in ST02 and SE02 must be identical.
	ST03	Implementation convention reference	'005010X223A2'	Always matches GS08.
SE		Transaction set trailer		
	SE01	Transaction segment count	<Total segments>	Total number of segments included in a transaction set including ST and SE segments.
	SE02	Transaction set control number	<Transaction set control number>	Transaction set control number assigned by sending party.

7. Payer-specific business rules and limitations

Cigna Healthcare accepts the maximum number of occurrences of loops and segments and all code values as stipulated in the HIPAA transaction and code set regulations. However, Cigna Healthcare does not utilize all information that can be transmitted. This document delineates the Cigna Healthcare criteria which could impact transaction submission.

Cigna Healthcare has implemented the use of unique patient identifiers. If a patient has a unique patient identifier, it must be used as the primary identification code in place of the patient's Social Security number (SSN). This unique identifier must be used on all inquiries, communications, and claims submissions. If a patient has not yet received a unique patient identifier, the submitting entity should continue to use the SSN until the patient receives the identifier.

To enable timely claim processing, Cigna Healthcare requests that the maximum number of service lines submitted on a claim should be 700.

When Cigna Healthcare rejects 837 transactions due to compliance errors, trading partners should create different interchange, group, and transaction control numbers on the resubmitted 837 transactions than what was originally used on the rejected transactions. Otherwise, the resubmitted transactions may fail duplicate file check procedures, causing delays in claim processing.

To ensure accurate and timely claim processing for all hospital claims from providers not contracted with Cigna Healthcare, the following should be included. However, Cigna Healthcare will not reject the claim if the taxonomy code is not included.

- Taxonomy code for the subpart providing the service should be reported in loop 2000A field PRV03, and
- PRV02 should be equal to "PXC" (mutually defined). PXC is used to indicate the health care provider taxonomy code.

To ensure accurate and timely claim processing for all freestanding ambulatory surgery center (ASC) claims from providers not contracted with Cigna Healthcare, the following should be included. However, Cigna Healthcare will not reject the claim if the taxonomy code is not included.

- Taxonomy code for the subpart providing the service should be reported in loop 2000A field PRV03, and
- PRV02 should be equal to "PXC" (mutually defined). PXC is used to indicate the health care provider taxonomy code.

To ensure accurate and timely claim processing for all freestanding ASC claims, the type of bill must be reported as 83X in loop 2300 in field CLM05, wherein CLM05-1 = 83, CLM05-2 = A (constant value), and CLM05-3 = X (appropriate value).

To ensure accurate and timely claim processing for all end-stage renal disease (ESRD) claims, they must be reported on UB with bill type '73X.' They can be reported in loop 2300 in field CLM05, wherein CLM05-1 = 73, CLM05-2 = A (constant value), and CLM05-3 = X (appropriate value).

Cigna Healthcare does not utilize information submitted using the following:

- Other payer attending provider identification segment in loop 2330C
- Other payer operating provider identification segment in loop 2330D
- Other payer other provider identification segment in loop 2330E
- Other payer service facility provider identification segment in loop 2330F
- Operating physician secondary identification segment in loop 2420A
- Other provider secondary identification segment in loop 2420B

Cigna Healthcare does not participate in commercial payer-to-payer coordination of benefits (COB).

Cigna Healthcare requires that a claim submitted for correction, for replacement, or to be voided to a previously submitted claim must be identified as such in the CLM05-03 claim frequency code in the CLM claim information segment of loop 2300.

- The payer-assigned claim number of the previously submitted claim must be provided in REF02 of the REF payer claim control number segment in loop 2300.

A National Provider Identifier (NPI) will be required when provider data is being submitted in loops 2010AA, 2310A, 2310B 2310C, 2310D, 2310E, and 2310F. If an NPI is not submitted, the claim will be evaluated to determine if the provider is an atypical provider. If the provider is not atypical, the claim will be rejected when the trading partner is set to standardized national implementation process (SNIP) level greater than 1-2.

An atypical service provider is one that does not furnish health care services as defined in section 1861 (u) of the Social Security Act. Example: Taxi drivers.

PWK02 values:

- The PWK02 value should only be set to 'EL' (electronic only) in the following scenarios:
  - When a corresponding 275 transaction is being sent by you, the submitter of the claim.
  - When the provider indicates in the claim that National Electronic Attachment will be submitting an attachment on the providers' behalf.
  - When there is an agreement between the trading partner and Cigna Healthcare of the PWK to share customized data in which case the PWK02 = EL and the PWK06 begins with //
- For all other attachments being submitted where Cigna Healthcare would be expected to pick up the attachment in a separate location, the PWK02 should = FT (file transfer) on the 837 transaction.

Relaxation of HIPAA compliance guidelines

Cigna Healthcare currently allows the following exceptions to the guidelines for submitted data as defined in the ASC X12N Implementation Guide (005010X223A2) Health Care Claim: 837 Institutional.

- The transaction will not be rejected if:
  - REF02 (provider secondary ID) is not in standard SSN format when REF01 = 'SY'.
  - REF02 (provider secondary ID) is not UPIN when REF01='1G'.
  - NPI is mandated for use and secondary ID segments are provided.
  - N301 or N302 (address information) in billing provider loop 2010AA has PO Box or lockbox information.
  - It does not meet requirements for SNIP Type 7 partner-specific edits.
  - Loop 2330x is used, even if NM109 in the associated 2310X loop holds the provider NPI.
- Institutional/inpatient/Medicare crossover claims will not be rejected if the Present on Admission indicator (element HI01-9 of the 2300 loop) is missing. For all other institutional/inpatient 837 transactions, the Present on Admission indicator is required.
- A warning will be sent if the number of claims exceeds the specified maximum.
- Segment REF (other operating physician secondary identification) may be used even after the NPI is mandated.
- ZIP code information must be present in loops and segments where the ZIP code is designated as a required field and match the required TR3 format guidelines for five- and nine-digit codes.
- International Classification of Diseases (ICD) validation will not be performed on Professional Medicare crossover claims.

8. Acknowledgements and/or reports

Cigna Healthcare will generate the TA1/999 acknowledgement for all inbound X12 transactions.

The following is the file naming convention for 999:

Node 1: File name
Format (with dashes separating these fields):

- Original inbound filename
- Time (hhmmss)
- Sequence (used when more than one acknowledgement has the same time stamp)
- 999

Node 2: File extension
Examples:

- PROVIDERABC_837P_COBRA-124729-6-999.dat
- TPAXYZ_837_Dental -184715-5-999.dat

- Inst837-014654-3-999.dat

The following is the file naming convention for TA1:
Node 1: File name
Format (with dashes separating these fields):

- Original inbound filename
- Time (hhmmss)
- Sequence (used when more than one acknowledgement has the same time stamp)
- TA1

Node 2: File extension
Examples:

- PROVIDERABC_837P_COBRA-124729-6-TA1.dat
- TPAXYZ_837_Dental -124715-5-TA1.dat
- Inst837-124654-3-TA1.dat

The following is the file naming convention for 277CA:
Node 1: Environment ('TST' for test or 'PROD' for production)
Node 2: Receiver ID of the transaction
Node 3: Addenda version and transaction type
Node 4: Date and time 277CA was generated (format ccyymmdd-hhmmss)
Node 5: Internal file extension
Node 6: Sequence number
Node 7: File extension

Examples:

- TST.TPAABC.005010X214.20110609-110525.dat.0000000001.ext
- PROD.PARTNER789.005010X214.20110609-053030.dat.1234567890.pgp

9. Trading partner agreements

Trading partner agreements for existing partners are currently on file with Cigna Healthcare. For new trading partners, please email your Cigna Healthcare Trading Partner Management representative.

10. Transaction-specific information (loops)

A transaction loop is a group of related segments. Cigna Healthcare-specific values are required for the elements which comprise the segments for the 837I transaction loops. The following section identifies these loops, their segments, and their required element values.

- Loop 2000A – Billing provider hierarchical level
- Loop 2000C – Patient hierarchical level
- Loop 2010AA – Billing provider name
- Loop 2010BA – Subscriber name
- Loop 2300 – Claim information
- Loop 2310E – Service facility location name
- Loop 2320 – Other subscriber information
- Loop 2400 – Service line number
- Loop 2430 – Line adjudication information

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10.1 Loop 2000A (837I) – Billing provider hierarchical level

Loop	Segment	Element	Name	Code(s)	Definition of code
2000A	PRV	PRV02	Reference identification qualifier	PXC	To ensure accurate and timely claim processing for all hospital claims from providers not contracted with Cigna Healthcare, the following should be included. However, Cigna Healthcare will not reject the claim if the taxonomy code is not included: PRV02 should be equal to "PXC" (mutually defined). PXC is used to indicate the health care provider taxonomy code.
2000A	PRV	PRV02	Reference identification qualifier	PXC	To ensure accurate and timely claim processing for all freestanding ASC claims from providers not contracted with Cigna Healthcare, the following should be included. However, Cigna Healthcare will not reject the claim if the taxonomy code is not included**:** PRV02 Should be equal to "PXC" (mutually defined). PXC is used to indicate the health care provider taxonomy code.
2000A	PRV	PRV03	Reference identification		To ensure accurate and timely claim processing for all hospital claims from providers not contracted with Cigna Healthcare, the following should be included. However, Cigna Healthcare will not reject the claim if the taxonomy code is not included**:** Taxonomy code for the subpart providing the service should be reported in loop 2000A field PRV03.

10.2 Loop 2000C (837I) – Patient hierarchical level

Loop	Segment	Element	Name	Code(s)	Definition of code
2000C	PAT	PAT08	Weight		If the first byte begins with a negative sign (-), the claim will be rejected.

10.3 Loop 2010AA (837I) – Billing provider name

Loop	Segment	Element	Name	Code(s)	Definition of code
2010AA	NM1	NM109	Identification code		When the billing provider's NPI is present in NM109 (identified by the value 'XX' in NM108), the NPI must be numeric and either 10 or 15 characters in length. If the NPI in NM109 contains non-numeric characters or is not a valid length, the claim will be rejected.

10.4 Loop 2010BA (837I) – Subscriber name

Loop	Segment	Element	Name	Code(s)	Definition of code
2010BA	NM1	NM109	Identification code		This data element is required when NM102 equals 1 (one). Cigna Healthcare has implemented the use of unique patient identifiers. If a patient has a unique patient identifier, it must be used as the primary identification code in place of the patient's SSN. This unique identifier must be used on all inquiries, communications, and claims submissions. If a patient has not yet received a unique patient identifier, the submitting entity should continue to use the SSN until the patient receives the identifier.

10.5 Loop 2300 (837I) – Claim information

Loop	Segment	Element	Name	Code(s)	Definition of code
2300	CLM	CLM02	Monetary amount		If the field is less than zero, the claim will be rejected.
2300	CLM	CLM05	Healthcare service location information		To ensure accurate and timely claim processing for all freestanding ASC claims, the following must be included: Type of bill must be reported as 83X in field CLM05, wherein CLM05-1 = 83, CLM05-2 = A (constant value), and CLM05-3 = X (appropriate value).
2300	CLM	CLM05	Healthcare service location information		To ensure accurate and timely claim processing for all ESRD claims, the following must be included: ESRD claims must be reported on UB with type of bill equal to 73X; it can be reported in field CLM05, wherein CLM05-1 = 73, CLM05-2 = A (constant value), and CLM05-3 = X (appropriate value).
2300	HI	HI##-5	Value information – monetary amount		For the value information HI segment (HI##-1 = BE where ## = 1 – 12), the monetary amount element HI##-5 (where ## = 1 – 12) must be greater than or equal to zero or the claim will be rejected.
2300	HI	HI05-5	Monetary amount		If the field is less than zero, the claim will be rejected.
2300	HCP	HCP02	Monetary amount		If the field is less than zero, the claim will be rejected.

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10.6 Loop 2310E (837I) – Service facility location name

Loop	Segment	Element	Name	Code(s)	Definition of code/notes
2310E	N3	N301	Address information		For 5010, the service facility loop is only to be used if the service facility is not a subpart of the organization. Under 5010, we would expect to see the service address in the billing provider loop.

10.7 Loop 2320 (837I) – Other subscriber information

Loop	Segment	Element	Name	Code(s)	Definition of code/notes
2320	CAS	CAS04	Quantity		If the first byte begins with a negative sign (-), the claim will be rejected.
2320	CAS	CAS07	Quantity		If the first byte begins with a negative sign (-), the claim will be rejected.
2320	CAS	CAS10	Quantity		If the first byte begins with a negative sign (-), the claim will be rejected.
2320	CAS	CAS13	Quantity		If the first byte begins with a negative sign (-), the claim will be rejected.
2320	CAS	CAS16	Quantity		If the first byte begins with a negative sign (-), the claim will be rejected.
2320	CAS	CAS19	Quantity		If the first byte begins with a negative sign (-), the claim will be rejected.
2320	AMT	AMT02	Monetary amount		If the field is less than zero, the claim will be rejected (exception AMT*D).

10.8 Loop 2400 (837I) – Service line number

Loop	Segment	Element	Name	Code(s)	Definition of code/notes
2400	SV2	SV203	Monetary amount		Use this amount to indicate the submitted charge amount. If the field is less than zero, the claim will be rejected.
2400	SV2	SV207	Monetary amount		If the field is less than zero, the claim will be rejected.
2400	HCP	HPC12	Quantity		If the first byte begins with a negative sign (-), the claim will be rejected.

10.9 Loop 2430 (837I) – Line adjudication information

Loop	Segment	Element	Name	Code(s)	Definition of code/notes
2430	SVD	SVD05	Quantity		If the first byte begins with a negative sign (-), the claim will be rejected.
2430	CAS	CAS04	Quantity		If the first byte begins with a negative sign (-), the claim will be rejected.
2430	CAS	CAS07	Quantity		If the first byte begins with a negative sign (-), the claim will be rejected.
2430	CAS	CAS10	Quantity		If the first byte begins with a negative sign (-), the claim will be rejected.

Loop	Segment	Element	Name	Code(s)	Definition of code/notes
2430	CAS	CAS13	Quantity		If the first byte begins with a negative sign (-), the claim will be rejected.
2430	CAS	CAS16	Quantity		If the first byte begins with a negative sign (-), the claim will be rejected.
2430	CAS	CAS19	Quantity		If the first byte begins with a negative sign (-), the claim will be rejected.

11. Appendices

11.1 Implementation checklist

Once you receive a welcome package, please sign on and test connectivity.

11.2 Business scenario

Not applicable.

11.3 Transmission example

Transmission example for the 837I transaction is currently under construction.

11.4 Change summary

This section describes the differences between the current companion guide and previous guide(s).

Date	Version	Description	Author
03/29/2011	1.0	Initial version	
07/28/2011	1.1	Post-delivery updates made based on feedback: • Removed CTX05, CTX06, and IK403 entries from table in section 3.1. • Corrections made to AK905 entries in table in section 3.1. • Removed HL, ST, and GS segment entries from table in section 3.2. • Corrections made to customer service information in sections 4.2 and 11. • Correction made to diagram text in section 4.2.1. • Added information regarding 277CA in section 4.3. • Replaced section 4.5 and made changes to password information in sections 4.6 and 11. • Corrections made to transaction set control number assignment in table in section 6.3. • Corrections made to clarify text in section 7. • Corrections made to remove text that is not applicable in section 7. • Corrections made to street address text in section 10.3 that exceeded 35 byte restriction. • Corrections made to pay-to address text in table in sections 10.3 and 10.4. • Removed NM109 segment entry from table in section 10.6. • Corrections made to HI text in table in section 10.7. • Corrections made to remove text that is not applicable in section 10.7. • Removed SV206 entry from table in section 10.10.	

Date	Version	Description	Author
08/18/2011	1.2	Post-delivery updates made based on feedback: • Text added to section 6.1 regarding the use of delimiters. • Corrections made to text in section 7.	
09/06/2011	1.3	Post-delivery updates made based on feedback: • Text removed from section 7 regarding reporting of patient weight. • Corrections made to clarify hospital and ASC text in section 7. • Text removed from section 10 that is not needed.	
09/14/2011	1.4	Post-delivery updates made based on feedback: • Corrections made to clarify text in section 7. • Corrections made to clarify text in section 10.1.	
10/04/2011	1.5	Post-delivery updates made based on feedback: • New Cigna logo added; name change and disclosure statement update made. • EDI technical assistance telephone number changed. • Text added to section 10.3 regarding the NPI. • Text added to section 10.3 regarding address information.	
11/14/2011	1.6	Post-delivery updates made based on feedback: • Text added to section 7 regarding the number of service lines on a claim.	
01/10/2012	1.7	Post-delivery updates made based on feedback: • Text added to section 4.3 regarding file naming conventions for 837 files. • Text added to section 8 regarding file naming conventions for TA1, 999, and 277CA files.	
02/14/2012	1.8	Post-delivery updates made based on feedback: • Text added to section 7 regarding the Relaxation of HIPAA compliance guidelines. • Text in section 10 regarding N301 address information replaced with text added to section 7. • Cigna email address changed for contact and reporting of issues.	
02/24/2012	1.9	Post-delivery updates made based on feedback: • EDI technical assistance telephone number changed.	
02/29/2012	1.10	Post-delivery updates made based on feedback: • Correction made to section 7 regarding the Relaxation of HIPAA compliance guidelines.	
03/20/2012	1.11	Post-delivery updates made based on feedback: • Correction made to text in section 7 regarding the Relaxation of HIPAA compliance guidelines. • Text added to section 7 regarding ZIP code format.	
06/1/2013	1.12	Updates	
10/1/2013	1.13	Post-delivery updates made to section 7 related to ICD-10 and NPI.	
10/1/2015	1.14	Updates made to section 7 related to ICD-10 and NPI.	GB
10/21/2015	1.15	Removed the reject for negative amounts in the CAS03, CAS06, CAS09, CAS12, CAS15, and CAS18 for loops 2320 and 2430 (SR 209702 implemented September 2015).	Karen Roberg
7/14/2016	1.16	Updated section 10.7 noting the exception to the rejection for AMT*D (SR212947 August 2016).	Karen Roberg

Date	Version	Description	Author
10/26/2016	1.17	Added the following business rule: The PWK segment on the 837 transaction should only be submitted with a PWK02 = EL (electronic only – used when attachment is being submitted in a separate transaction) when a corresponding 275 transaction is being sent. For any proprietary attachments being submitted, the PWK02 = FT (file transfer) should be submitted on the 837 transaction. The only exception to this would be an agreed-upon use, between the trading partner and Cigna Healthcare, of the PWK to share customized data, in which case the PWK02 = EL and the PWK06 begins with //	GB
2/14/2022	1.18	Clarified the PWK02 value rules on page 15.	Taylor Morelli-Zwiebel
01/21/2026	1.19	Section 7 – ICD-10 code manifestations, external causes, sequelae, or "code first" cannot be primary.	Melissa Neeley
08/01/2026	1.20	• Updated contact information in sections 2.1, 4.2, 5.1, 9, and 11.4. • Moved "Roles and responsibilities" from section 11.4 to section 4.2. • Removed the remainder of section 11.4, which contained the same information as section 4.2. • Updated section 4.2.1. • Removed section 4.5 Security and authentication requirements; invalid information. • Removed ICD-9 and ICD-10 information from section 7. • Made editorial updates.	Tori Bakalas

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