CORRECTED CLAIMS REFERENCE GUIDE

Cigna-HealthSpring Star+Plus TX MMP

STAR+PLUS website:
StarPlus.CignaHealthSpring.com

TX MMP website:
Cigna.com/medicare/healthcare-professionals/tx-mmp

Provider Services department:
1-877-653-0331, Monday to Friday, 8:00 a.m.-5:00 p.m. (CST)

Publication date:

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including HealthSpring Life & Health Insurance Company, Inc. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, Inc. Cigna-HealthSpring CarePlan is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees. © 2017 Cigna H8423_MCDTX_17_56458_PR Approved
# Table of Contents

Corrected Claims Reference Guide .................................................................................................................. 2
How to locate the claim number .......................................................................................................................... 3
CMS 1500 Corrected Claim Process .................................................................................................................... 6
UB04 Corrected Claim Process ............................................................................................................................ 8
Common Rejection Reasons .................................................................................................................................. 10
Corrected Claims Reference Guide

A corrected claim is a claim that has previously been adjudicated, whether paid or denied. A provider would submit a corrected claim if the original claim adjudicated needs to be changed. e.g., provider billed with an incorrect date of service/incorrect number of units. Corrected claims can be resubmitted via paper, electronically through a clearing house or Cigna-HealthSpring Claims Portal.

Corrected claims are regarded as claims reconsiderations and are not considered claims appeals.

Reconsideration requests for STAR+PLUS must be made within 120 days from the date of remittance of the Explanation of Payment (EOP).

Reconsideration requests for MMP must be made within sixty (60) days from the date of remittance of the Explanation of Payment (EOP).

Four ways to file a corrected claim with Cigna-HealthSpring STAR+PLUS:

1. **Electronically** – (Payer ID# 52192) – via 1 of the following 3 Cigna-HealthSpring accepted claims clearinghouses: (1) Emdeon, (2) PayerPath, or (3) Availity.

2. **Via secure Provider Portal** - Submit CMS 1500 and UB04 as batch or individual claims. Administered by Change Healthcare for claims submissions.

3. **Via Mail** paper claims.
   a. **Acute care and LTSS services (including inpatient acute care services)**
      Cigna-HealthSpring
      P.O. Box 981709 – STAR+PLUS
      El Paso, TX 79998-1709
   b. **Behavioral health services (including inpatient behavioral health services)**
      Cigna-HealthSpring
      P.O. Box 981709 – STAR+PLUS
      El Paso, TX 79998-1709

4. **Via the TMHP.com** provider website.

Resources:

Providers can access training dates, provider manuals, claims presentation, quick reference guides and other training materials at our website:

- STAR+PLUS Website: starplus.cignahealthspring.com
- TX MMP Website: Cigna.com/medicare/healthcare-professionals/tx-mmp

For more information or if you have questions, please contact our Provider Services Department Monday to Friday, 8 a.m. to 5 p.m. Central Standard Time at 877-653-0331.
A reference number will be needed each time you submit a corrected claim. The reference number is the original claim number. You can locate the claim number on a paper copy of an EOP, HSConnect provider portal or Cigna-HealthSpring Claims portal.

**Explanation of Payment (EOP):**
Locate the Claim Number by locating the Member’s Medicaid ID and Name. See highlighted red sections below.

**HSConnect**
1. Log into the HSConnect portal and accept the terms and conditions.
2. Select the Claim Search link at the top of the Home Page.
3. To search by member, select the Find Member link to locate the member.
4. Complete at least one of the available fields in the Claim Info section:
   a. Claim Number: Number assigned by Cigna-HealthSpring to the claim.
   b. Provider PCN: Patient Control # the provider assigns to claim or member.
   c. Online Conf. No: Number assigned to a claim submitted on the portal.
   d. Rendering LTSS / TPI: Long Term Services and Support number or Texas Provider Identifier
5. Select the Search button. The matching search results display.
6. In the Search results you can locate the Claim ID by matching up the Member information. Navigate through the records by selecting the First, Previous, Next or Last links.
7. Select a column heading to sort the claim details.
   a. The "No claims match your criteria" message displays if there are no claims that match the criteria.
8. Select the Details link for the claim you want to display.
9. View the information for the claim in the Claim Details, Payment Details, Claim Line Details, and Explanation of Reason Codes sections.
10. Select the "Return to claim search" link at the top of the screen to return to the previous search results.
Cigna-HealthSpring Claims Portal (administered by Change HealthCare)

Payer Claim ID in Claim detail report
If the payer received the claim and the payer issues claim IDs to clearinghouse, then the payer’s claim ID appears in the payer Claim ID field. However, a blank payer Claim ID field does not necessarily mean that the payer has not received the claim.
### Claim Detail Fields

- **Insured ID**: Insurance ID number of the patient listed on the claim. This number is created by the insurance company (the Payer) but is given to Change Healthcare by the provider on the claim form.
- **Patient Name**: Name of patient on claim.
- **Patient DOB**: Patient date of birth.
- **Diagnosis Codes**: Diagnosis Codes related to the claim.
- **Procedure Codes**: Procedure Codes related to the claim.
- **Claim Amount**: Amount of claim in US dollars.
- **Service From**: Start date of claimed service.
- **Service To**: End date of claimed service.
- **Provider Tax ID**: Tax ID of service provider, e.g., physician.
- **Billing Provider ID**: ID number of provider for billing purposes.
- **Billing Provider NPI**: NPI number of billing provider. This NPI could correspond to a provider organization or to a particular provider depending on the claim.
- **Site ID**: Designation of a specific provider site, e.g., clinic/office location.
- **Patient Control No.**: Internal patient tracking number generated by provider.
- **Payer Name**: Name of Payer organization.
- **Provider Data Cleansing**: Click View Corrections link to access Provider Data Corrections report. This report displays any corrections made to the claim based upon data correction at the payer.
- **5010 Format**
  - **Yes**: Claim is in 5010 format.
  - **No**: Claim is not in 5010 format.
  - **Not Available**: Claim format information is not available.
- **Payer Claim ID**: A Payer-assigned reference number which signifies that the Payer has received the claim. This reference number should be used when corresponding with the Payer regarding the status of the claim. **Note**: If claim is rejected at Change Healthcare, no Payer Claim ID will appear.
- **Claim Received Date**: Date claim received at Change Healthcare or Payer.
- **Change Healthcare File ID**: Change Healthcare number assigned to receive claim file. The Change Healthcare file is a batch file that can contain more than one claim.
- **Change Healthcare Claim ID**: Change Healthcare number assigned to a specific claim.
- **Payer ID**: ID Number of Payer as submitted on claim.
- **Worked Status**
  - **Checked**: Claim is currently designated as being worked;
  - **Unchecked**: Claim is not currently designated as being worked.
  - The Worked status condition (checked or unchecked) in the Claim Detail will be displayed in the Worked column in any Claim Summary report in which the claim appears. The Worked checkbox is also available in the Claim Summary report. If you set a claim as Worked (by placing a check in the checkbox) in either a Claim Summary report or the Claim Detail report, the setting will be reflected in the other report (that is, the Worked checkbox is linked between these reports). You can access the Worked checkbox for a claim in either a Claim Summary view, or a Claim Detail. The Worked status in either view is the same; if you change the status in one view, the change is reflected in the other.
Corrected claims can be resubmitted via paper, by entering a “7” for the Resubmission code, and the original claim number as your Original Reference No on box 22 of the CMS 1500 form. The original claim number can be found on the original EOP.

**Paper Claim**

**Field 22:** If submitting a corrected claim, enter 7 as the Resubmission Code, followed by the Original Claim Number in the Original Reference Number.

**Electronically using Cigna-HealthSpring Claims Portal (administered by Change HealthCare)**

**Claims List** - Claims List allows you to view, edit, submit and manage claims. Before using Claim List for the first time, you must have completed and saved the claim. Any claim can be edited and saved as a new claim, which helps to avoid re-keying the same information for multiple claims per patient

1. From the **Claims** tab, select **Claims List**
2. Search for your previously keyed claim in the **Search Text** field
3. Once you have selected the claim that you want to correct, select **Edit**, the previously **Submitted** claim will open and you are able to change the information within the claim template.
4. When corrections are made, scroll to the bottom of the page, and enter the number “7” at the **Resubmission Code** field to indicate it’s a corrected claim.
5. Enter original claim number from which you are correcting at the **Resubmission Reference Number** field – the claim number must be exact.
6. Do not remove existing text from the “Remarks” field.
7. Click **Save as New Claim**.
8. Your claim is now updated with your corrections. Return to the Claims List to retrieve the corrected claim from the Claims List. Once you select the new claim from the “Claims List”, click Submit Selected

**Note:** Only available for CMS 1500 claims format.
**UB04 Corrected Claim Process**

Corrected claims can be resubmitted via paper, by entering a “7” for the Replacement of Prior Claim in box 4 Type of Bill Code. The original claim number as your Original Reference number in box 80 of the remarks of a UB04 claim form. The original claim number can be found on the original EOP.

### Field 4 – Enter the Type of Bill Code.

<table>
<thead>
<tr>
<th>First Digit—Type of Facility:</th>
<th>Second Digit—Bill Classification (except clinics and special facilities):</th>
<th>Third Digit—Frequency:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 1 Hospital</td>
<td>• 1 Inpatient (including Medicare Part A)</td>
<td>• 0 Nonpayment/zero claim</td>
</tr>
<tr>
<td>• 2 Skilled nursing</td>
<td>• 2 Inpatient (Medicare Part B only)</td>
<td>• 1 Admit through discharge</td>
</tr>
<tr>
<td>• 3 Home health agency</td>
<td>• 3 Outpatient</td>
<td>• 2 Interim-first claim</td>
</tr>
<tr>
<td>• 7 Clinic (rural health clinic [RHC], federally qualified health center [FQHC], and renal dialysis center [RDC])</td>
<td>• 4 Other (for hospital-referenced diagnostic services, for example, laboratories and X-rays)</td>
<td>• 3 Interim-continuing claim</td>
</tr>
<tr>
<td>• 8 Special facility</td>
<td>• 7 Intermediate care</td>
<td>• 4 Interim-last claim</td>
</tr>
</tbody>
</table>

### Field 80 – Enter any remarks that pertain to the claims. For example: “Signature on File”, “Corrected Claim

---

**Submit a Batch of Corrected Claims of CMS 1500 or UB04 for processing**

Follow these steps to upload and submit a claim file:

1. Create a claim file using your Practice Management System.
2. Select Claims, then Import from the main menu. The Import Claims main window opens. Read the explanatory text if you are not familiar with claim file formats.
3. Click proceeds to next Step. The Send Claim File form opens in a separate window.
Note: You must be registered to use the Import Claims service. In addition, before submitting a claim file using the Import Claims service you must verify that your claim file format is valid. If you have not validated your claim file format with a help desk representative, please contact customer support for additional information.

4. Click Browse to locate the claim file. Select the claim file you want to send for processing and click open. The file name populates the field.
5. Select the mode in which to send the file.
6. Normal - Your file is encrypted, transmitted, authenticated, validated, and delivered for processing.
7. Test your internet connection - This option allows you to test your internet connection before actually sending the file for processing. The claim file is neither transmitted, nor presented for processing at any time.
8. Click Submit Claim for processing. Once the file is submitted, a message appears indicating whether the transmission succeeded or failed.
   Note: Leave the Send Claims window open during file transmission. Closing the window indicates that you want to terminate the connection and abort the transmission. You can minimize the window, but it must not be closed or the process will end immediately.
9. When the claim file is received and processed, a claim status report is sent to your secure inbox within the application.
10. Click Cancel to close the Send Claim File window after your claim file is successfully transmitted.
11. Check your secure inbox within the application for messages about the status of your claims.
Common Rejection/Denial Reasons

The following information will help you resolve and prevent issues with claim files.

- Refer to the STAR+PLUS or MMP Provider website for the most up to date portal link. Using a saved link in your Favorites list will cause your claims to not be submitted.
- If your claim file cannot be processed, Send Claims generates a transmission failure message and posts it in the Send Claim File window. Help identify the source of the problem by making a note of the error message before closing the message window.
- Do not close the Send Claim File window during processing. The Send Claim File window must remain open throughout your session, or your claims will not be processed. You may minimize the window, but it must not be closed, or your session will terminate and your claim submission process will end. Since transmission failure messages appear in your Send Claim File window, which is not visible once your session terminates, you will not notice your transmission has failed until much later.
- Place of service (POS) needs to be the appropriate location where services were rendered. Refer to TMHP website, Volume 1: Section 6, Claims Filing manuals under section Place of Service (POS) Coding [http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_ProviderManual_Current.aspx](http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_ProviderManual_Current.aspx).
- Rejected claims for the NPI or TPI not matching are caused by how the information is entered in the fields. Providers billing as a group must list the:
  - a. Rendering provider's NPI in the unshaded portion of box 24j;
  - b. Rendering provider's TPI in the shaded portion of box 24j;
  - c. Service location address in box 32
  - d. Group provider's NPI in box 33a; and
  - e. Group's TPI in box 33b.
  - f. Individual providers who are part of a group should bill with their individual NPI in box 24j and the group’s NPI in box 33a.
- Providers submitting claims using EVV must bill each date on a separate line. For example if billing DOS 01/01/2017 to 01/15/2017 will bill each date of service on (DOS) a separate line. The DOS 01/01/2017 on the first line, DOS 01/02/2017 on the second line, DOS 01/03/2017 on the third line, and so on.
- PAS provider can bill unit in the full amount or partial amount.
- If two identical claims are received for the same service on the same date for the same Member, one of the claims will be denied as an ‘exact’ duplicate; unless noted as a corrected claim (resubmission code 7 on line 22 of a CMS 1500 form).
- If there is a break in service, do not bill for the days that you did not provide services to the patient. Enter the start date on the next line for services that resumed upon the patients return.
- If you previously filed a claim with us and were reimbursed for those services, do not file a separate claim for the entire month, which includes the same dates of service previously processed. Your claim will be denied as a duplicate.
  Example: Provider billed and was reimbursed for dates of service 10/1/16 – 10/5/16. A separate claim billed for dates of service 10/1/16 – 10/30/16.
- AT modifier should be billed on PT/OT/ST claims for members over age 21.
- ER/Transportation providers should use the ET modifier on their claims.
- Check NDC list and verify requirements and utilize the Nordian crosswalk link on the THMP website for valid combinations.
- Billing with a UE (used equipment) modifier for DME services will result in a claims denial.
- When using diagnosis codes, please ensure that they are valid.
- Verify that a value is entered in the unit’s area, 24G, of the claim form.
- Using incorrect modifiers will cause a claim to deny. Claim information must match the authorization provided by Cigna-HealthSpring STAR+PLUS.
- Exceeded amount of units from an authorization is due to a provider over billing on claims. Providers must follow the CarePlan assigned for the Member to be within the limits of the authorization.