

SECTION 4

Getting Paid





Timely Filing

(New Jersey practitioners: please refer to the Medical Management Program – Provider Guide, Section “New Jersey,” for more detailed information.)

(Texas practitioners: please refer to the Medical Management Program – Provider Guide, Section “Texas,” for more detailed information.)

The CIGNA Participating Provider Agreement requires that claims be submitted within 60 days from the date of covered services being rendered. Claims submitted beyond 60 days may be denied. All claims for services rendered must be submitted within one year (365 days) of the date of covered services being rendered (unless otherwise specified by the participant's employer group or Medicare).

If proof of timely filing is required to perfect a claim, such proof would include: an Explanation of Benefits (EOB) from another carrier showing the claim was submitted in error, but in good faith, to that carrier; an account ledger showing the original date submitted; or, an original claim form with the original date submitted or mail receipt indicating the claim was received in a CIGNA office within the allotted timeframe.

Practitioners must use the [CMS-1500](#) form, while facilities must use the [UB-04](#) form itemizing charges for inpatient claims. CIGNA defines a ‘clean claim’ as a claim that has no defect or impropriety, including a lack of substantiating documentation, or particular circumstances requiring special treatment that prevent timely payment from being made on the claim. If additional documentation (i.e., medical records) involves a source outside of CIGNA, the claim is not considered clean.

Claims submitted for services provided in California are not subject to automatic denial if submitted within one (1) year from the date covered services were rendered as mandated by California law.

When CIGNA is not the claims payor, but is responsible for providing and/or arranging for the provision of mental health and substance abuse services, CIGNA will make reasonable efforts to require the payor to make payment to practitioners within 30 days receipt of a properly completed bill for covered services by CIGNA or its designee. This payment period may be extended if CIGNA or the payor, in good faith, requires additional time to determine responsibility for such billed services.

CIGNA participating practitioners agree to refrain from duplicate billing within 30 days of submitting a bill for Covered Services to CIGNA or its designee. For additional information, please call CIGNA’s Claim Customer Service:

California HMO Participants	California Customer Service	800.753.0540
Participants in East Coast Area	Claim Customer Service	800.274.7603
Participants in Southern States	Claim Customer Service	800.283.6226
Participants in West Coast Area	Claim Customer Service	800.866.6534
General Electric Participants	Claim Customer Service	800.442.4227



CIGNA's Interactive Response System (IVR)

CIGNA's Interactive Voice Response System (IVR) eliminates the need to speak directly with a representative to obtain routine information. This service is available 24 hours per day, 7 days per week, and allows practitioners to quickly obtain information about:

- Claim status
- Effective coverage dates for subscribers and/or dependents
- Behavioral care benefits
- Status for authorization of benefits
- Web Assistance
- Application and Contract Information

The automated system will quickly and accurately respond to queries by touch-tone keys or voice commands. CIGNA's Customer Service Representatives are available during normal business hours (Monday, Tuesday, Wednesday, and Friday: 7:30-5:00 CST, Thursday 8:30-5:00 CST).

CIGNA IVR

CIGNA COB IVR (for participants to call)

Refer to above phone numbers

800.472.1680

Claim Payment with CMS-1500

The claim submission address and the authorization number for field number 23 on the CMS-1500 form are included in the authorization letter. To ensure timely payment, please complete and submit the CMS claim form to the claim payor as indicated on the authorization letter.

Please refer to the sample claim form in [Appendix B](#) or visit our website at www.cignabehavioral.com when submitting claims. The blank CMS-1500 form may be copied for your use in filing claims.

No authorization letter is generated for Assessment & Referral model EAP cases; please refer to Section 6 EAP.

Claim Payment with UB-04 (CMS-1450)

The authorization letter with referrals provides the claim submission address and the authorization number for field number 63 on the UB-04 (CMS-1450) form. To ensure timely payment, complete the UB-04 as completely as possible with all required information. Attach an itemization of charges and submit to the claim payor as indicated on the authorization letter.

Refer to the [sample claims](#); the [blank UB-04](#) (CMS-1450) form can be copied for filing claims.

Using the Correct Procedure Codes

Claims must be submitted with the correct/current procedure codes (CPT, HCPCS, and/or Revenue). Claims submitted with outdated codes will be denied. The practitioner must then resubmit the claim(s) with the correct code.



For all EAP sessions (including SAP referrals), you should submit your claims utilizing the CPT code 99404. You will find an EAP claim form located in [Appendix B](#), or for faster and more accurate claim payment, you can use our online Web Claims tool. The service is free and can be accessed via our website www.cignabehavioral.com at the Online Tools Link.

Using the Correct ICD-9-CM Diagnosis Codes

Claims must be submitted with the correct/current ICD-9-CM Diagnosis codes. Claims submitted with outdated or incomplete diagnosis codes will be denied. The practitioner must then resubmit the claim(s) with the correct diagnosis code. A complete ICD-9-CM diagnosis code includes all digits up to two decimal places per the current coding structure in place.

Assignment of Benefits

CIGNA will direct payment to the practitioner if the participant is a CIGNA participant and services were authorized. Payment is made according to the rate specified in the CIGNA Participating Provider Agreement.

Given that CIGNA services many different types of plans, it is important to remember to obtain an assignment of benefits to receive direct payment from CIGNA. To indicate assignment from your client, include either the participant's signature or the notation "signature on file" on line 13 and check the "yes" box on line 27.

With the advent of the Care Advocacy Program (CAP), CIGNA will process participating practitioners (CAP applicable) as in-network. If the participant wants to use their Out-of-network (OON) benefits, the process is the opposite. We would need a letter from the participant verifying that they wanted to use OON benefits.

Copayment, Coinsurance, and Deductibles

Copayment, coinsurance, and/or deductible amounts to be collected from the participant appear on the Remittance Advice/Explanation of Payment (EOP) form that accompanies the claim payment. Additional information regarding participant benefits may be obtained either through CIGNA's Claim Customer Service or IVR.

No copayment is collected from EAP/SAP participants.

Overdue Copayments, Deductibles, and Coinsurance

The practitioner may not, under any circumstances, charge interest to participants for overdue copayments, deductibles, or coinsurance.

Eligibility

When CIGNA refers a participant, every effort is made to give practitioners the correct eligibility information. With the exception of EAP cases, practitioners may then bill the participant directly.



Self-Paying Participants

The practitioner must obtain written approval from the participant, in the form of a Self-Pay Agreement, including full financial disclosure, for any services for which authorization was not requested by the practitioner, that were denied by CIGNA, or that were not covered services, *in advance* of those services being rendered.

Services not covered by CIGNA include, but are not limited to:

- Phone therapy
- Late appointment cancellations
- Court-ordered treatment
- Missed EAP appointments

Please see [Appendix D](#), which contains an approved CIGNA Self-Pay Agreement. The practitioner may use a Self-Pay Agreement of their own design; however, all data elements as described in [The Self-Pay Agreement](#) must be contained therein. Self-Pay Agreements signed by the participant either at the time of admission to the facility or at the start of outpatient treatment, that reference the possibility of a self-pay arrangement in the future will not be accepted as proof of a self-pay agreement. In these circumstances, the participant must be financially held harmless as per the terms of the provider agreement.

(For Maine practitioners, please refer to the Medical Management Program – Provider Guide, Section “Maine”

The Agreement must include the following:

- That the participant is aware of CIGNA's appeal process and declines to appeal.
- A statement that the Agreement applies only to the specific level of care or services the participant is requesting. If the participant moves to a different level of care, an authorization must be obtained or another Self-Pay Agreement signed.
- The Agreement is in effect only from the date the participant signs it, until or unless it is rescinded; the Agreement may never be retroactive.

Although by signing the Agreement the participant, in effect, waives his/her right of appeal at that time, the participant may request an appeal at a later date.

Out-of-Network Referrals to Participating CIGNA Practitioners

With the advent of the Care Advocacy Program (CAP), CIGNA will process participating practitioners (CAP applicable) as in-network. If the patient wants to use their out-of-network benefits, the process is the opposite. We would need a letter from the participant verifying that they wanted to use out-of-network benefits.

Coordination of Benefits (COB)

Whenever another group benefit plan is potentially responsible for a portion of the payment, CIGNA requests other insurance information from the participant. To expedite claim payment, participating practitioners need to request that the participant complete the 'Coordination of Benefits' form (see [Appendix B](#)) and submit it with their first claim submission. Updated COB information must be requested yearly or as information changes.



If CIGNA is a secondary payor, the practitioner should submit the claim to the primary carrier first, and then enclose a copy of the EOB with their claim submission to CIGNA.

Now available through CIGNA is an IVR telephone line expressly for policyholder/participant updates for COB. If the policyholder/participant has no other insurance, the policyholder/participant can call 800.472.1680 to automatically update their insurance information. If the policyholder/participant does have other insurance, the [COB form](#) should be completed as indicated above.

Delays in Claim Payment

Obtaining complete information from the participant and carefully reviewing claim forms to ensure accuracy and completeness can prevent delays in processing. Some common problems (list not all inclusive) that may create delays may include:

- Failure to obtain prior authorization
- Federal tax ID number not included
- Billing Address on claim form does not match information on file with CIGNA
- Visits or days provided exceed the number of visits or days authorized
- Date of service is prior to or after the authorized benefit period
- Practitioner is billing for unauthorized services
- Insufficient itemization of charges
- Participant has exceeded benefits
- Preexisting conditions not covered, specific to an employer plan
- An unauthorized practitioner rendered services (for example, CIGNA authorized benefits from a PhD but services were rendered by a social worker)
- Mixed services protocol (charges including both medical and behavioral health treatment)
- Explanation of benefits from primary carrier is not attached to the claim when secondary coverage is requested (often referred to as "Coordination of Benefits" or COB, wherein an individual is covered by more than one benefit plan—under your agreement with CIGNA, the total recoverable may not exceed the contracted rate)

Claims lacking information may either be returned to the practitioner for completion before processing or information may be requested directly from the participant on an EOB. If there is not prompt payment for a claim, it may be pending due to one (or more) of the above reasons. In all instances, CIGNA claim staff will pursue resolution of these issues as quickly as possible.

Overpayment Recovery Procedure

(New Jersey practitioners: please refer to the Medical Management Program – Provider Guide, Section "New Jersey," for more specific information.)

(Tennessee practitioners: please refer to the Medical Management Program – Provider Guide, Section "Tennessee," for more specific information.)

In states where applicable, when CIGNA identifies that an overpayment has been made on a participant's account, CIGNA will reverse that payment out of that participant's account, leaving a negative balance in the practitioner's file. The negative balance is then deducted (offset) from any future payments being made to that practitioner. In those states where there are laws regulating overpayment recovery, the state law supersedes this procedure.

If the overpayment on the practitioner's file has not offset within thirty (30) days, an overpayment letter is sent to the practitioner requesting the refund. If CIGNA does not receive the refund within sixty (60) days, a second refund request letter is sent advising that if CIGNA does not receive the



refund within the next thirty (30) days, a third notice will be sent. If the refund is not received within the next thirty (30) days, CIGNA will again attempt to deduct (offset) the negative balance from future payments to be made to the practitioner.

If at any time we receive the refund from the practitioner and the overpayment has already been offset, CIGNA will return the check to the practitioner with a letter advising that the overpayment has been offset.

Explanation of Payments/Benefits (EOP/EOB)

Example of practitioners' EOPs and participants' EOBs are provided in [Appendix B](#). Also attached are definitions of the fields on the EOP/EOB.

Non-CIGNA Claims

Please note that in some instances claims are submitted to the medical carrier, not CIGNA. The participant's membership card indicates where to submit claims.

Electronic Claims

Submitting claims electronically is one of the best ways to simplify and streamline the reimbursement process. Chances are you already have everything you need to get started. If you have a computer with Internet access, CIGNA accepts electronic claims via the web (www.cignabehavioral.com) and directly from many Practice Management applications. CIGNA's electronic claims program is:

- Free—there is no charge for electronic claims submissions.
- Fast—we process, within 15 days, all electronic claims that auto-adjudicate.
- Practical—full integration with your billing procedures. Easy setup and implementation.
- Secure—a higher level of data security than is possible with paper-based process.
- Efficient—electronic claims typically have fewer errors than paper claims, so more electronic claims auto-adjudicate.

We offer two types of electronic submission: 1) Web Claims—for those practitioners who have access to the Internet, and 2) eClaims—for those practitioners who are using practice management software or who use a clearinghouse to submit their claims. Below is some general information on both types of electronic submission. For complete details (and to enroll), please visit our website at www.cignabehavioral.com.

Web Claims

Using our Web Claims feature is the simplest, most efficient way for you to submit your claims. Filing a web-based claim requires no specialty software and is the most convenient option for many practitioners. It requires only that you have an Internet connection, web browsing software (such as Internet Explorer or Netscape), and an email address. To begin using the service, you will need to register for web claims submission at www.cignabehavioral.com and then use your ID to log in.

Which Claims can be Submitted Via Web Claims?

Any claim that you would normally submit to CIGNA using a CMS-1500 form can be submitted through our Web Claims system.

What are the Minimum Requirements for Getting Started?

Must be a practitioner providing covered services to a CIGNA participant.

- Able to connect, navigate, and interact with the Internet
- Have an active email account



- Utilize an industry standard browser. Of the most popular browsers, our secure Web pages support AOL version 5.0, Netscape version 4.0 (or higher), Microsoft Internet Explorer version 4.0 (or higher) for PC computers
- Enable JavaScript on your browser

We encourage you to print copies of the claims you submit and the corresponding confirmation page for your records.

How Do I Sign Up?

Signing up to submit Web Claims is as easy as 1-2-3.

Create a Unique Login to Access Our Claim Entry Web Page

Your user name must be at least 6 characters long and something that will be easy for you to remember. Your password must be at least 8 characters long. Both the user name and password are limited to 10 characters and are case sensitive; i.e., "Howard" is not the same as "howard."

User Account Verification

In the future, if you forget your user name or password, Customer Support Services will require your verification data as additional security for you.

Tell Us Who You Are

We need your name, address, telephone number and email address, so we know who is submitting claims.

How Do I Log In?

Enter the user name and password you just created and click the 'Submit' button to start submitting Web Claims.

We ask you to review your contact information every time you log in and keep it current. You can change your contact information as needed, and then click the 'Submit' button to save your changes. For security purposes, we do not allow you to edit your user name and password. If no changes are necessary, you can proceed to our secure claim entry page by clicking the 'Proceed to claims entry' button.

How Do I Enter a Claim?

The form looks similar to a standard CMS-1500 form. You move forward from field to field by hitting the TAB key or by clicking on the field with your mouse and entering the information as you would on a paper form. To move back one field, hold down the SHIFT key while hitting the TAB key. Hints for each section of the form are available by clicking on the 'CMS Form Help' button at both the top and bottom of the form.

Once you have started filling out the Web Claim form, the screen will 'time out' after one hour for security purposes. This means that you must complete the claim information and click on the 'Submit' button before one hour has elapsed. Each time you submit a complete claim, the timer starts over. If the form times out before you complete it, you will need to log in again and reenter the claim information. Only reenter the claim information for the claim that timed out, not the entire session.

How do I Get Help with Questions?

If you have any questions, please call the eCommerce Answer Line at 888.259.6279.