5010 Claim and Encounter (837)

Transaction Input Changes

Released November 18, 2011

We have provided the changes we are aware of in the electronic Claim and Encounter transactions based on the 5010 standard. However, there may be differences in how your vendor presents these changes and your vendor's timeline for implementation. Please contact your vendor for information on the changes you may experience.

Professional, Institutional and Dental Claim Formats

- Billing Provider:
  - The "Billing Provider Address" must be a street address. A PO or lock box address should only be submitted in the "Pay to Provider" address field.
  - The "Billing Provider" cannot be a clearinghouse or a billing service.
  - The "Billing Provider" must represent the most detailed level of national provider identifier (NPI) subpart enumeration, as determined by your organization.
  - You must use the same NPI to identify yourself to each payer.
  - Review and update your "Billing Provider" and "Pay to Provider" name and address information with Cigna to avoid claim rejections, delays, or processing errors especially if you will be changing how you submit claims.
- The "Billing Provider" and "Service Facility" ZIP codes must be nine digits.
- If the patient has a unique identification number assigned by Cigna, that number should be used and submitted as the "Subscriber." Only that patient's data is necessary on the claim submission (e.g., name, sex, date of birth, address.)
- The allowed list of dependent relationship codes has been reduced. Please review these codes in your system to be sure you are not using codes that are no longer on the allowed list.
- The "Provider Accepts Assignment" indicator will be required on **all** claims.

Professional and Institutional Claim Formats

- Compound drugs are reported in a standard format (a single Healthcare Common Procedure Coding System is tied to a single National Drug Code).
- A compound drug association number must be included to link together the compound drug ingredients.

Professional Claims

- Anesthesia must be reported as minutes instead of units.
- The surgical code related to anesthesiology services can be included on the claim.
- A primary diagnosis code must be included on the claim.

- The Medicare Durable Medical Equipment Regional Carrier (DMERC) Certificate of Medical Necessity (CMN) form includes a new location to report Oxygen Therapy information from the Centers of Medicare and Medicaid Services (CMS). Confirm that your system can accommodate this form change, if applicable.

Institutional ICD Procedure Code

- Only International Classification of Diseases Clinical Modification (ICD-9-CM) procedure codes can be sent at the claim level, and only for inpatient claims.
- Health Care Financing Administration Common Procedural Coding System (HCPCS) codes can no longer be sent at the claim level.

While the new claim formats support submission of ICD-10 Diagnosis and Procedure codes, ICD-10 codes are not valid for use until October 1, 2013.

Enhancements

For all claim formats

- “Other” (previous) payer amounts and subscriber dates of birth are no longer required for coordination of benefit (COB) submissions. However, these COB amounts are still required:
  - Payer Paid Amount
  - Total Non-Covered Amount
  - Remaining Patient Liability
- A description field has been added to the service line for unclassified CPT codes. These codes should not be submitted as comments.

For institutional claims

- The definitions for inpatient and outpatient services are now aligned with the National Uniform Billing Committee standard definitions in the UB04 Data Specifications Manual.

For dental claims

- The “Patient Student Status Code” has been eliminated.
- You can now send diagnosis codes for some specialty services. Cigna does not require diagnosis codes on any dental format claims.
- The 5010 standard now defines how the service location address should be sent.

For professional claims

- Additional anesthesia units can be reported for additional complexity beyond normal obstetric services.
- The surgical code related to anesthesiology services can be included on the claim.
- The number of diagnosis codes and pointers has been expanded.
- Drop-off and pick-up information can be included for ambulance claims.

While we do not anticipate you will see any differences in your claim transactions other than those noted above, we recommend you contact your electronic transaction vendor for information about any additional changes you may experience. Some clearinghouses or vendors may begin automatically converting transactions between the current version (4010) and the new version (5010). As a result, you may notice these changes earlier or later than the date your system creates transactions in version 5010.

Check with your vendor or software supplier about their 5010 readiness and testing plan. Cigna will no longer accept 4010 transactions after a trading partner has migrated to 5010.

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