
SUMMARY

This section explains the process and requirements for processing claims and submitting claims for CIGNA members.

CLAIMS CHECKLIST

- Verify Members Eligibility and Benefits.
- Make sure that appropriate Pre-certifications and/or referrals are obtained prior to submittal of claim.
- Use CPT coding schemes from 2001 to designate procedures and ICD- 9-CM codes for diagnoses.
- Submit claims to the claims office identified on the back of the members ID card.
- Bill within 180 days.

MAILING CLAIMS

Check the back of the member ID card for appropriate claim billing address.

CLAIM STATUS / QUESTIONS

- Call the telephone number on the member ID Card
- Call the telephone number on the EOB

EOB

For each claim submitted, CIGNA will issue an EOB. The EOB will state the amount paid on the claim, or why the claim was denied.

Remark codes are listed on the EOB. These codes explain how the claim was processed.

ELECTRONIC SUBMISSION OF CLAIMS

CIGNA claims can be submitted electronically for faster claims filing. For information on electronic submission, please call CIGNA Provider Services at 520.571.6650 or 800.572.9990.

CLAIMCHECK

CIGNA uses a software program, ClaimCheck, to audit accuracy of CPT coding on submitted claims. ClaimCheck will automatically audit the codes and identify payment for the acceptable procedure codes. Codes identified, as an integral part of major procedures billed will be denied.

SUMMARY

This section explains the process and requirements for challenging claims for CIGNA members.

CLAIMS APPEALS

An important part of CIGNA HealthCare's program is the mechanism through which physicians can ask questions and resolve reimbursement issues that arise. It is to the advantage of all concerned if a question can be answered quickly and a problem resolved promptly, fairly and informally.

THE PURPOSE OF THE CLAIM APPEALS PROCESS IS TO:

- Allow the provider to voice concerns and appeal claim denials or perceived under payments.
- Ensure these concerns are acted upon promptly.
- Ensure the concerns are addressed consistently and fairly

Your request for claim review will be expedited when you include the following:

- Cover letter explaining your request for review/reconsideration
- Copy of HCFA or UB92
- Copy of the EOB
- Supporting medical documentation (i.e., notes, reports, etc.)

1ST LEVEL APPEALS

Initially, the physician should address any question regarding claim payment or denial to Member Services at the telephone number on the member's identification card or by calling **Member Services at 800.572.9990**. A Customer Service Associate (CSA) will investigate the claim and, when appropriate, forward the claim to a nurse reviewer for review. The CSA or nurse reviewer will respond to the physician in writing after the claim has been reviewed.

OR

A written request for review may be sent to the Claims Office that originated the Explanation of Benefits.

2ND LEVEL APPEALS

A physician who is not satisfied with the 1st level determination may submit a written request for reconsideration to the Claims Payer or Employer Group. The Medical Director, or his designee, will review the issue and notify the physician of the decision in writing.

3RD LEVEL APPEALS

A physician who is not satisfied with the 2nd level determination may appeal to Managed Care Consultants (MCC) Medical Director's (or his designee's). The physician may submit a written request asking for a review of the decision rendered by the local Claims Payer or Employer Group.

THE FOLLOWING INFORMATION SHOULD BE SUBMITTED:

- Written request for review
- Medical records and pertinent notes
- Copy of the EOB
- Copy of letter of determination from the health plan's Medical Director

THIS INFORMATION SHOULD BE FORWARDED TO:

**CIGNA HEALTHCARE
PROVIDER APPEAL COUNCIL, A-136
900 COTTAGE GROVE RD.
HARTFORD, CT 06152-1136**

The Provider Appeal Council meets quarterly and will communicate its decision to the physician in writing.