



EDI Claims Submission Guide

In support of Health Insurance Portability and Accountability Act (HIPAA) and its goal of administrative simplification, Coventry Health Care encourages physicians and medical providers to submit claims electronically. Electronic claims submission can have a significant, positive impact on the productivity and cash flow for your practice.

- **Reduces Paperwork and Costs** associated with printing and mailing paper claims.
- **Reduces Time** to receive a claim by eliminating mailing time.
- **Reduces Delays** due to incorrect claim information by returning errors directly to you through the same electronic channel. These claims can be corrected and re-submitted electronically.
- **Improves Accuracy** by decreasing the chance for transcription errors and missing/incorrect data.
- **Tracks and Monitors Claims** through claim status reports received electronically.

Electronic claim submission to the Coventry Health Care payers is easy to establish. **Contact your practice management system vendor or clearinghouse to initiate the process.** Electronic claim submissions will be routed through Emdeon who will review and validate the claims for HIPAA compliance and forward them directly to Coventry.

Providers can also submit directly to Emdeon. Emdeon will provide the electronic requirements and set-up instructions. Providers should call **(800) 215-4730** or go to www.emdeon.com for information on direct submission to Emdeon.

EDI claim submitters should review the electronic claim submission requirements starting on the next page.

Coventry encourages and recommends regular review of all EDI Acknowledgement and Reject reports returned to you. We have staff available to assist you with EDI claim filing. For more details on each of these topics please select from the topics below.

This document was last revised February 2011.

1. EDI Specifications -

The 837 claim transaction is utilized for electronic professional and institutional claims and encounters. Coventry Health Care, Inc. uses the ASC X12N 837 Professional Health Care Claim (004010X098A1) and the ASC X12N 837 Institutional Health Care Claim (004010X096A1) implementation guides. The official implementation guides for claim transactions are available electronically from the Washington Publishing Company website at www.wpc-edi.com.

This Coventry document contains clarifications and payer specific requirements related to data usage and content with submitting an EDI claims to Coventry. Please note that this document is intended to list only those elements where payer specific requirements or clarifications apply.

The loop, segment and data element references below in *italics* relate to the 004010X098A1 or 004010X096A1 format. If you submit your electronic claims using a different format, you should check with your software vendor or clearinghouse to ensure that your data is mapped to the proper data elements.

2. Coventry Specific Payer Edits at Emdeon:

All EDI claims submitted through Emdeon will be subject to these Coventry specific payer edits (unless indicated for one transaction only) that are in place at Emdeon. Submitters will receive these type of rejections on their level 1 payer rejection reports.

- The insured id must be at least two characters in length or the claim will reject.
- To allow zero dollar line charges and zero dollar claim charges.
- The billing provider id may not contain a value of 999999999 or the claim will reject.
- If the procedure code begins with 0, then Anesthesia Minutes are required or the claim will reject (Prof Only). Excluding procedure code is 01995 or 01996 then service units are required and the Anesthesia Minutes should contain 00 or the claim will reject. If the procedure code begins with a 0 and ends with a T, then service units are required and the Anesthesia Minutes should contain 00 or the claim will reject (Prof Only).
- If the procedure code does not begin with a 0, then service units are required and the Anesthesia Minutes should contain 00 or the claim will reject (Prof Only).
- The discharge hour must contain a numeric value of 00-23 or 99 if the batch type contains an inpatient value of x10, x11, x14 or x17 and the statement period from date is equal to the statement period thru date (Inst Only).

NOTE:

Refer to [2011 Claim Submission Logo Grid](#) at http://www.mhbp.com/web/groups/public/@cvty_mailhandlers_mhbp/documents/webcontent/c059942.pdf to locate the respective Emdeon payer ID and paper mailing address for all Coventry health plans. Coventry has consolidated several of our Emdeon Payer IDs into a single payer id to make claim submission easier. Please refer to the consolidated Emdeon Payer ID on the logo grid for the Health plans included.

3. Professional EDI Claim Submission Information

Key Information required by HIPAA/Coventry or clarified as to Coventry's use of the data:

Provider

- **Federal Tax ID (TIN) of Billing Provider** (9 digit number).
- **National Provider ID (NPI) is required** for Billing, Rendering, Referring providers, and all other provider loops.
- **Billing Provider's Last Name (NM103)** and **Provider's First Name (NM104)** are both required if the provider entity type qualifier indicates "person". Provider first name should be submitted completely and not just a first initial.

- **Rendering Provider Name and ID Number** (*Loop 2310B*) is required when different than the billing provider (*2010AA*). Provider first name should be submitted completely and not just a first initial.
 - If you submit rendering provider information at the claim header level (*Loop 2310B*), do **not** also submit service line level (*Loop 2420A*) rendering provider information. Coventry will read the provider at the claim header level only. If you do not have a rendering provider at the claim header, Coventry will read the billing provider data.
- **Referring Provider Name and ID Number** (*Loop 2310A*)
 - If the referring provider is a person, both the first name (*NM104*) and last name (*NM103*) are required.
 - Do **not** submit referring provider information at the service line level (*Loop 2420F*). Coventry will read provider data at the *claim* level only (*Loop 2310A*).
 - When there is only one referral on the claim, use code *DN* in *NM101*. When two referrals are reported, use code *DN* in *NM101* of the first iteration of the loop and code *P3* in *NM101* in the second iteration of the loop. Coventry will only read the first referral submitted.
- **Service Facility Location** (*Loop 2310D*) is required when the service location is different than the location in the billing provider (*2010AA*).
 - Service facility location name (*NM1*) is required except when the place of service is the patient's home.
 - Include Service Facility NPI
 - Do not submit service facility location information at the service line level (*Loop 2420C*).
- **Pay-To Provider (Loop 2010)**. Coventry accepts and stores "Pay-To" provider data. However, will only use this data in claim filing on an exception basis. Please contact the EDI support number below if your submissions require provider matching based on data in this loop. The Coventry standard is to use the rendering or billing provider information for claims.

Other Claim Header Information:

- **Admission Date** (*Ref02 where REF0=435*) is required per HIPAA guides for inpatient medical visits and ambulance claims when the patient was admitted to the hospital.
- **Compliant Medical Code Sets** such as HCPCS, ICD-9, and CPT-4 are required on both electronic and paper claims.
- **ICD-9-CM** codes should be submitted with the highest level of specificity (the correct number of digits) for proper adjudication.

Patient

- **Member ID Number** as shown on the patient's ID card.
- **Member Date of Birth & Gender Code**
- **Subscriber's Date of Birth** (*DMG02 where DMG01=D8*) and **Gender Code** (*DMG03*) are preferred and are required if either:
 - The subscriber is the same person as the patient.
 - For secondary COB claims when using *Loops 2320 and 2330*.
- **Insurance Type Code** is required on secondary COB claims (*Loop 2320 SBR05*).

Special Data Items

- **Anesthesia EDI Claims.** Coventry requires the submission of time-based CPT codes (formally called ASA codes) for all anesthesia services. Anesthesia claims submitted with surgical CPT codes will be denied during processing.
 - Total Anesthesia Minutes are required on all time-based CPT codes, with the exception of 01995 and 01996. Total Minutes should be entered in the SV104. The qualifier MJ should be entered in the SV103.
 - All non time-based services (01996 included) require units of service. Units should be entered in the SV104, with a Qualifier of UN in the SV103.
- **Claims with Attachments.** Coventry is able to receive and use in processing the EDI Claim Supplemental Information paperwork segment as defined in the Health Care Claim 837 Implementation Guide. This segment contains paperwork codes to indicate documents available to the payer if needed. 4010 Specifications for 2300 Loop - PWK Segment

- PWK01 - Report Type Code (see applicable codes below)
- PWK02 - Report Transmission Code *must be 'AA'* for available on request at provider site.
- PWK06 - Attachment Control number (if applicable).
- PWK07 - Description (optional)(UB claims only).

Coventry's business practices support the following paperwork codes (PWK01), which will be considered during adjudication:

- (AS) Admission Summary
- (DG) Diagnostic Report
- (DS) Discharge Summary
- (NN) Nurse Notes
- (PN) Physical Therapy Notes
- (B3) Physician Order
- (OB) Operative Notes
- (EB) Explanation of Benefits
- (RT) Report of Tests and Analysis Report
- (RR) Radiology Reports

Please note for claims with attachments:

- The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established policies.
- If the documentation is needed for adjudication, Coventry will contact you and request a faxed copy. This copy must be received within 72 hours of the request or the claim will be denied.
- The specific paperwork codes in the PWK segment will trigger processors to consider the contents of the supplemental information obtained via fax. Therefore, use of these codes incorrectly may delay the processing of the claim as compared to a like claim without a PWK.
- Coventry will continue to accept paper claims with attachments.
- **Secondary COB Claims - secondary claims may be submitted electronically.**
 - Send the secondary claim electronically using the 837 4010A1 using *Loops 2320 and 2330* for claim header data and *Loops 2420G and 2430* for claim service line data.
 - All COB secondary claims must contain information regarding the other payer approved and allowed amounts. Additionally, we need to receive the applicable claim adjustment reason codes at the header or line level for other payer amounts.
 - Coventry does not require secondary COB claims to be submitted electronically. Providers may continue to submit COB claims on paper and attach a copy of the paper EOB.

NOTE: Coventry receives Medicare Part A & B primary claims automatically through the cross over process for secondary payment. To eliminate duplicate claim submissions, refer to the EOB/RA from Medicare (look for code "MA-18" on your Medicare Remittance Advice) before submitting secondary claims directly to Coventry.

- **Resubmitted Claims** - Corrected or replacement claims may be submitted electronically. Use the *Claim Frequency Type Code (CLM05-3)* value equal to "7" to indicate a replacement claim.
- **Pharmaceutical Claims** - May be submitted electronically. These drug claims should not be for retail pharmacy claims nor can they be in an NCPDP format. If you are submitting a claim for pharmaceutical services, the HCPCS J codes are required to identify the drug. However, if the appropriate J-code is J3490 or J9999, we also require the NDC code using *Loop 2410*. Use a F2 qualifier on the service line level to indicate DOSAGE for this NDC code. If you cannot submit the 2410 loop, then place the NDC and dosage information in the claim header note segment (2300 NTE). We do not read NTE information at the claim line level.

DATA NOT USED

Although Coventry accepts the following data, it is not used in claim adjudication.

- **Providers loops and segments at the claim line level.**

- **Supervising provider information** - Please contact the EDI support number below if your submissions require provider matching based on data in this loop. The Coventry standard is to use the rendering or billing provider information for claims.
- **Purchasing provider information.**
- **Currency.** Information in the *CUR* segment will not be considered in processing. All electronic transactions will be with trading partners in the United States.
- **Select Patient Information Segment** including **date of death** (*PAT06*), **Weight** (*PAT08*), and **Pregnancy Indicator** (*PAT09*).
- **Responsible Party Information** (*Loop 2010 BC*) information submitted on appropriate legal documentation and maintained in internal files will be used.
- **Participation Indicator** (*Loop 2300 CLM16*) we will use the participation indicator in our internal provider files.
- **Service Authorization Exception Code** in *Loop 2300 REF*.
- **Ambulatory Patient Group** in *Loop 2300 REF*.
- **Demonstration Project Identifier** in *Loop 2300 REF*.
- **Durable Medical Equipment Service** (*Loop 2400 SV5 segment*). DME should be billed in the *Loop 2400 SV1 segment*.
- **Mandatory Medicare Crossover Indicator** (*Loop 2300 REF*).
- **Mammography Certification Number** (*Loops 2300 and 2400 REF*).
- **DMERC CMN Indicator** (*Loop 2400 PWK*).
- **Hospice Employee Indicator** (*Loop 2400 CRC*).
- **Credit/Debit Card Account Holder Name** (*Loop 2010BD*) and **Credit/Debit Card Maximum Amount** (*Loop 2300 AMT segment*)

4. Institutional (UB) Claim Submission Information

Key Information required by HIPAA/Coventry or clarified as to Coventry's use of the data:

Provider

- **Federal Tax ID (TIN) of Provider** (9 digit number).
- **National Provider ID (NPI)** for Billing, Rendering, Attending providers, and all other provider loops.
- **Billing Provider's Last Name** (*NM103*) and **Provider's First Name** (*NM104*) are both required if the provider entity type qualifier indicates "person". Provider first name should be submitted completely and not just a first initial.
- **Attending Provider Name and ID Number** (*Loop 2310A*) is recommended on all institutional claims.
 - If the attending provider is a person, both the first name and the last name are required.
- **Service Facility Name and Address** (*Loop 2310E*) is required when the service facility is different than the billing provider (*2010AA*).
- **Admission Date and Time** is required for all inpatient claims. *DTP03* should be in this format: *CCYYMMDDHHMM* where *DTP01=435* and *DTP02=DT*.
- **Service Line Date** is required on outpatient claims. *DTP03* where *DTP01=472* in *Loop 2400*.
- **Unit or Basis for Measurement Code** *SV204* in *Loop 2400* (days, units, international unit or dosage) is required at the service line level.
- **Quantity Segment** (*QTY* in *Loop 2300*) should only be used for information related to DAYS, such as the number of covered, co-insured, life-time reserve or non-covered days. Do not use this segment on outpatient claims.
- **Compliant Medical Code Sets** such as HCPCS, ICD-9, and CPT-4 are required on both electronic and paper claims.
- **ICD-9-CM** codes should be submitted with the highest level of specificity (the correct number of digits) for proper adjudication. These codes should be submitted without the decimal point on electronic claims.
 - ICD-9-CM codes are expected on all outpatient surgery claims.

Patient

- **Member ID Number** (10-11 digit number) as shown on the patient's ID card.
- **Member's Date of Birth and Gender Code**
- **Subscriber's Date of Birth** (*DMG02 where DMG01=D8*) and **Gender Code** (*DMG03*) are required if either:
 - The subscriber is the same person as the patient.
 - For secondary COB claims when using *Loops 2320 and 2330*.
- **Patient Status Code** *CL103 in Loop 2300* (2-digit code from box 22 of the UB-92) is required on all inpatient claims.

RECOMMENDED INFORMATION

- **Claims with Attachments.** Coventry is able to receive and use in processing the EDI Claim Supplemental Information paperwork segment as defined in the Health Care Claim 837 Implementation Guide.
4010 Specifications for 2300 Loop - PWK Segment
 - PWK01 - Report Type Code (see applicable codes below)
 - PWK02 - Report Transmission Code *must be 'AA'* for available on request at provider site.
 - PWK06 - Attachment Control number (not used now, but will be implemented in the future).
 - PWK07 - Description (optional)(UB claims only).

Coventry's business practices support the following paperwork codes (PWK01), which will be considered during adjudication:

- (AS) Admission Summary
- (DG) Diagnostic Report
- (DS) Discharge Summary
- (NN) Nurse Notes
- (PN) Physical Therapy Notes
- (B3) Physician Order
- (OB) Operative Notes
- (EB) Explanation of Benefits
- (RT) Report of Tests and Analysis Report
- (RR) Radiology Reports

Please note for claims with attachments:

- The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established policies.
- The specific paperwork codes in the PWK segment will trigger processors to consider the contents of the supplemental information obtained via fax. Therefore, use of these codes incorrectly may delay the processing of the claim as compared to a like claim without a PWK.
- If the documentation is needed for adjudication, Coventry will contact you and request a faxed copy. This copy must be received within 72 hours of the request or the claim will be denied.
- Coventry will continue to accept paper claims with attachments.
- **Secondary COB Claims** - secondary claims may be submitted electronically:
 - Send the secondary claim electronically using the 837 4010A1 using *Loops 2320 and 2330* for claim header data and *Loop 2430* for claim service line data.
 - All COB secondary claims must contain information regarding the other payer approved and allowed amounts. Additionally, we need to receive the applicable claim adjustment reason codes at the header or line level for other payer amounts.
 - Coventry does not require secondary COB claims to be submitted electronically. Providers may continue to submit COB claims on paper and attach a copy of the paper EOB.

NOTE: Coventry receives Medicare Part A & B primary claims automatically through the cross over process for secondary payment. To eliminate duplicate claim submissions, refer to the EOB/RA from

Medicare (look for code "MA-18" on your Medicare Remittance Advice) before submitting secondary claims directly to Coventry.

- **Pharmaceutical Claims** - may be submitted electronically using an 837. These drug claims should not be for retail pharmacy claims nor can they be in an NCPDP format. If you are submitting a claim for pharmaceutical services, the HCPCS J codes are required to identify the drug. However, if the appropriate J-code is J3490 or a J9999, we also require the NDC code using *Loop 2410*. Use a F2 qualifier on the service line level to indicate DOSAGE for this NDC code. If you cannot submit the 2410 loop, then place the NDC and dosage information in the claim header note segment (2300 NTE). We do not read NTE information at the claim line level.

DATA NOT USED

Although Coventry accepts the following data, it is not used in claim adjudication.

- **Providers loops and segments at the claim line level.**
- **Payer Secondary Information.** (*Loop 2010BB REF*)
- **Currency.** Information in the *CUR* segment will not be considered in processing. All electronic transactions will be with trading partners in the United States.
- **Responsible Party Information** (*Loop 2310BC*) will not be considered in processing. The information submitted on appropriate legal documentation and maintained in internal files will be used.
- **Demonstration Project Identifier** in *Loop 2300 REF*.
- **File Information** in *Loop 2300 K3 segment*. This is not needed as no usage for this segment has been defined.
- **Peer Review Organization Approval Number** (*Loop 2300 REF segment*). Information on internal files will be used.
- **Medicare PPS Assessment Date** (*Loop 2400 DTP*).
- **Explanation of Benefits Indicator** (*CLM18*). Information from our internal files will be used.
- **Treatment Code Information** (*in Loop 2300 HI segment*). Home Health Agency treatment plan information is not needed for processing at this time.
- **Credit/Debit Card Account Holder Name** (*Loop 2010BB*) and **Credit/Debit Card Maximum Amount** (*Loop 2300 AMT segment*)
- **Property and Casualty Claim Number** (*REF segments in Loops 2010BA and 2010CA*)

4. EDI Acknowledgement and Reject Reports

For every claim filed electronically, the provider should monitor whether or not that claim has been rejected by reviewing EDI Acknowledgement and Reject reports on a regular basis. The following reports should be monitored regularly.

- **Initial Reject Report (Emdeon report Rpt 05 or equivalent vendor report)** - This is a report that shows claims rejected by Emdeon that were not forwarded to Mail Handlers Benefit Plan. These claims should be corrected and re-submitted electronically.
- **Initial Accept Report (Emdeon Envoy Report Rpt 04 or equivalent vendor report)** - This is a report that shows Emdeon accepted the EDI claim and forwarded it to Coventry for processing.
- **Payer Reject Report (Emdeon Report Rpt 11 or equivalent vendor report)** - This report states why the Coventry health plan rejected the claim. These claims should be corrected and re-submitted electronically when possible.

Monitoring Your EDI Reports

Please note that claims appearing on the **Initial Reject Report** have not met the initial clearinghouse criteria approved by Coventry and have not been sent to Coventry for adjudication. Any claims appearing on this report must be corrected and should be re-submitted electronically as soon as possible to avoid timely filing issues.

Claims displayed on the **Initial Accept Report** have passed the clearinghouse edits and have been forwarded to Coventry for additional payer editing. Do to the size of this report a file summary report might be more appropriate

to monitor the number of accepted claims.

It is also important to note that a claim can pass the clearinghouse edits and be displayed on the Initial Accept Report, but still be rejected by Coventry. Claims rejected by Coventry payors will appear on the **Payer Reject Report**. Any claims appearing on this report should be corrected and re-submitted electronically as soon as possible to avoid timely filing issues.

Timely Filing

Coventry must accept a claim within its timely filing limit or it will be denied for untimely filing. If you are not receiving the described clearinghouse and payer reports on a regular basis, please contact your clearinghouse or Emdeon. A provider can avoid timely filing issues through understanding and regular monitoring of EDI Reports. This process will help to ensure all rejected claims are re-filed timely and electronically.

5. Common Rejection Reasons

Review the following tips for assistance with resolving the most common rejections received by providers. The most common claim reject reason for Coventry is "member not found." **Use the Coventry Health Care secure provider portal, *directprovider.com*, *Emdeon*, or an *integrated solution through your vendor or clearinghouse* to verify/validate member's eligibility prior to submitting claims.**

Member Identification Number

Submit the 10 or 11 digit number as displayed on the patient's ID card.

Patient Date of Birth

Submit a valid date of birth for the patient.

- Do not send "00" for the month or date.
- Do not send dummy dates such as "17760704".
- Do not send a date of birth greater than the date of service.

A claim will be rejected if a valid date of birth does not match the date of birth on file in the Coventry system. If this is the case, please verify the patient date of birth with the patient or policyholder.

Date Format

Submit all dates in the following format CCYYMMDD unless otherwise specified.

- Submit valid dates of service.
- Do not submit future dates of service.

Monetary Amount Format

Include the decimal point in all monetary amounts unless otherwise specified.

- Do not submit negative dollar amounts.

Coding Detail

Consider the following when verifying service codes and/or modifiers that have been rejected.

- Submit service codes and modifiers appropriate to the age and gender of the patient.
- Submit service codes and modifiers appropriate to the date of service.
- Submit service codes to their greatest level of specificity.

6. EDI Assistance

Your Clearinghouse - typically, your first point of contact for resolving an EDI issue is your practice's specific clearinghouse or vendor.

Emdeon - The Emdeon customer service center can track all EDI submissions received by them. Emdeon also maintains the status message returned on an EDI claim from the health plan. This information is readily available for 45 days after the submission. Information on older submissions is also available but will need forwarded to

their research division for follow-up. Emdeon Customer Support can be reached at **(877) 469-3263**. Additionally, Emdeon has a new web-based application, Vision for Claim Management, that compiles claim information received and generated during claim filing and processing. It is an easy to use application for tracking EDI claim submissions. For more information and registration for Vision for Claim Management, go to http://transact.emdeon.com/editrx_services.php

Coventry staff is available to assist you with electronic filing concerns as they relate to our submission requirements or status messages. Please contact us at (302) 283-6570 or via email at EDIClaims@cvty.com.