What does “SNIP Level Validation” mean?

- The **Workgroup for Electronic Data Interchange (WEDI)** was formed by the Secretary of Health and Human Services (HHS) and was named in the HIPAA legislation as an advisor to HHS
- The **Strategic National Implementation Process (SNIP)** is a WEDI project that collaboratively developed the industry standard testing levels to validate compliance with HIPAA
- **SNIP Level Validation has seven levels of implementation**
  - Level 1: EDI syntax integrity testing
  - Level 2: HIPAA syntactical requirement testing
  - Level 3: Balancing
  - Level 4: Situation testing
  - Level 5: External code set testing
  - Level 6: Product types or line of services
  - Level 7: Implementation Guide-Specific Trading Partners

Does this impact paper claims?

No. HIPAA requirements are different for paper claims and this change will not affect our process for adjudicating claims submitted in that manner. Level 1 and Level 2 continue to apply after this change.

How will Cigna-HealthSpring notify providers of this change?

- The Summer Provider Newsletter will feature a cover story on the planned approach and reasoning for this update.
- Letters are being mailed to all providers, clearing houses, and delegates to **notify of the change** from warning to rejection effective August 15th.

What should you do to prepare for this change?

- Confirm your billing process includes a review of **response files** from **clearinghouses** to verify that submitted claims are processed or rejected, before requesting status from Cigna-HealthSpring.
- Contact your Practice Management System vendor and/or Billing company and Clearinghouse to ensure claims are submitted at SNIP Level 7 compliance.

When is Cigna-HealthSpring implementing these changes?

- Effective **August 15,** Cigna-HealthSpring will implement **SNIP Levels 1-7** validation and begin **rejecting** claims/encounters and eligibility data records that do not comply with **HIPAA ASC X12 version 5010** implementation guidelines.

What is HIPAA ASC X12 5010?

- **HIPAA ASC X12 version 5010 and NCPDP version D.0** are the current standards regulating the electronic transmission of specific healthcare transactions, including eligibility, claim status, referrals, claims, and remittances.
- Use of the 5010 version of ASC X12 and the NCPDP D.0 standard is required by federal law
- **HIPAA X12 5010 Standard Transactions include:**
  - 837 Health Care Claim (Professional, Institutional, and Dental)
  - 835 Health Care Claim Payment/Advice
  - 834 Benefit Enrollment and Maintenance
  - 820 Payroll deducted and other group premium payment for insurance products
  - 278 Authorization request and response
  - 276/277 Claim Status Request and response
  - 270/271 Eligibility Benefit Inquiry and response

How did Cigna-HealthSpring identify the impact of this change on providers?

- We solicited **regional network leads, claims management, and provider services** to serve on the leadership team coordinating communications and network support.
- We also developed **Rejection Reports, Talking Points** and this **FAQ** for Network Operations and Provider Services

What are the benefits of this decision?

- Improved payment cycle times by processing cleaner claims faster
- Improved CMS data quality from fewer error cycles with data

Why do I need to do this?

- Claims must meet the SNIP level technical specifications in order to pass through Cigna-HealthSpring's adjudication system.
- Claims that don't meet the specifications will be **rejected** (NOT denied) and your billing office or service must correct the claim before resubmitting.
- Your billing service should have received warning messages for these edits since November 2014.
- Detailed reasons for rejection are listed as Warnings on clearinghouse reports explaining the error.

How do I know if my claims are processing?

- If you've received a remittance advice or explanation of payment (EOP) from Cigna-HealthSpring, then your claim has met specifications and has been adjudicated!
- If you file electronically, your claims may be sent to a clearinghouse, but may NOT have been received by Cigna-HealthSpring. Therefore, it is imperative to check the daily Rejection Report from your clearinghouse for any claims that may not have been accepted by your clearinghouse, Cigna-HealthSpring's clearinghouse or Cigna- HealthSpring direct.
- If you are unsure about your Electronic Data Interchange (EDI) claims activity, contact your clearinghouse first to verify claims are being transmitted correctly.
- If you have NOT received a Remittance Advice within 45 days for a claim you have submitted, please check the status online through HSConnect. If that claim is not in our system, please contact your clearinghouse first to ensure your claims are being transmitted correctly.