Infinedi
ELECTRONIC DATA INTERCHANGE

# Print Image Secondary Claims - Method #1

## Sending a Batch of Print Image Secondary Claims

- Make sure all of the fields are correctly populated and formatted as per **"Print Image Secondary Formatting Guide."** (attached)

- Batch your print image secondary claims in your practice management system and transmit them to Infinedi via Connect2Infinedi.

- Log In to Infinedi.net to view batch.

Infinedi
ELECTRONIC DATA INTERCHANGE

1500 08/05

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

Primary Payer ID (Optional)

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

SE-08-20-09 **47** (only need **ins type code** if medicare secondary)

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

## ... Service Lines Below ...

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? For govt. claims, see back YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH #

a. NPI b.

**Box 24 A through J**

| From | To | POS | EMG | CPT/HCPCS | MODIFIER | POINTER | $ CHARGES | UNITS | Rsv | EPSDT | PROVIDER ID. # | NPI |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 073009 | 073009 | 11 | | 99213 | 25 | 1 | 65.00 | 001 | | | | 1234567899 |
| COMMENT | AE,45,57.31 PR,2,17.19 D,,40.12 | | | | | | | | | | | |

| From | To | POS | EMG | CPT/HCPCS | MODIFIER | POINTER | $ CHARGES | UNITS | Rsv | EPSDT | PROVIDER ID. # | NPI |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 073009 | 073009 | 11 | | 78465 | | 1 | 1295.00 | 001 | | | | 1234567899 |
| COMMENT | AE,45,654.81 PR,2,196.44 D,,458.37 | | | | | | | | | | | |

Date 08/20/09

# EXPLANATION OF BENEFITS

**Bob Smith MD**

**NPI Number: 9191919191**

**Tax ID Number: 999999999**

**Check Number: 23645**

**Check Amount: 498.49**

**Check Date: 08/20/09**

## PAYER NAME

ADDRESS

CITY/STATE/ZIP

PHONE

(Box 19 on Claim=Paid Date)

SE-08/20/09

PATIENT NAME
ADDRESS
CITY STATE ZIP
MEMBER ID
PATIENT ACCOUNT NUMBER

AE CO PR D

| DOS | POS | CPT | UNITS | CHARGES | ALLOWED AMOUNT | PPO DISCOUNT | CO-INS | DEDUCT | PAID AMOUNT |
|---|---|---|---|---|---|---|---|---|---|
| 07/30/09 | 11 | 99213-25 | 1 | 65.00 | 57.31 | 7.69 | 17.19 | 0.00 | 40.12 |
| 07/30/09 | 11 | 78465 | 1 | 1295.00 | 654.81 | 640.19 | 196.44 | 0.00 | 458.37 |
| **Totals** | | | | 1360.00 | 712.12 | 647.88 | 213.63 | 0.00 | 498.49 |

Total Patient Responsibility: 213.63

Total Adjustment/Discount: 647.88

Total Provider Payment: 498.49

| | |
|---|---|
| D | Paid Amount |
| PR | Patient Responsibility |
| CO | Contractual Obligation |
| AE | Approved Amount |

**This information is entered on the service line comments of the claim**

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# Print Image Secondary Claims Formatting Guide

| FIELD | CONTENTS | FORMAT | EXAMPLE | OTHER INFORMATION |
|---|---|---|---|---|
| **Box 9C** | Primary Payer ID | 99999 | 73159 | (Optional) Claim will not reject without this payer id. However if claim rejects at the payer for payer ID, you can edit the claim online, plug in the payer id for the primary payer and resubmit your claim. |
| **Box 19** | Adjudication Date/Primary Paid Date | SE-MM/DD/YY Other Data<br><br>*(Any other information that the claim requires. There must be a space after the YY)*<br><br>***Example:*** *If Medicare Secondary, Box 19 must also contain Insurance Type Code.* SE-12/23/09 **47**<br><br>***See Also Alert Dated 12/23/09***<br>***http://www.infinedi.net/News/INews.aspx?newsId=361***<br><br>**CODE DEFINITION**<br>**12** Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan<br>**13** Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group health plan<br>**14** Medicare Secondary, No-fault Insurance including Auto is Primary<br>**15** Medicare Secondary Worker's Compensation<br>**16** Medicare Secondary Public Health Service (PHS) or Other Federal Agency<br>**41** Medicare Secondary Black Lung<br>**42** Medicare Secondary Veteran's Administration<br>**43** Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)<br>**47** Medicare Secondary, Other Liability Insurance is Primary | **If Commercial Insurance or Medicaid:**<br><br>SE-09/30/09<br><br>*(Dash or a space will work in this format)*<br><br>**If Medicare Secondary:**<br><br>SE-12/23/09 **47** | Our System assumes that each service line was adjudicated on the same day and therefore each service line adjudication will receive a DTP*573 (Adjudication Date) derived from the date in Box 19 on the outbound claim. |
| **Service Line Comments** | Adjudication Information from Primary Explanation of Benefits (EOB) | AG,RRR,9999.99 AG,RRR,9999.99 AG,RRR,9999.99<br><br>AG – Adjustment Group Code<br>RRR – Adjustment Reason Code<br>9999.99 – Amount | AE,45,57.31 PR,2,17.19 D,,40.12 | **AG = Adjustment Group Code:**<br><br>The possible values are:<br><br>D – Paid Amount<br>AE – Approved Amount<br>*(Note: Truncated from AAE)*<br>CO – Contractual Obligation<br>CR – Correction and Reversals<br>OA – Other Adjustments<br>PI – Payer Initiated Reductions<br>PR – Patient Responsibility |

| FIELD | CONTENTS | FORMAT | EXAMPLE | OTHER INFORMATION |
|---|---|---|---|---|
| | | • The Service Line Comment field is 80 characters in length.<br>• Separate Adjustments with a single space<br>• Each adjustment requires three fields. (Ex. Group Code, Reason Code, Amount)<br>• If the field is blank then just put the delimiting coma. (Ex. AE,,60)<br>• The adjustments are found in the ERA/EOB from the Payer | | **RRR = Adjustment Reason Code:**<br>The Adjustment Reason Code further defines the Adjustment and is mandatory.<br>The Primary Payer on the ERA/EOB should supply the Reason Code. You may visit link for a total list of codes:<br>http://www.wpc-edi.com/content/view/698/1<br>**9999.99 - Amount**<br>If the Amount is Zero (Ex. Paid Amount = 0) then do not include on the claim<br>Only use what characters you need<br>Don't zero fill amounts (Ex. 50.10 = 50.1)<br>Represent whole numbers without a decimal |

# Medicare Secondary Payer Rejections/Denials for Insurance Type Code

## Date: 12/23/2009

Effective **December 1, 2009**, CMS Medicare began additional editing and screening of all (MSP) Medicare Secondary Payer claims to ensure that information on the claim matches the (CWF) Common Working File. Providers may experience more claim rejections than normal.

Providers submitting claims to Infinedi in Print Image format will be required to include the Insurance Type Code on their claims in block 19 of the CMS-1500. Infinedi will reject Medicare print image secondary claims that do not contain this information. However, Infinedi cannot edit claims to ensure the appropriate type code has been submitted. Providers will be responsible to send the code most appropriate for the claims they are submitting or payer may still reject/deny the claims.

Please use the following format to send the type code behind SE-MM/DD/YY in block 19

Example:

SE-MM/DD/YY **47**

*(There must be a space after the YY to separate adjudication date from insurance type code)*

Providers may consult the list below to select the appropriate **Insurance Type Code**.

| CODE | DEFINITION |
|---|---|
| **12** | Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan |
| **13** | Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group health plan |
| **14** | Medicare Secondary, No-fault Insurance including Auto is Primary |
| **15** | Medicare Secondary Worker's Compensation |
| **16** | Medicare Secondary Public Health Service (PHS) or Other Federal Agency |
| **41** | Medicare Secondary Black Lung |
| **42** | Medicare Secondary Veteran's Administration |
| **43** | Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) |
| **47** | Medicare Secondary, Other Liability Insurance is Primary |

Providers submitting in ANSI 837P format should already have this information coming over in their claims files in 2000B SBR 05. Infinedi will reject Medicare secondary claims that do not contain this information. However, Infinedi cannot edit claims to ensure the appropriate type code has been submitted. Providers

will be responsible to send the code most appropriate for the claims they are submitting or payer may still reject/deny the claims.

Below are some of the reject/denial messages that providers may see on their Medicare Remittance Advice if an incorrect Insurance Type Code was submitted on Medicare Secondary Claims.

**CO-16 –** Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
**MA04 –** Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
**N155 –** Alert: Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.

# Provider Action:

If you have experienced a recent increase in rejections from Medicare, please select a type code and resubmit your claim to Infinedi.

Providers may access complete impact statement from Medicare by clicking link provided.

https://www.trailblazerhealth.com/tools/notices.aspx?DomainID=1&ID=13344

# Payment Adjustment Group Codes (CAS)

## CO-- Contractual Obligations

Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment.

## CR-- Correction and Reversals

Use this code for corrections and reversals to PRIOR claims. Use when CLP02=22, Reversal of Previous Payment.

## OA -- Other adjustments

## PI-- Payor Initiated Reductions

Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).

## PR-- Patient Responsibility