Infinedi
ELECTRONIC DATA INTERCHANGE

Print Image Secondary Claims - Method #2

Online Editing and Conversion of Primary Claim to Secondary

- Print your secondary claim from your practice management system. You can do this on plain paper if you prefer. Also, have a copy of the primary Explanation of Benefits (EOB) available for reference as you will be entering this information on the secondary claim once online.

- Log in to VIC and access Search feature. Locate the original Primary Payer's claim for the date of service (DOS) and patient you want to edit.

- Click "edit" feature to enter the claim you wish to edit.

- At the top of the claims image, you will notice "Edit Claim" link. Click this link to start edit process.

- Hover mouse over the area of the claim you wish to edit. The area will turn blue. Click once to make change.

- Make changes to the Primary claim that correspond with the printed version of your Secondary claim. Note: Many fields *(including payer name/address)* will be different on your Secondary claim than what is on the original Primary claim. *(Make sure ALL of your changes are made before clicking on the "submit edited claim" link.)*

- Click "update claim" after each change.

- Once all of the demographic related information has been changed and updated, you can enter your Primary EOB information in field 19 and service line comments.

- See **"Print Image Secondary Formatting Guide"** (attached) to see how to format and enter your primary payer adjudication (EOB) information. *These instructions relate to line 9c, line 19 and service line comment fields only.*

- Once you have edited all of the fields on the claim form, click on "Submit edited claim" link at the top of the screen to submit your claim for processing.

- You are now on a message screen advising you when your edited claim will process. Infinedi processes claims corrected online at 9:00 AM and 2:00 PM. *(This means if you resubmitted a claim* online at 2:45 PM, you will not see the batch in VIC for this claim until the next morning after 9:00AM). Log In to VIC to view your batch.

Infinedi
ELECTRONIC DATA INTERCHANGE

1500 08/05

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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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 Primary Payer ID (Optional)	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
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
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
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. 2. 3. 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	QUAL	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	QUAL	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

Bob Smith MD

NPI Number: 9191919191

Tax ID Number: 999999999

Check Number: 23645

Check Amount: 498.49

Check Date: 08/20/09

EXPLANATION OF BENEFITS

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

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 *(Any other information that the claim requires. There must be a space after the YY)* ***Example:*** *If Medicare Secondary, Box 19 must also contain Insurance Type Code.* SE-12/23/09 **47** ***See Also Alert Dated 12/23/09*** ***http://www.infinedi.net/News/INews.aspx?newsId=361*** 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	**If Commercial Insurance or Medicaid:** SE-09/30/09 *(Dash or a space will work in this format)* **If Medicare Secondary:** 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 AG – Adjustment Group Code RRR – Adjustment Reason Code 9999.99 – Amount	AE,45,57.31 PR,2,17.19 D,,40.12	**AG = Adjustment Group Code:** The possible values are: D – Paid Amount AE – Approved Amount *(Note: Truncated from AAE)* CO – Contractual Obligation CR – Correction and Reversals OA – Other Adjustments PI – Payer Initiated Reductions PR – Patient Responsibility

FIELD	CONTENTS	FORMAT	EXAMPLE	OTHER INFORMATION
		• The Service Line Comment field is 80 characters in length. • Separate Adjustments with a single space • Each adjustment requires three fields. (Ex. Group Code, Reason Code, Amount) • If the field is blank then just put the delimiting coma. (Ex. AE,,60) • The adjustments are found in the ERA/EOB from the Payer		**RRR = Adjustment Reason Code:** The Adjustment Reason Code further defines the Adjustment and is mandatory. The Primary Payer on the ERA/EOB should supply the Reason Code. You may visit link for a total list of codes: http://www.wpc-edi.com/content/view/698/1 **9999.99 - Amount** If the Amount is Zero (Ex. Paid Amount = 0) then do not include on the claim Only use what characters you need Don't zero fill amounts (Ex. 50.10 = 50.1) 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