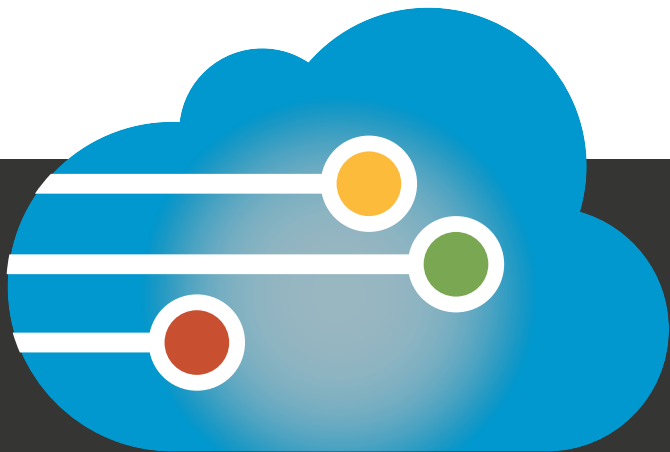


Quick Guide to Secondary Claims

Would you like to:

Please click below what you would like help with to be directed to that specific section in this guide.

- [Convert your primary claim to a secondary claims pg. 3](#)
(if your practice management system does not support the rolling over of secondary claims you will need to convert your primary claim to a secondary claim)
- [Edit an existing claim pg. 3](#)
- [Edit the persons section of an existing claim pg. 3](#)
(patient or subscriber information)
- [Edit the payer section of an existing claim pg. 4](#)
(destination and other primary payer)
- [Edit the service line adjudication/adjustment\(s\) pg. 5](#)
- [Learn more about secondary claims pg. 2](#)
- [View the glossary pg. 8](#)
- [View appendix A pg. 9](#)



Infinedi

To convert your primary claim into a secondary claim you will work in three sections in the Infindi claim editor; the persons section, the payer section and the service line section.

You will need the following documents:

- Your primary payer's ERA/EOB
- Both insurance policy cards

The following information is required:

- All necessary payer information.
(Name, address and payer ID as needed by specific payer.)
- Both subscribers to each payer's policy.
(Payer IDs, demographic and date of birth.)
- On the primary payer record, you need the total amount paid from the primary payer insurance payment.
- Each service line should contain the following:
 - The primary paid payment
 - Service line adjustment and reason
 - The date of the ERA/EOB
 - The primary payer ID number

Persons Section

A secondary claim will have the subscriber and patient (if applicable) fields completed. The subscriber is who owns the secondary policy. In most cases, only the following information is required: subscriber name, gender, member ID number, date of birth, address, city, state, zip code, plan name and relationship.

The "other primary subscriber" is required also. This is the subscriber who owns the primary payer. In most cases the only required information is: the subscriber name, member ID number and relationship.

Please make sure the correct subscriber number and subscriber name is attached to each subscriber fields.

Payer Section

The destination payer should be the secondary payer. The destination payer is the insurance company you are sending this claim to. If the secondary payer is Medicare, you will need to add the Insurance Type. [Please see Appendix A.](#)

The other primary payer is the original primary payer, who has processed the original claim. In most cases, only the following information is required: payer name, claim filing indicator, payer ID and the total primary payment amount.

Service Line Area Section

The service line will include: procedure code type, procedure code value, procedure modifier(s), paid service unit count and line number.

This section is also where you will include the identifier types and values, amount types, quantities and values and adjustment types, adjustment reason codes, adjustment amount value and the adjustment quantities.

Please be sure to click “Update” when you have finished a section, or your information will not be saved

Start here to begin editing an existing claim

1. Locate and open your intended primary claim.
2. Select the boxes “Show All Persons” and “Show All Payers.” Only use the necessary boxes.

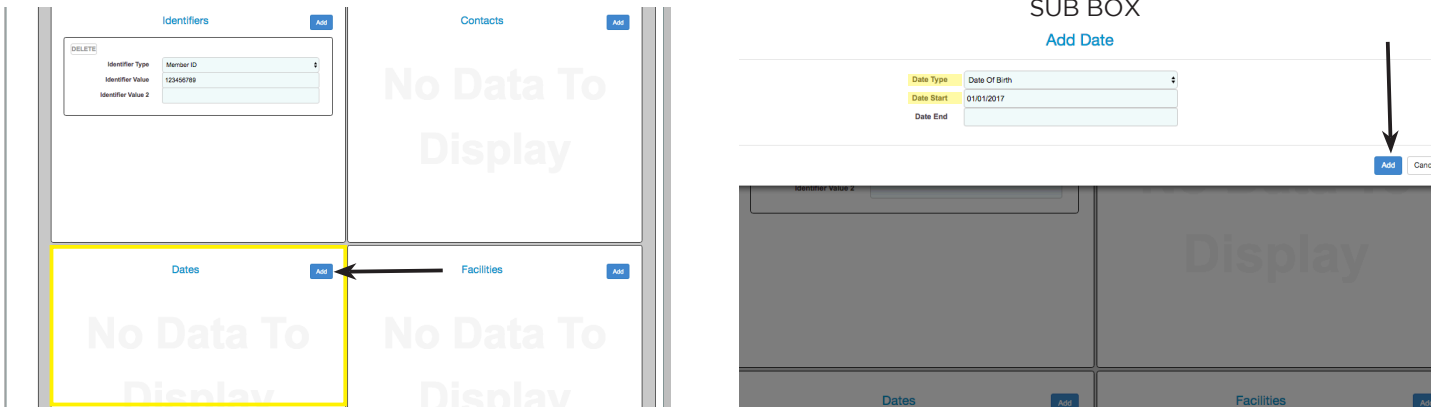
Start here to begin editing the persons section of an existing claim

3. In the subscriber field complete: name, sex, address, city, state, zip code and relationship.
4. Click “Name” to bring up the sub box and complete the name in the sub box. Click save. The name will auto populate the fields. The rest of the fields will allow you to enter data directly into it.

5. Click on the title “Subscriber” in your subscriber box to be directed to additional data boxes below.
6. To add the member ID, click “Add” in the Identifier box. In the sub box:
 - Click “Identifier Type” and select “Member ID”.
 - Enter the member ID number from your insurance care in the Identifier Value. Click “Add”.

7. To add the date of birth, click “Add” in the Dates box.

- Click “Data Type” in the sub box and select “Date of Birth.”
- Type in or select the date in the calendar in the “Date Start”. Click “Add”.



8. Scroll up to the top of your page. In the other primary subscriber fields follow the above steps but only complete: name and relationship. Then, follow the above steps to add the member ID in the identifiers box.

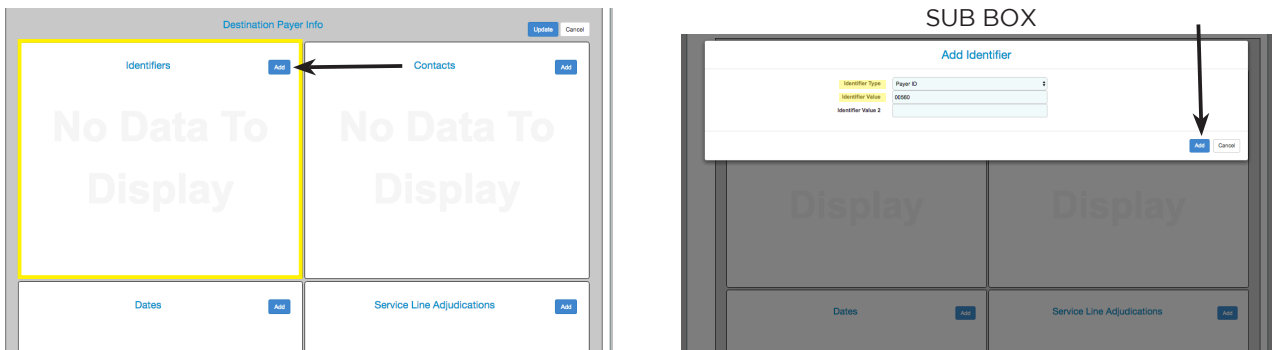
Start here to begin editing the payer section of an existing claim

9. In the destination payer field fill in the: payer name, address 1, city, state, zip, claim filing indicator and responsibility (if the secondary payer is Medicare, you will need to add the insurance type).

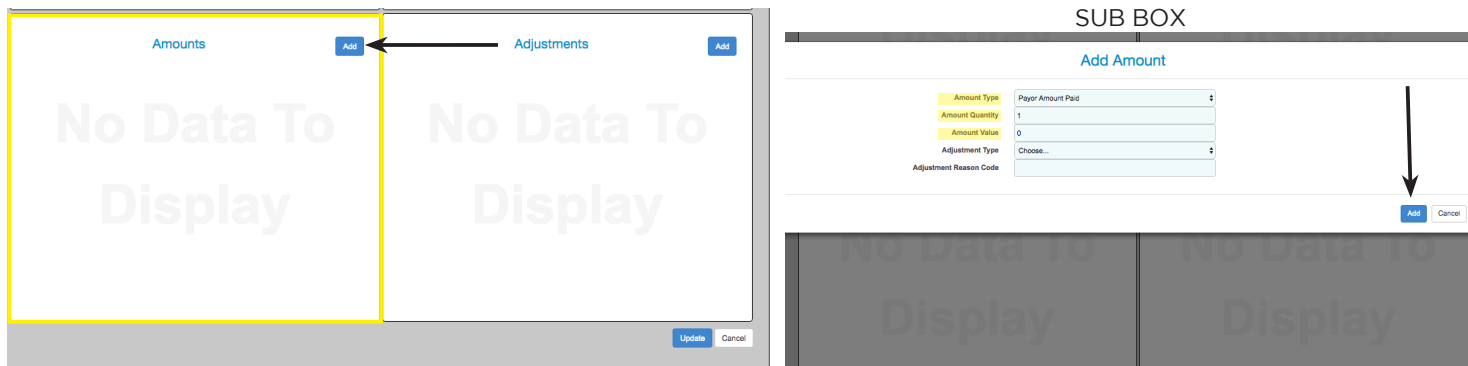
10. Click on the title “Destination Payer” in your box to be directed to additional data boxes.

11. To add the payer ID click “Add” in the identifiers box.

- Use the drop down arrow to select the payer ID in the Identifier Type line.
- Fill in the payer ID number for the original primary payer in the identifier value. Click “Add”.



12. Scroll down to find the “Amounts” Box. To add the total primary payer payment amount click “Add”.
 - Choose the “Payer Amount Paid” (this exact data is required) in the drop down menu in the amount type.
 - Type “1” (this exact data is required) in the amount quantity.
 - Enter the primary payer payment for the total claim paid in the amount value. Click “Add”.

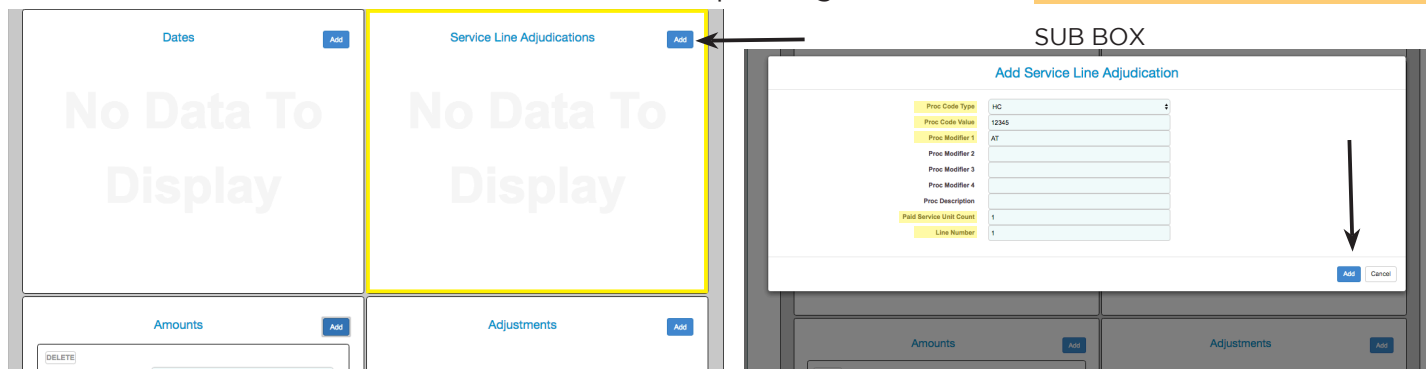


Start here to begin editing the service line section of an existing claim

Please note: These following steps are required on every service line.

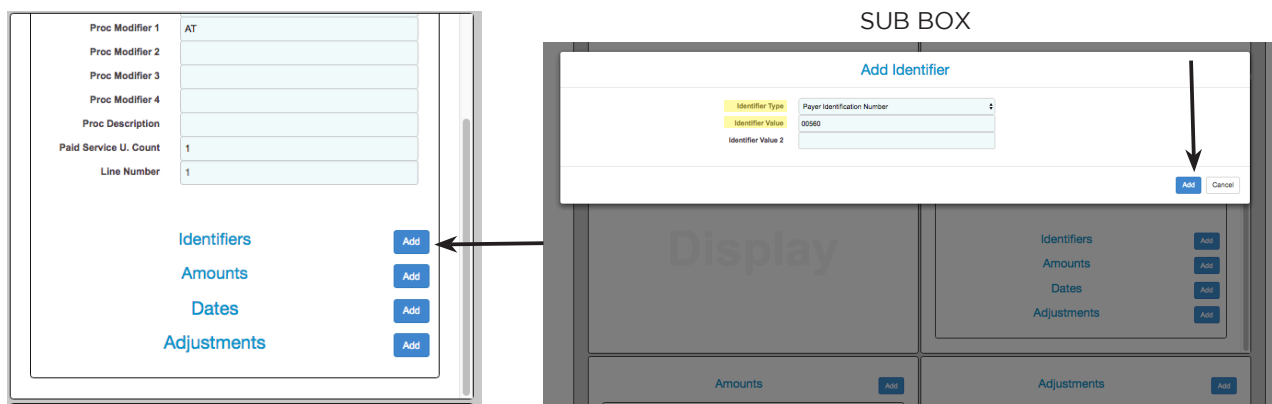
13. Scroll up to the service line section and click in the white area below the date of service date to be directed to the additional service line boxes. Scroll down to the service line adjudications box and click “Add”.
14. In the service line info sub box input the following information:
 - Proc Code Type: HC Qualifier (this exact data is required).
 - Proc Code Value: Enter the service line CPT or HCPC code.
 - Proc Modifier 1: If you have a modifier on the service line enter the same modifier. Repeat for additional modifiers if applicable.
 - Paid Service U. Count: 1 (this exact data is required).
 - Line Number: Enter the corresponding line number

COMING SOON:
A new feature that will automatically input information



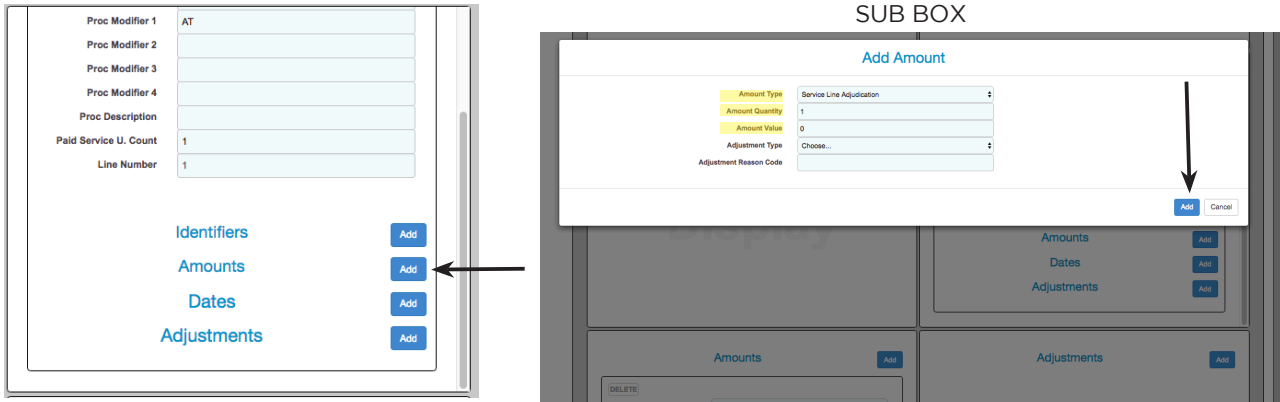
15. Click “Add” and you will then notice “Identifiers, Amounts, Dates and Adjustments” will appear below.
16. Click “Add” next to Identifiers.

- Select “Payer Identification Number” in the drop down menu of Identifier Type
- Enter the payer ID number for the original primary payer in the identifier value. Click “Add”.



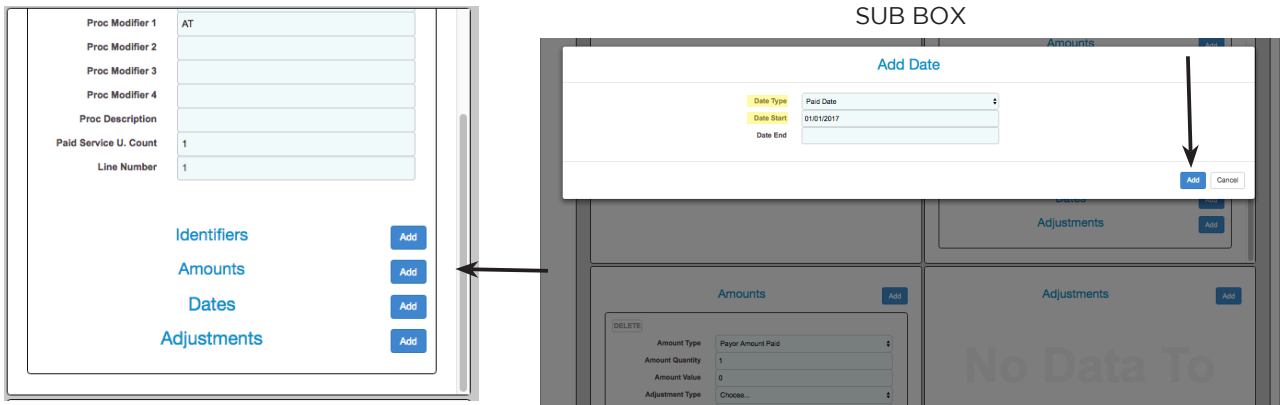
17. Click “Add” next to Amounts.

- Select “Service Line Adjudication” in the drop down menu of the Amount Type.
- Enter “1” (this exact data is required) in the Amount Quantity.
- Enter the primary payer payment for this service line item in the Amount Value.



18. Click “Add” next to Dates.

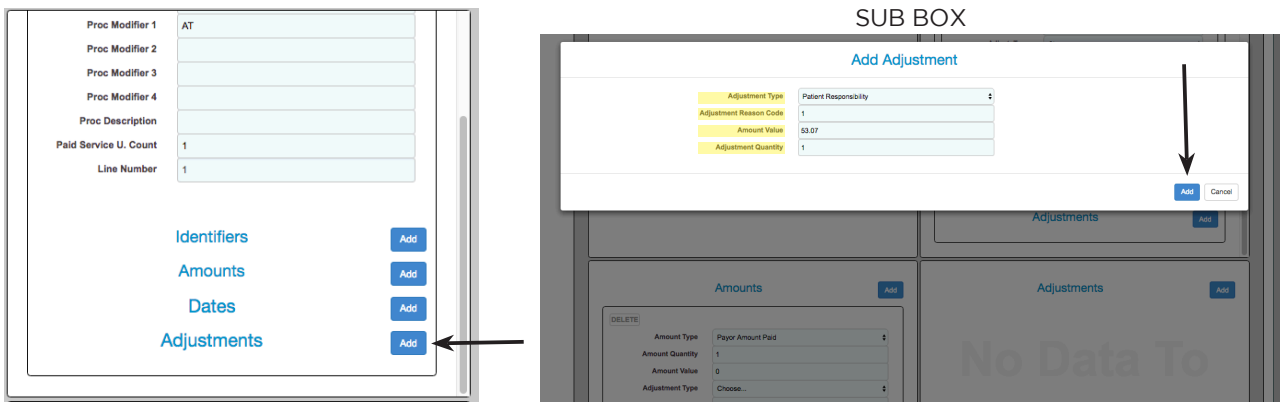
- Select “Paid Date” (this exact data is required) in the drop down menu of the Date Type.
- Enter the date the primary payer paid the claim in the “Date Start”. This date is on the primary payer’s EOB or ERA. Click “Add”.



19. Click “Add” next to Adjustments.

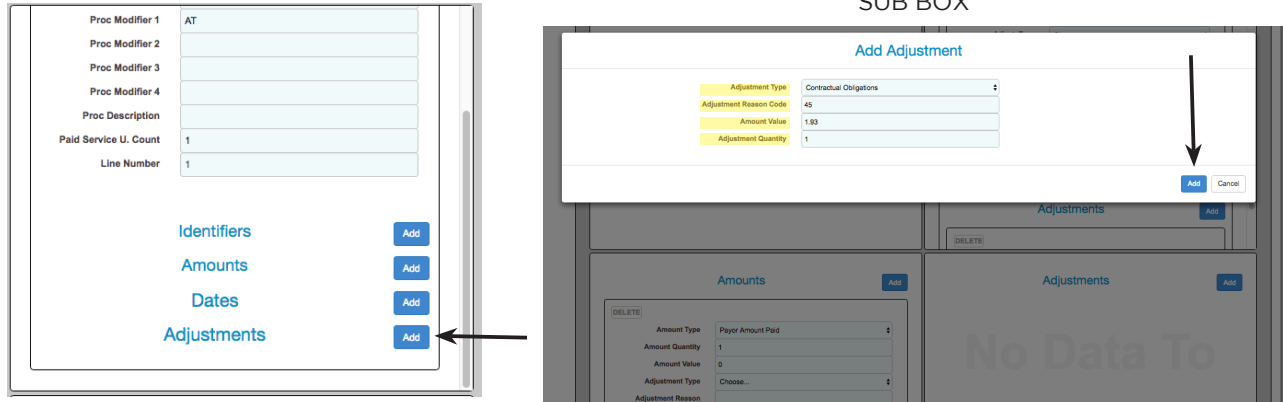
- Choose from the drop down menu per the EOB in “Adjust Type”.
- Enter the reason code in “Adjust. Reason Code”. This reason code is on the primary payer’s EOB or ERA (see appendix A for help).
- Enter the balance due in the “Amount Value”.
- Enter “1” in the “Adjust Quantity”. Click “Add”.

COMING SOON:
A new feature that will automatically input information

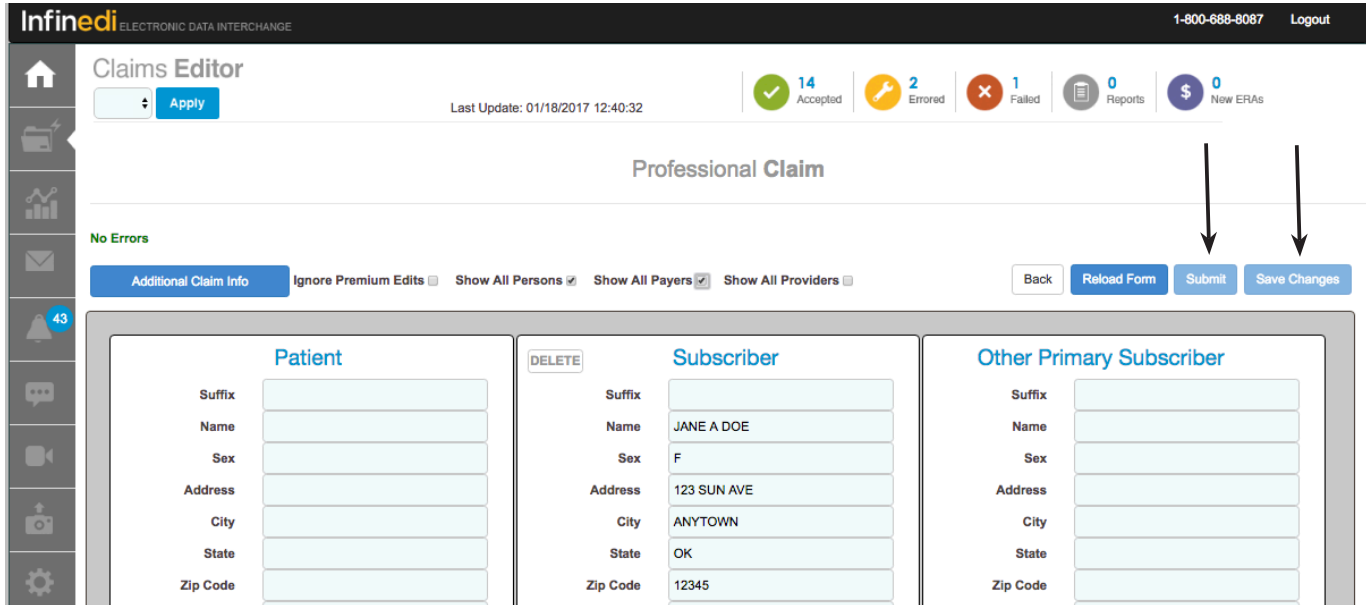


If a contractual obligation write off was taken, follow the steps below:

- Choose “Contractual Obligations” in the drop down menu for “Adjust Type”.
- Enter the reason code in “Adjust. Reason Code”. This reason code is on the primary payer’s EOB or ERA (see appendix A for help).
- Enter the balance due in the “Amount Value”.
- Enter “1” in the “Adjust Quantity”. Click “Add”.



20. After all information has been completed scroll to the top of the screen and click “Save Changes”, then click “Submit”.



Glossary

Adjudication - The claim process used for verification of eligibility, level of benefits available and determination of reimbursement amount.

ANSI - 837i, 837p. American National Standard Institute (ANSI) is a private, not for profit organization that sets and approves standards for many industries. Healthcare ANSI Standards are approved by the ANSI organization and are published by the Washington Publishing Company. Visit www.ansi.org or www.wpc-edi.com for more information.

CPT Code (Current Procedural Terminology) - CPT codes are a medical code set used to report medical, surgical and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations.

EOB (Explanation of Benefits) - The remittance advice sent with payment from a payer.

ERA (Electronic Remittance Advice X835 transaction) - Electronic explanation of claims payment (ANSI 835) received by the provider from the payer. Requires a set up fee and is a billed per transactions. (For every CLP-01 segment (patient account number) returned to Infindi from payer, a transaction fee will apply.)

HCPCS Code (Healthcare Common Procedure Coding System) - HCPCS codes are reported on healthcare claims to indicate nature of procedures performed for a specific patient on a specific date of service. The maintenance of these codes is the responsibility of the Health Care Financing Administration-CMS. HCPCS codes are five characters with one alpha and four numeric configuration (e.g.,A0042). Codes are reviewed annually or additions and revisions.

Line Item - Service line or item specific detail on a claim or remittance advice.

Payer ID Number - An alpha-numeric, numeric or alpha code used for the routing of electronic claims to a specific payer. Usually the back of a patient ID card will advise if payer can receive electronic claims.

PCS Code (Procedure Coding System) - A system of medical classification used for procedural codes that track various health interventions taken by medical professionals. The system uses three to seven digit alphanumeric codes to specify medical procedures. The first digit indicates the section of medical practice and the following digits specify the body system, root operation, body part, approach and the device used. The seventh character is a qualifying digit. The crucial first three digits of a code are stored in the ICD manual for reference.

Print Image - A claim submitted to Infindi in text format instead of ANSI format.

Primary Payer - An insurance policy, plan or program that pays first on a claim for medical care. This could be Medicare or other health insurance.

Secondary Payer - An insurance policy, plan or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the situation.

Subscriber - The owner of the insurance policy (parent, spouse or self).

Appendix A

Washington Publishing Company is a website that gives you claim adjustment reason codes. You can visit this website at <http://www.wpc-edi.com>.

Insurance Type

If the secondary payer is Medicare, you will need to add the insurance type. Only Medicare secondary requires this insurance type - it explains why Medicare is secondary.

A helpful hint: There are multiple choices to choose from, we supply all of the choices in our claim editor, many claims fall under one of these two choices:

- 12 Medicare secondary working aged beneficiary or spouse with employer group health plan
- 43 Medicare secondary disabled beneficiary under age 65 with large group health plan (LGHP)

Other secondary reason type codes are:

- 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.

Appendix A