HOW TO CREATE A SECONDARY CLAIM

Secondary claims are accepted for those payers that are indicated on our Payer List by a "Y" in the column for secondary's (the column header is "SEC").

In some instances, a patient may have coverage with two insurance companies. When the secondary payer is one of the payers indicated on our payer list as a payer able to send secondary's electronically then you may bill these claims electronically.

For all methods of claim submission you will need to bill the primary payer as normal. When you receive the EOB or ERA from the primary insurance, you may then bill the secondary payer electronically.

PRINT IMAGE USERS ONLY – *(IF YOU ARE NOT SUBMITTING A PRINT IMAGE, SKIP TO THE NEXT SECTION)*

Upload your print image secondary claim, just as you would a primary claim, EXCEPT the payer name in the top right of the CMS1500 form must contain the secondary payer name plus the word "secondary". We will recognize this as a secondary claim and send the clam to your claim fix so that you can key in the information from the primary EOB or ERA.

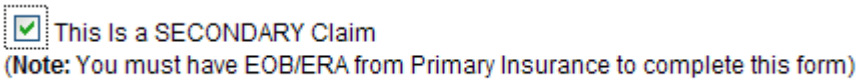
Example:
Medicare Northern CA Secondary
<Street Address>
<City>, <State> <Zip>

Example:
Blue Shield of CA Secondary
<Street Address>
<City>, <State> <Zip>

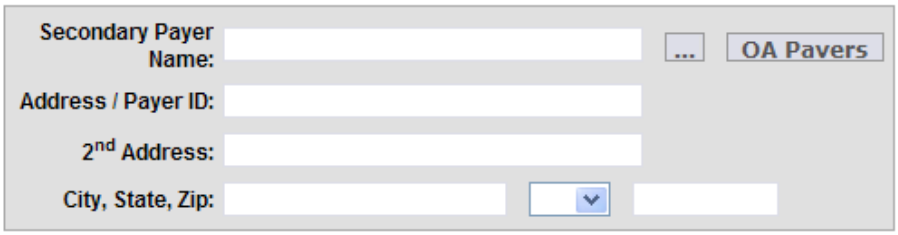
HOW TO SUBMIT A SECONDARY CLAIM ELECTRONICALLY

1. Create a new claim if you are an Online Entry (OLE) user, or if you are a print image user, locate the rejected secondary claim in your claim fix.

2. At the top of the claim, check the box "This Is a SECONDARY Claim"

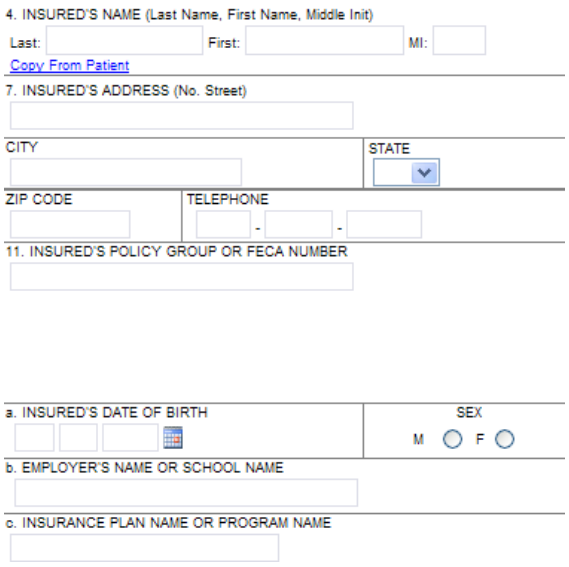


3. Enter the information for the secondary payer (this is where the claim will be sent).

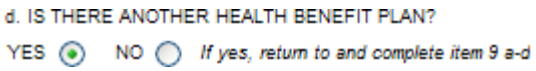


4. Boxes 2, 3, 5 – Enter the patient demographics here

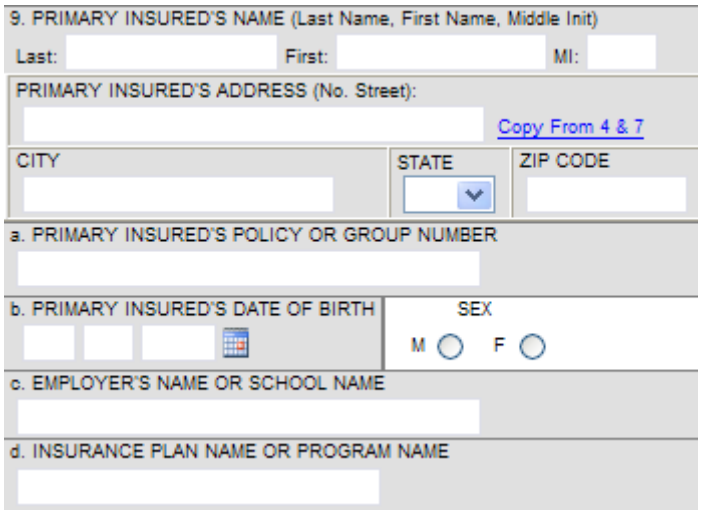
5. Boxes 4, 7, 11, 11a-c – Enter the data of the policyholder of the Secondary Insurance payer (this is the payer that the secondary claim is being sent to)



6. Box 11d – choose YES. Since this is a Secondary claim, there must have been another health benefit plan (the Primary).

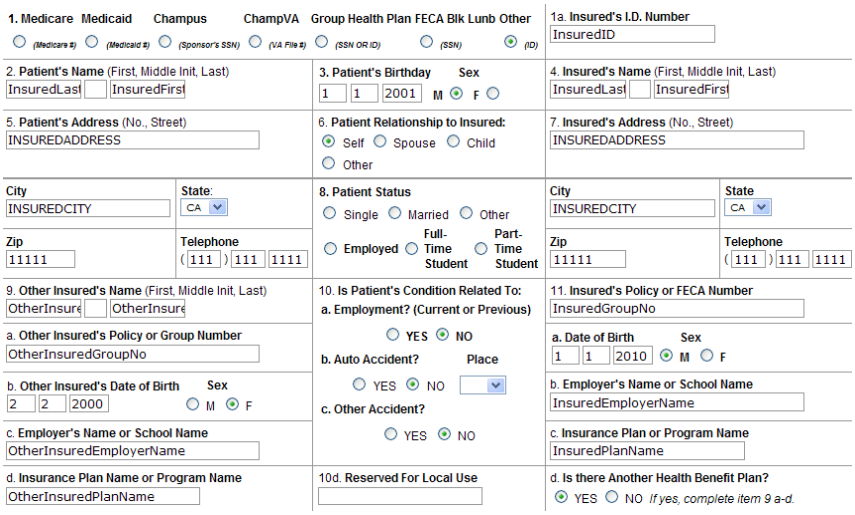


7. Boxes 9, 9a-d – Enter the data of the policyholder of the Primary Insurance payer (this is the payer that the primary claim has already been billed to)

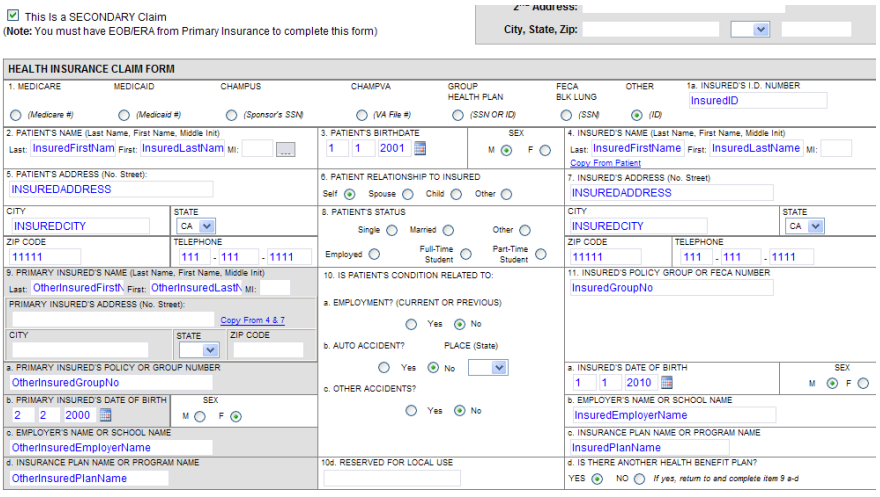


NOTE: If you are using a stored patient record from Manage HCFA Stored Information, then after checking the "This Is a SECONDARY Claim" box, you MUST manually edit the data so they are populated in the appropriate fields. See examples below.

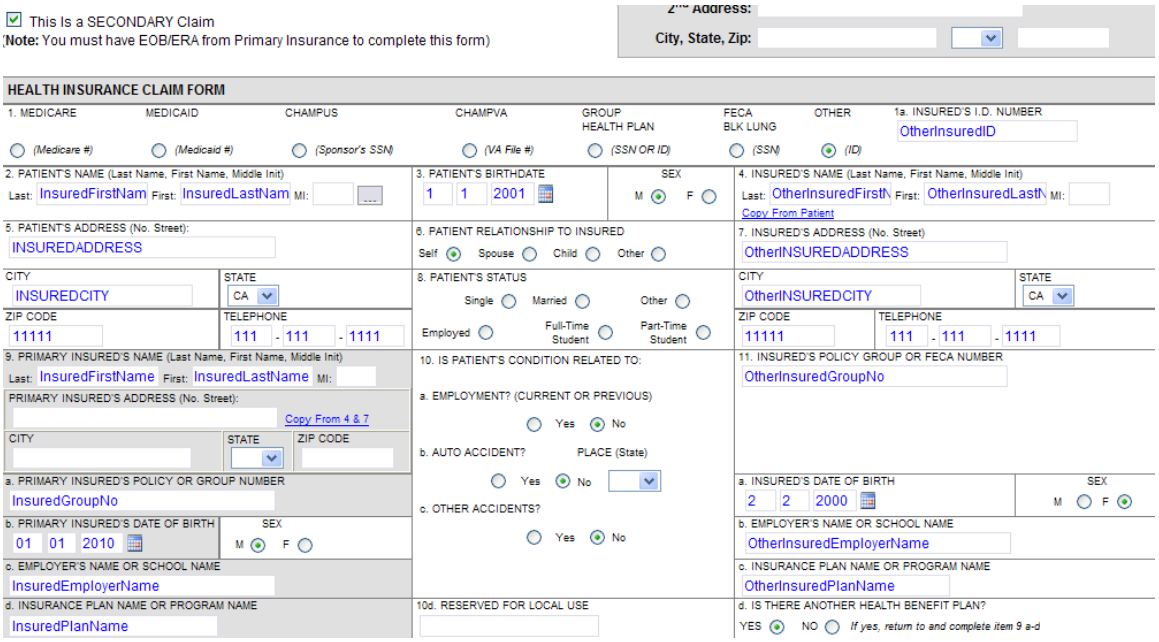
- For example, this is the patient record in Manage HCFA Stored Information:



- This is the claim using the stored info, after checking the "This Is a SECONDARY Claim" box (note fields 1a, 4, 7, 11 and 9a-d are the same as the stored information):



- This is what the claim should look like once data is manually edited for the appropriate fields (note the data from fields 1a, 4, 7, 11 are now in 9a-d and vice versa)

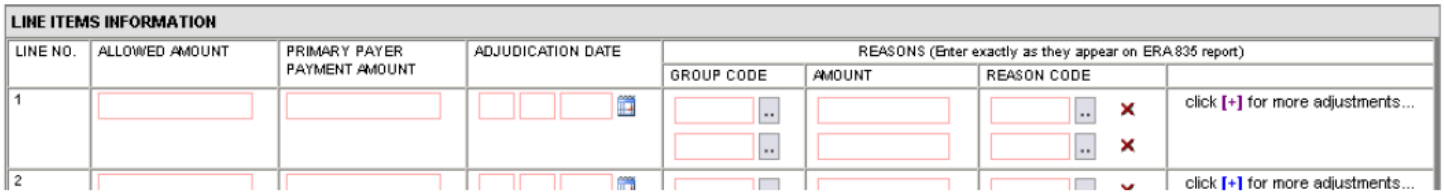


KEYING IN THE INFORMATION FROM THE PRIMARY EOB

You will need to key in all the information from the primary EOB or ERA for each line item. This includes keying in:

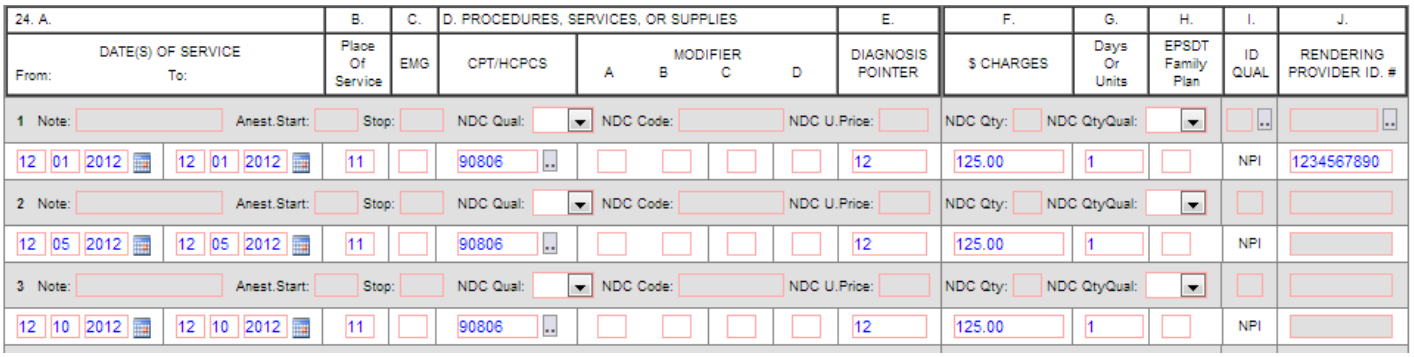
- The allowed amount
- The payment amount
- The adjustment amounts, co-insurance amount, deductible amount, co-payment amount, patient responsibility, and any other applicable charges, credits, payments, or adjustments which relate to the CPT code.
- The adjustment reasons and group codes
- The adjudication date

ALL OF THESE AMOUNTS AND REASONS MUST BE KEYED IN FOR EACH LINE ITEM!



- Allowed Amount: In the first column, under allowed amount, enter the amount the primary insurance allowed for the CPT code listed in line item 1 of box 24.

  NOTE: IMPORTANT LINE ITEM INFORMATION - When filing out the line item information in box 24, be sure that the CPT codes and the charges are EXACTLY the same as the primary claim. The charges should *NOT* be the amount that is unpaid by the primary insurance. That information will be covered in the next few steps.



24. A. DATE(S) OF SERVICE From: To:	B. Place Of Service	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER A B C D	E. DIAGNOSIS POINTER	F. $ CHARGES	G. Days Or Units	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
1 Note: Anest.Start: Stop: NDC Qual: NDC Code: NDC U.Price:						NDC Qty: NDC QtyQual:				
12 01 2012 — 12 01 2012	11		90806		12	125.00	1		NPI	1234567890
2 Note: Anest.Start: Stop: NDC Qual: NDC Code: NDC U.Price:						NDC Qty: NDC QtyQual:				
12 05 2012 — 12 05 2012	11		90806		12	125.00	1		NPI	
3 Note: Anest.Start: Stop: NDC Qual: NDC Code: NDC U.Price:						NDC Qty: NDC QtyQual:				
12 10 2012 — 12 10 2012	11		90806		12	125.00	1		NPI	

- Primary Payer Amount: List the amount the primary payer actually paid for the CPT code in line item 1 of box 24.

- Adjudication Date: The date the primary payer processed the claim.

- Reasons: Under "Reasons" you must key in everything the primary payer did not pay for that CPT code.
  - You must also key in the reasons why they did not pay. This includes keying in any adjustments, contractual obligations, co-pay amounts, amounts applied to the deductible, and co-insurance amounts which are listed on the EOB.

- Group Code: The general reason for the adjustment. Click the grey box with the two dots on it to get a list of group codes and their meanings.

- Amount: After selecting the appropriate group code enter the amount of the adjustment associated with that group code.

- Reason Code: Select the Reason Code listed on the EOB for the adjustment amount you have entered. Click the grey box with the 2 dots on it to get a list of Reason Codes.

A GOOD RULE OF THUMB TO FOLLOW IS:

- Everything that the insurance company paid should be typed in under PAYMENT AMOUNT

- Everything that the insurance company did not pay should be typed in under REASONS
  - This includes keying in any adjustments, contractual obligations, co-pay amounts, amounts applied to the deductible, and co-insurance amounts which are listed on the EOB.

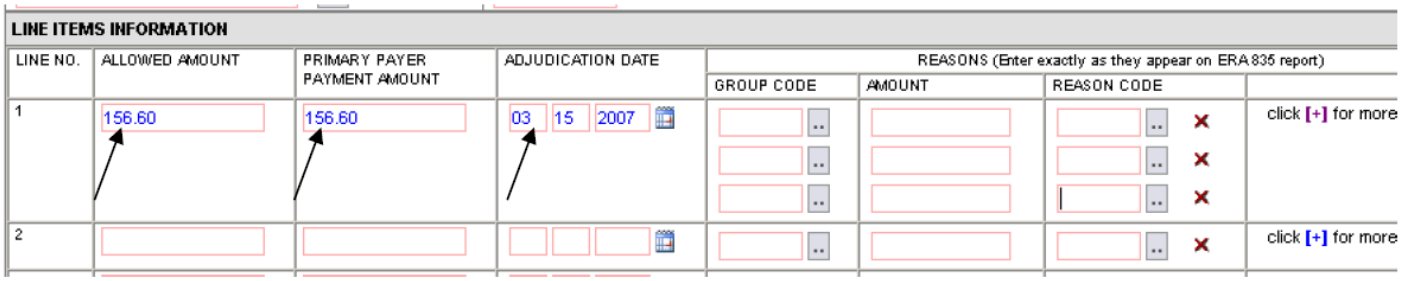
    PAID AMOUNT + AMOUNT NOT PAID = BILLED AMOUNT

EXAMPLE

You are billing $425.00 for the first CPT code and the payment information from the primary EOB is as follows:

The primary insurance allowed	$156.60	
The primary insurance paid	$156.60	
Patient Responsibility (PR)	$ 74.40	deductible amount (1)
Contractual Obligations (CO)	$176.60	charges exceed your contracted fee arrangement (45)
Patient Responsibility (PR)	$17.40	co-insurance amount (2)

FIRST, TYPE IN THE ALLOWED AMOUNT, PAYMENT AMOUNT AND ADJUDICATION DATE:

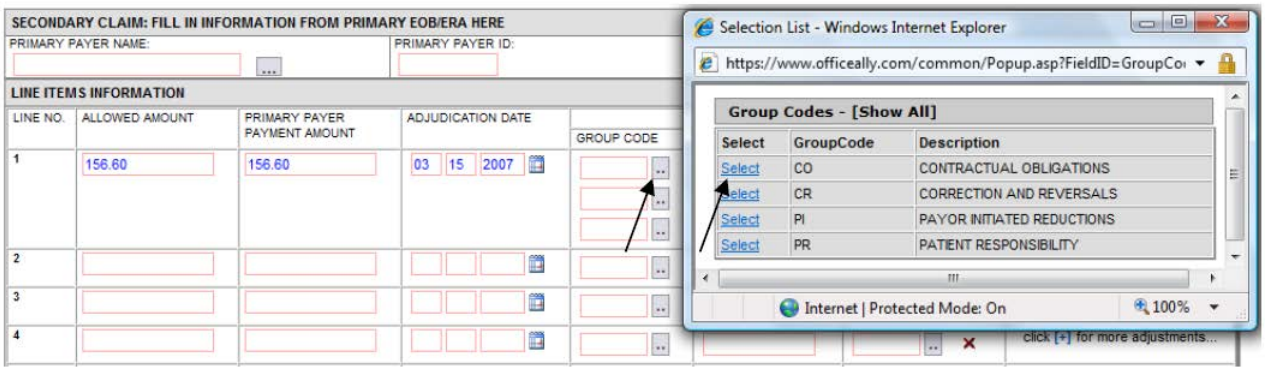


NEXT, UNDER "REASONS", TYPE IN WHAT THE INSURANCE COMPANY DID NOT PAY

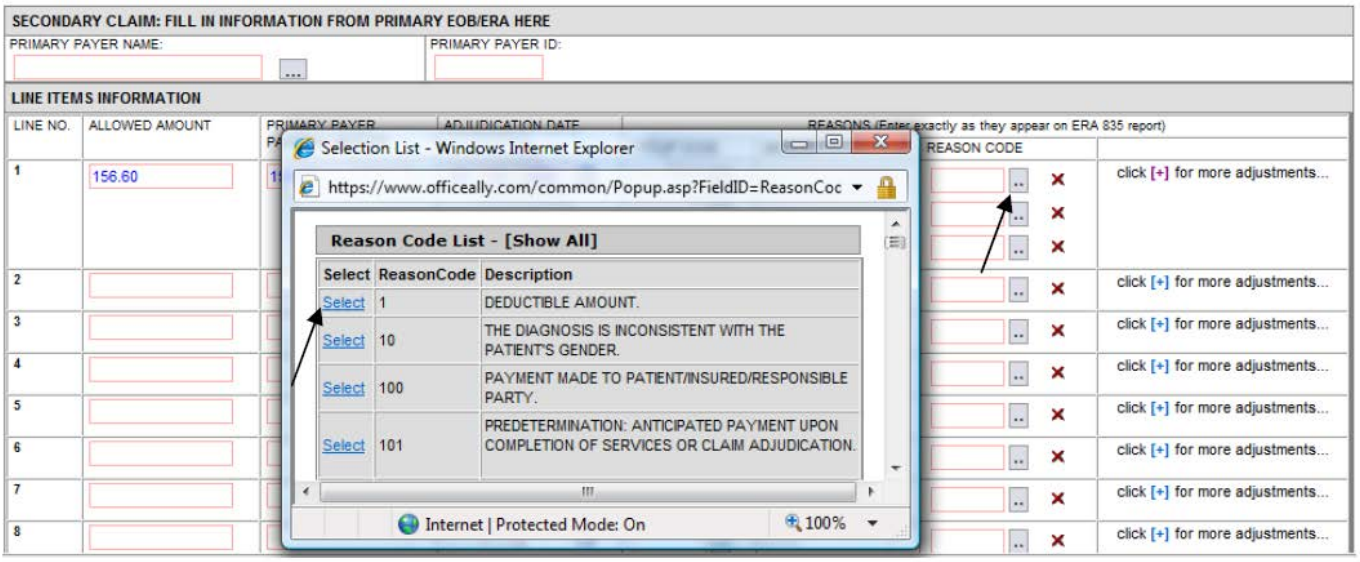
Patient Responsibility (PR)	$ 74.40	deductible amount (1)
Contractual Obligations (CO)	$176.60	charges exceed your contracted fee arrangement (45)
Patient Responsibility (PR)	$ 17.40	co-insurance amount (2)

Because there are three different amounts to key in under "Reasons" for the first CPT code, click the blue plus sign to expand the fields.

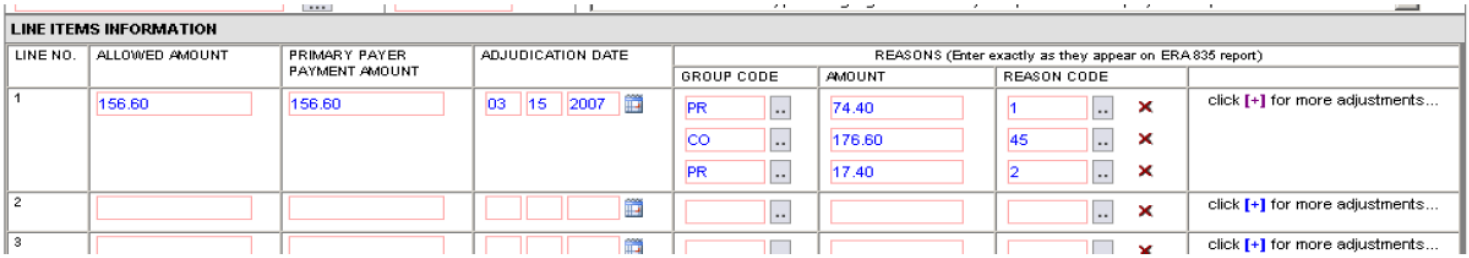
- To select the correct group codes and reason codes, click the grey box with the two dots. A list of valid group codes and reason codes will appear on your screen.
- To search within the Reason Codes list, click on the window and press the "Ctrl" key plus "F" at the same time. Type in part of the search criteria and click "Enter" until you find the code you are looking for.
- Click "Select" to select the appropriate code. See the picture below to see how to select the group code:



See the picture below to see how to select the reason code:



AFTER YOU HAVE FINISHED ENTERING THE REASONS, YOUR CLAIM SHOULD LOOK LIKE THIS:



You will notice the sum of what the payer did pay ($156.60) plus what they did not pay ($74.40 + $176.60 + $17.40) equals the billed amount for that line item ($425.00).

- When you have finished entering all the payment and adjustment amounts for the first CPT Code, you may move onto filling in the same information for any remaining CPT codes billed on that claim.
- When you have entered all the information, click "Update" at the bottom of the form.

After clicking update, you will see a message on your screen saying that the claim has been updated successfully. Office Ally will automatically pick up the claim that night and process it for you. You will receive a file summary on your claim the following day.

If you have any questions, please contact Customer Support at (360) 975-7000 opt. 1.