CREATING SECONDARY CLAIMS IN SERVICE CENTER

To find payers who accept secondary claims, go to the Resource Center> Payer List, and look for the indicator “Y” in the “SEC” column. This indicates that you can send secondary claims electronically to that payer.

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

### Print Image Users Only

**Note:** If you are not submitting a print image, skip this section.

Upload your print image secondary claim, just as you would a primary claim, EXCEPT the payer name in the top right of the CMS 1500 form must contain the secondary payer name, plus the word, “secondary.” We will recognize this as a secondary claim and send the claim to your claim fix so that you can key in the information from the primary EOB or ERA.

**Example:**
Medicare Northern CA **Secondary**
PO Box 1051
Augusta, GA 30903

**Example:**
Blue Shield of CA **Secondary**
PO Box 272540
Chico, CA 95927

### HOW TO CREATE A SECONDARY CLAIM

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. **Payer Information block**
   a. Enter the information for the Secondary Payer. This is where the claim will be sent.

4. **Boxes 2, 3, 5**
   a. Enter the patient demographics.

5. **Boxes 4, 7, 11, 11a-c**
   a. Enter the data of the policyholder of the Secondary Insurance payer.
      i. This is the payer that the secondary claim is being sent to.
6. Box 11d
   a. Choose YES.
      i. Since this is a secondary claim, there must have been another health benefit plan (the Primary Insurance).

7. Boxes 9, 9a-d
   a. 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, you MUST manually update/edit the data so they are populated in the appropriate fields after checking the “This Is a SECONDARY Claim” box. See examples below.

Example:

This is the claim using a stored information record, after checking “This Is a SECONDARY Claim” box. (Note: Primary Insured data gets loaded in 1a, 4, 7, 11, and Other Insured data gets loaded in 9a-d.)
This is what the secondary claim should look like once data is manually edited for the appropriate fields (note the Primary Insured data is now in 9a-d and Other Insured date is now in 1a, 4, 7, and 11.)

Note: IMPORTANT LINE ITEM INFORMATION - When filling out the line item information in box 24 make 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.

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 the:

♦ Allowed Amount
♦ Primary Payer Payment Amount
♦ Adjudication Date
♦ Adjustment Reasons and Group Codes
♦ Adjustment Amounts
  - Co-insurance amount
  - Deductible amount
  - Co-payment amount
  - Patient responsibility
  - Other applicable charges, credits, payments, or adjustments which relate to the CPT code
ALL OF THESE AMOUNTS AND REASONS MUST BE KEYED IN FOR EACH LINE ITEM!

- **Allowed Amount**
  - In the first column of Line No. 1, under ALLOWED AMOUNT, enter the amount the Primary Payer allowed for the CPT code listed in line item 1 of box 24.

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

- **Adjudication Date**
  - Enter the date the Primary Payer processed the claim.

- **Reasons (Adjustments)**
  - Under the “Reasons” section you must key in everything the Primary Payer did not pay for that CPT code. This included keying in any adjustments, contractual obligations, co-pay amounts, amounts applied to the deductible, and co-insurance amounts which are listed on the EOB.
  - Click “[+] more adjustments…” to edit the Group Codes, Amount, and Reason Codes for the line.
    - **Group Code**
      - This is the general reason for the adjustment. Click the two dot box, to get a list of possible group codes and their meanings to select from.
    - **Amount**
      - 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 two dot box, to get a list of possible Reason Codes and their meanings to select from.

- **Once you’ve entered all the adjustments for this line, click Update.**
A Good Rule of Thumb to Follow Is

♦ Everything that the insurance company did pay should be typed in under PAYMENT AMOUNT
♦ Everything that the insurance company did not pay should be typed in under REASONS
♦ The ALLOWED AMOUNT does not factor in to the amount paid or reason codes.

<table>
<thead>
<tr>
<th>PAID AMOUNT</th>
<th>AMOUNT NOT PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Primary Payer Payment Amount)</td>
<td>(Sum of Adjustment Amounts)</td>
</tr>
</tbody>
</table>

= (equals) ORIGINAL BILLED AMOUNT (Line Item Charge in 24)

Example:

You had billed $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
- Adjudication Date 3/15/2013
- Patient Responsibility (Grp Code: PR) $74.40 Deductible amount (Reason Code: 1)
- Contractual Obligations (Grp Code: CO) $176.60 Charges exceed your contracted fee arrangement (Reason Code: 45)
- Patient Responsibility (Grp Code: PR) $17.40 Co-insurance amount (Reason Code: 2)

1. Type in the allowed amount, payment amount, and adjudication date.

2. Click “[*] more adjustments…” to enter the Group Codes, Amounts, and Reason Codes for what the Primary Payer did not pay.

<table>
<thead>
<tr>
<th>Group Code</th>
<th>Amount</th>
<th>Reason Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>PR (Patient Responsibility)</td>
<td>$74.40</td>
<td>1 (Deductible amount)</td>
</tr>
<tr>
<td>CO (Contractual Obligations)</td>
<td>$176.60</td>
<td>45 (Charges exceed your contracted fee arrangement)</td>
</tr>
<tr>
<td>PR (Patient Responsibility)</td>
<td>$17.40</td>
<td>2 (Co-insurance amount)</td>
</tr>
</tbody>
</table>

3. When you are done, click Update.
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:**

[Link to Customer Support](support@officeally.com) / (360) 975-7000 ext. 8000