## Updated 3-9-2011

Secondary EMCs are only available for Medisoft version 11 or greater using the current release of the 3.1.x.x EDI module. In the main window of the program, there is a button for Enter Primary EOBs for EMC Secondaries and a Claim Sequence selector box in the Send Claims window. To send secondaryclaims you will need to use these functions to enter in the paper primary EOB payment/adjustment information.

For most carriers this will require some research to convert the adjustment reason codes to the appropriate Adjustment Reason code. If you received the EOB as an Electronic 835, from the 835 Viewer you can click on Record and InterfaceEDI will record the information for you. You do not have to have the 835 Autopost to use this feature.

In Medisoft, make sure that each charge has the allowed amount from the EOB. The Allowed amount is required by Medicare.

In the InterfaceEDI program, click on Enter Primary EOBs for EMC Secondaries Claims will only show in this window if the primary status is Done and the secondary status is Ready to Send and the Media 2 is Electronic.

🚴 Secondary EDI Claims List 📃 🗖 🔀												
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Start by select the claim you want to send. Click on the Claim Number to highlight the claim number. Then click on the **Basic** button.

To successfully send a secondary claims, you will need the following,

Group and Reason codes to explain why the primary payer did not pay 100% of what was billed. You will also need the **Adjudication Date** and **Payer Total Payment** for the claim from the EOB.

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Each charge has to have adjustment reason codes and amounts to explain why the primary didn't pay 100% of what was billed. The charge amounts have to balance with the payment amounts and the adjustment amounts, a simple(assuming all amounts are positive) formula for this balance is Charge Amount = Payment Amount + any adjustment amount (whether it is applied in the practice management software or not). Some short cuts have been created to help you enter the most common adjustment reasons.



If the allowed amount is less than the billed amount, start with the **Allowed Amount** button, it will create CO-45 with an amount that is equal to the difference between the amount billed and the allowed amount.

New Adjustment Group												
Group Code [ CO	<u>S</u> ave											
Reason Code	Amount	Units	Cancel									
45	40.97											



The **Co-Insurance** button will create PR-2 with the remaining unexplained balance. The Balance indicator will read 0.00 when you are done with the charge and everything is in balance.

New Adjustment Group												
Group Code R	Group Code PR - Patient Responsibilit											
Reason Code	Amount	Units	Cancel									
2	56.03											
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The **Deductible** button is a short cut, it will create PR-1 with the remaining unexplained balance. The Balance indicator will read 0.00 when you are done with the charge and everything is in balance. If only part of the remainder is applied to the patients deductible, you can change the dollar amount.

Once you have the charge amount in balance with the payment and adjustment reasons, the program will automatically skip to the next procedure code. This process must be repeated for each of the charges on the claim.

If the allowed amount from the primary payer is zero and they did not pay for the procedure, a group and code or codes must be entered to explain why.

here is a list of current codes http://www.wpc-edi.com/codes/claimadjustment

Each adjustment reason has a **Group Code** and an **Adjustment Reason Code**. you enter each group separately and each group can have up to 6 reason codes and amounts. If you have 2 or more Adjustment Reason Codes with the same Group Code, then you create one Group code and fill in the Reason Codes.

Examples, CO-45 (an allowed amount adjustment) and CO-A2. The Adjustment Code Group is CO and the Reason Code is 45 or A2

PR-1 (Deductible) PR-2 (Co-insurance) the adjustment code group is PR and the Reason Code is 1 or 2

Some common reasons for non payment are

**97:** The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.use a group code of **OA** and **97** 

**38:** Services were not provided by a network provider. Use a group code of **OA** and **38. 149:** Lifetime benefits exceeded. Use a group code of **OA** and **149.** 

96 and 204: If the procedure code is not covered by the patients plan and thus does not have an allowed amount, use a combination of codes. If the patient is responsible use the **PR** Group Code with both a code 96 and 204. Put the charge amount on the code 96.

Once you have finished with the transactions, verify the Adjudication Date and Payer Payment Amount. Then Click on the Save button, then click on the Exit icon with the Door and Arrow.

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To Send the claim, exit from the Secondary EDI Claim list. Choose the Send Claims icon, like you do when you send primary claims. Select the Secondary option in the Claim Sequence selector group. Then click send claims and everything is the same as sending primary claims