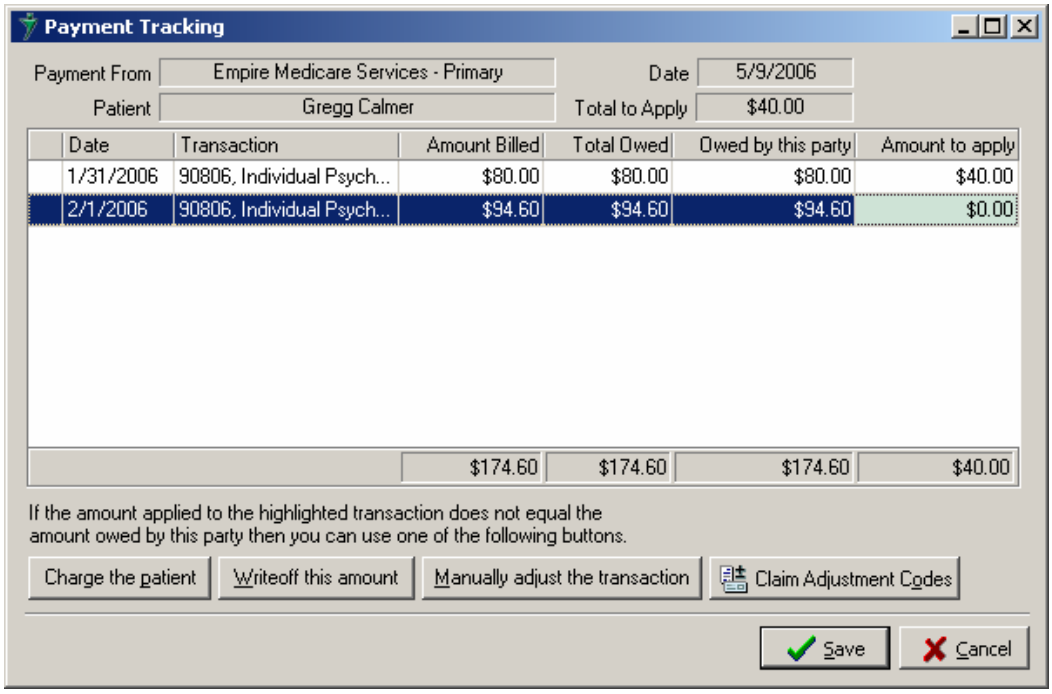
Sending Electronic Secondary Claims

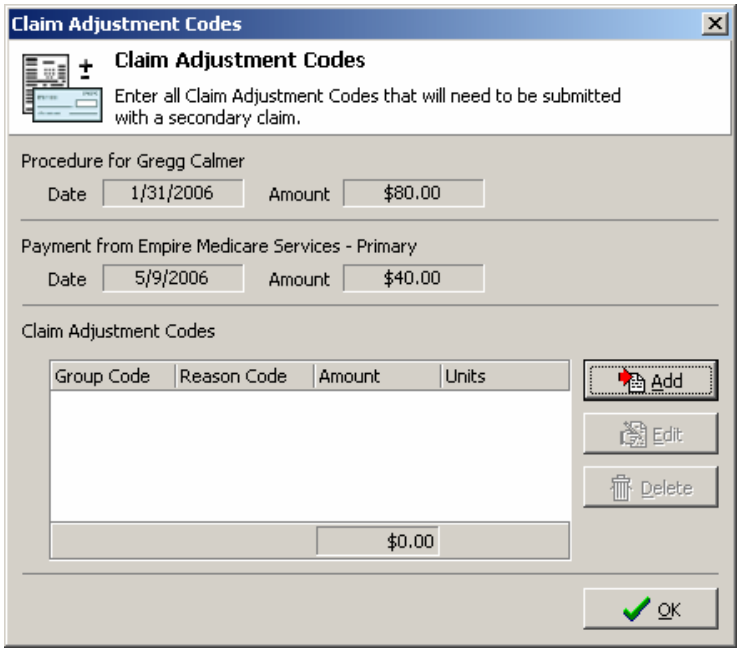
Claim Adjustment Codes

When submitting secondary claims electronically, you need to add Claim Adjustment Codes (CAS). These are adjustment codes that associate any adjustment activity provided by the primary insurance company payment. These are populated automatically for the electronic remittance advice (ERA) but have to be done manually when posting payments. You will see updated screens in the Encounter | Claim Adjustment Codes and Payment Tracking and the Payment Info screen.

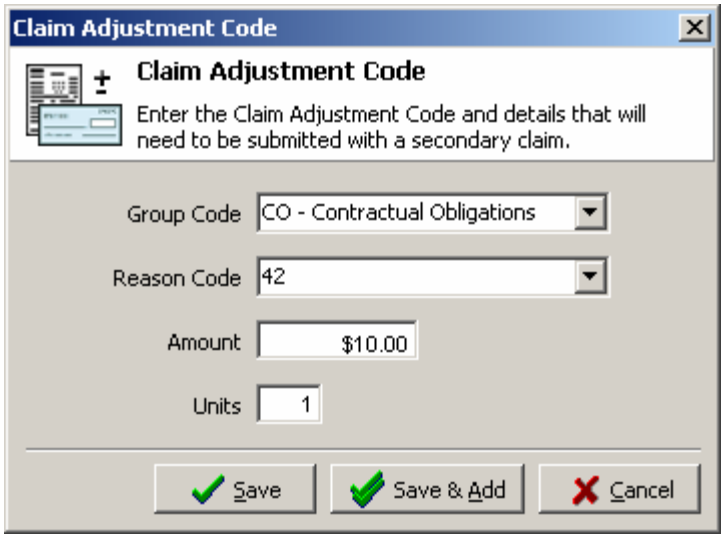
When you are in the Payment Tracking screen you will see a new button for Claim Adjustment Codes. If you are posting a payment for the primary insurance and plan to submit the secondary claim electronically, then you will need to click this button to enter all the claim adjustment reason codes listed on the EOB from the primary insurance.



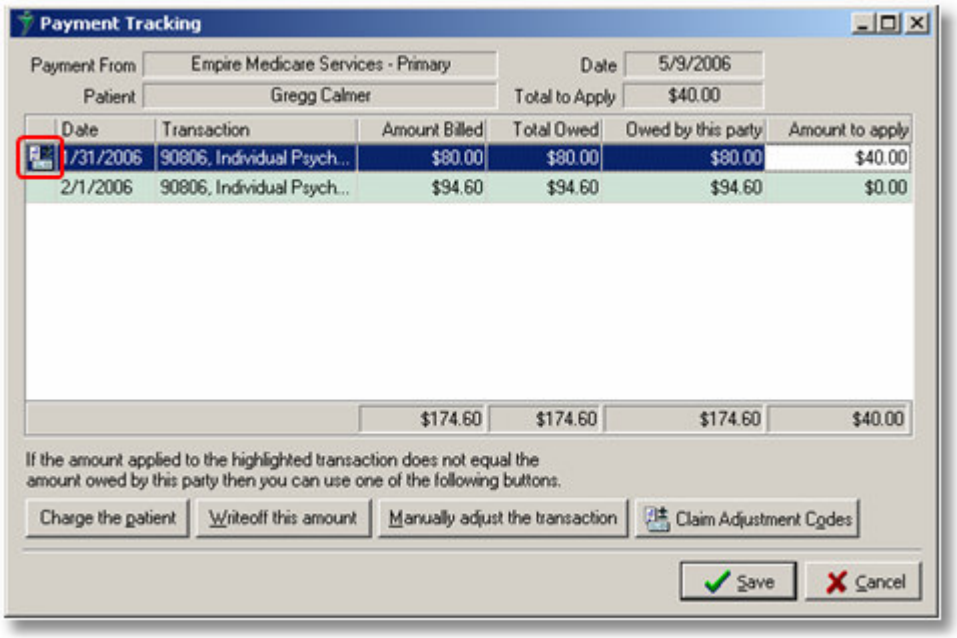
This is the Claim Adjustment Code screen which will list the current codes associated with this payment. Click **Add** to add a new code to the list. For codes already entered you have the option to **Edit** or **Delete**.



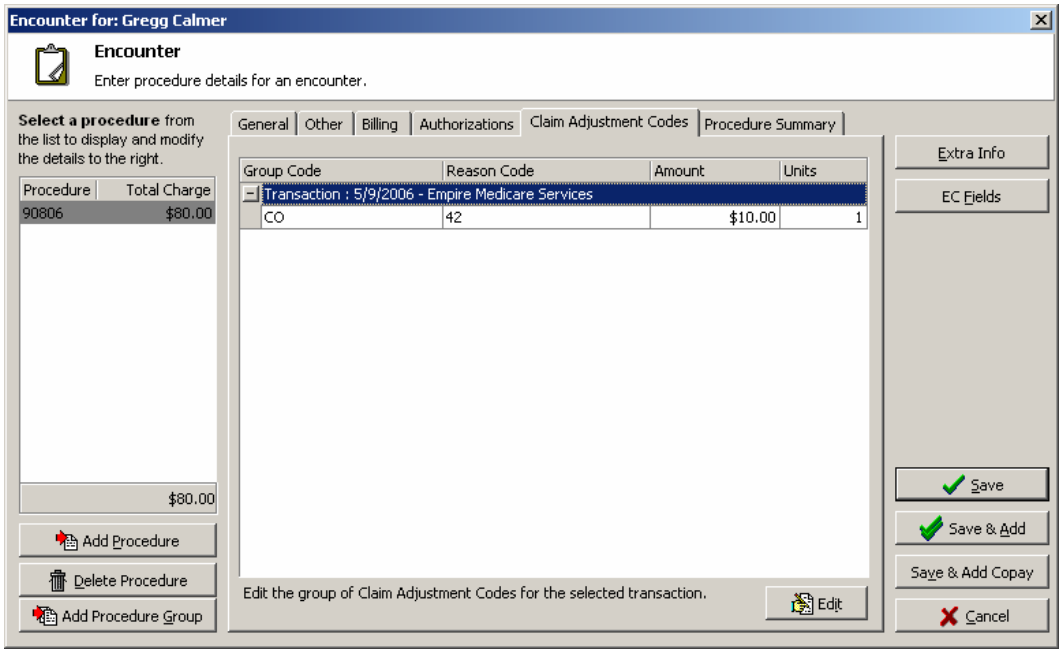
Following is the screen that displays when clicking Add or Edit. All fields must be populated. The Group and Reason codes are based on the list provided by Medicare. A list of Reason Codes is found at the end of this document. For those primary insurances other than Medicare you will need to select the most applicable match.



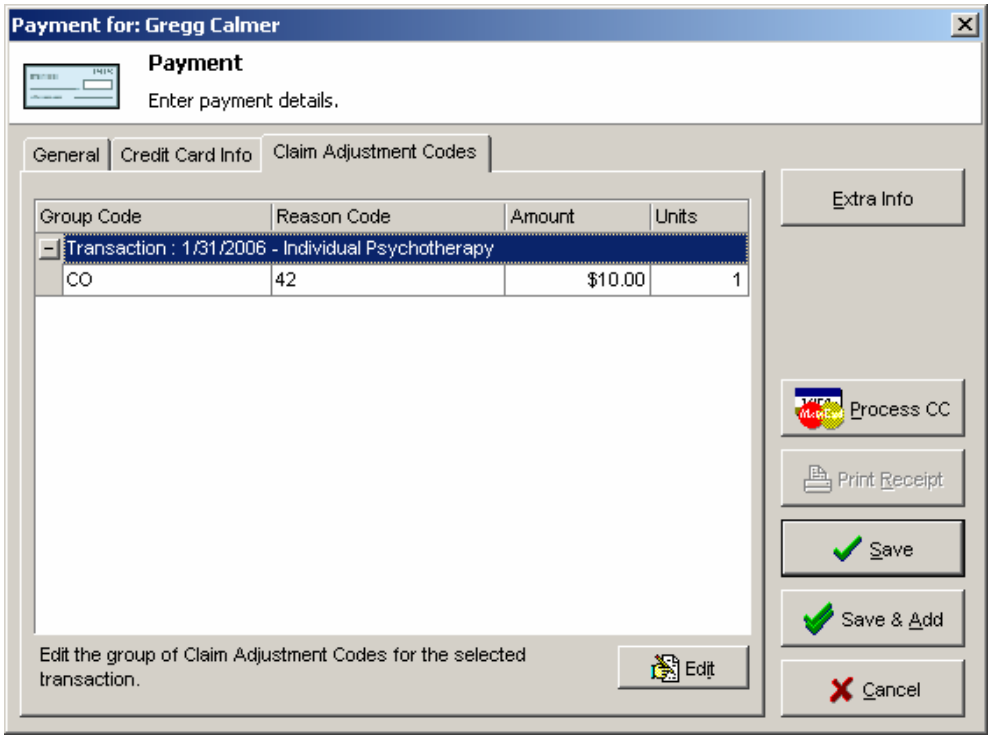
For any transactions that a Claim Adjustment Code is associated with, you will see the CAS icon displayed on the far left side of that transaction line in Payment Tracking. Click the Claim Adjustment Code button next to the transaction to view the codes again.



Select **Encounter | Claim Adjustment Codes** tab to display all the CAS codes posted for this procedure and to edit those codes associated with the highlighted transaction. You can add new codes, edit existing codes, and delete codes from that screen. However, you cannot associate a new payment with this encounter from this screen.



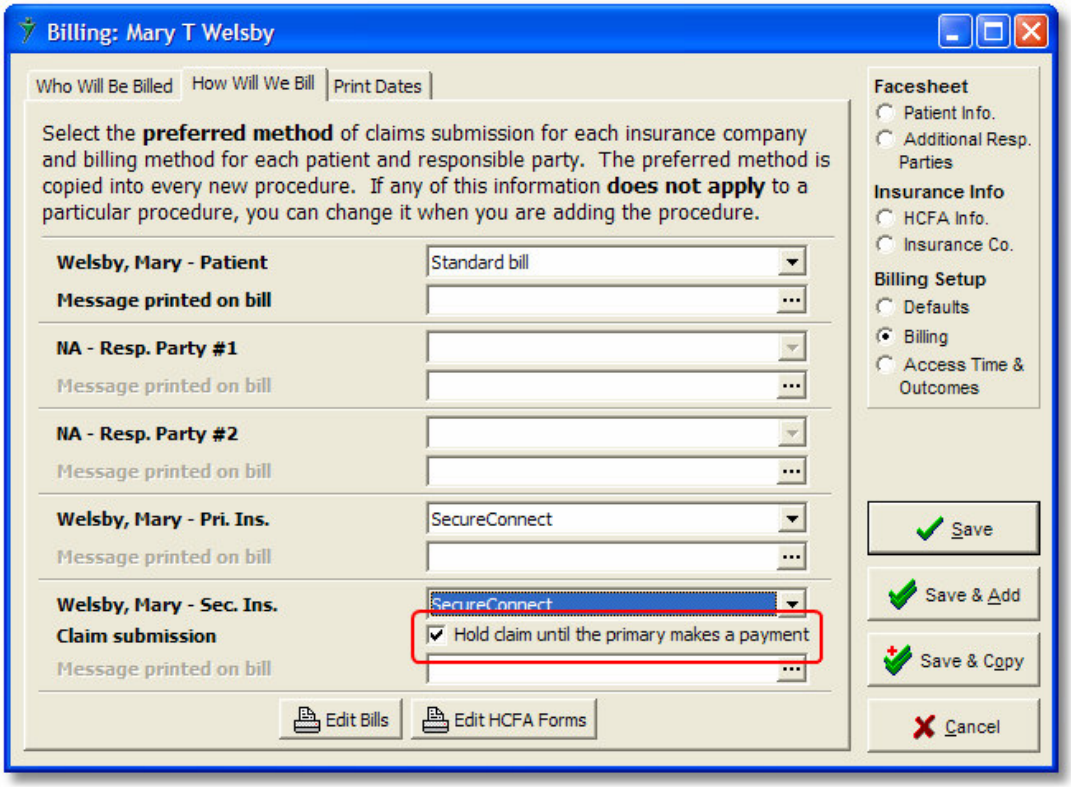
You can also see the associated Claim Adjustment Codes on that tab in the Payment details. It works just like on the Encounter screen: you can add new codes, edit existing codes, and delete codes but not associate any new payments.



To hold the secondary claim until the primary makes a payment

1. Double-click the patient from Helper's main screen.
2. Click the Billing radio button.
3. Click the **How We Will Bill** tab.

4. Click the **Hold claim until the primary makes a payment** check box. This allows you to hold the secondary claims until the primary pays. Once the primary insurance pays and you post the payment, it will then automatically submit the claim to whatever you have set on this screen, in the example below it would be transmitted to SecureConnect.



5. Click **Save**.

Quick Steps for adding a Claim Adjustment Code during payment posting

The follow is the step-by-step method to post a payment for a patient's primary insurance and add the claim adjustment code for the secondary insurance that is being sent electronically.

To enter the payment for the primary and add the claim adjustment codes to it:

1. Select the patient from Helper's main screen, and click the **Transactions** button.
2. Click **New** then **Payment**.
3. Enter the **Amount**, **Method of Payment**, and **Check Number** (if needed).
4. In the Payment From field, select the primary insurance.
5. Click **Save**. The Payment Tracking screen displays.
6. Click the **Claim Adjustment Codes** button. The Claims Adjustment screen displays.
7. Click the **Add** button.
8. Enter the **Group Code**, **Reason Code**, **Amount** and **Units**. All fields must be completed.

Note: All the Reason Codes are listed in the Appendix. These were obtained from the Washington Published Edits at http://www.wpc-edi.com

9. Click **Save**.
10. Click **OK** in the Claim Adjustment screen.
11. Click **Save** in the Payment Tracking screen.

Appendix

The Claims Adjustment Reason Codes

These codes are for use with Medicare secondary electronic claims submissions and have been obtained from Washington Published Edits.

1	Deductible Amount
2	Coinsurance Amount
3	Co-payment Amount
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure/revenue code is inconsistent with the patient's age. *Note: Changed as of 6/02*
7	The procedure/revenue code is inconsistent with the patient's gender. *Note: Changed as of 6/02*
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). *Note: Changed as of 6/02*
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender. *Note: Changed as of 2/00*
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. *Note: Changed as of 2/01*
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate *Note: Changed as of 2/02*
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. *Note: Changed as of 2/02*
18	Duplicate claim/service.
19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
20	Claim denied because this injury/illness is covered by the liability carrier.
21	Claim denied because this injury/illness is the liability of the no-fault carrier.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits. *Note: Changed as of 2/01*
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments *Note: Changed as of 2/01, and 6/05*
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. *Note: Changed as of 6/00*
25	Payment denied. Your Stop loss deductible has not been met.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
29	The time limit for filing has expired.

30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements. *Note: Changed as of 2/01. This code will be deactivated on 2/1/2006.*
31	Claim denied as patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Claim denied. Insured has no dependent coverage.
34	Claim denied. Insured has no coverage for newborns.
35	Lifetime benefit maximum has been reached. *Note: Changed as of 10/02*
38	Services not provided or authorized by designated (network/primary care) providers. *Note: Changed as of 6/03*
39	Services denied at the time authorization/pre-certification was requested.
40	Charges do not meet qualifications for emergent/urgent care.
42	Charges exceed our fee schedule or maximum allowable amount.
43	Gramm-Rudman reduction.
44	Prompt-pay discount.
45	Charges exceed your contracted/ legislated fee arrangement.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid. *Note: Changed as of 6/00. This code will be deactivated on 2/1/2006.*
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
50	These are non-covered services because this is not deemed a `medical necessity' by the payer.
51	These are non-covered services because this is a pre-existing condition
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed. *Note: Changed as of 10/98. This code will be deactivated on 2/1/2006.*
53	Services by an immediate relative or a member of the same household are not covered.
54	Multiple physicians/assistants are not covered in this case .
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
56	Claim/service denied because procedure/treatment has not been deemed `proven to be effective' by the payer.
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply. *Note: Inactive for 004050. Split into codes 150, 151, 152, 153 and 154.*
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. *Note: Changed as of 2/01*
59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules. *Note: Changed as of 6/00*
60	Charges for outpatient services with this proximity to inpatient services are not covered.
61	Charges adjusted as penalty for failure to obtain second surgical opinion. *Note: Changed as of 6/00*
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. *Note: Changed as of 2/01*
66	Blood Deductible.
69	Day outlier amount.
70	Cost outlier - Adjustment to compensate for additional costs. *Note: Changed as of 6/01*
74	Indirect Medical Education Adjustment.
75	Direct Medical Education Adjustment.
76	Disproportionate Share Adjustment.

78	Non-Covered days/Room charge adjustment.
85	Interest amount.
87	Transfer amount.
88	Adjustment amount represents collection against receivable created in prior overpayment. *Note: Inactive for 004050.*
89	Professional fees removed from charges.
90	Ingredient cost adjustment.
91	Dispensing fee adjustment.
94	Processed in Excess of charges.
95	Benefits adjusted. Plan procedures not followed. *Note: Changed as of 6/00*
96	Non-covered charge(s).
97	Payment is included in the allowance for another service/procedure. *Note: Changed as of 2/99*
100	Payment made to patient/insured/responsible party.
101	Predetermination: anticipated payment upon completion of services or claim adjudication. *Note: Changed as of 2/99*
102	Major Medical Adjustment.
103	Provider promotional discount (e.g., Senior citizen discount). *Note: Changed as of 6/01*
104	Managed care withholding.
105	Tax withholding.
106	Patient payment option/election not in effect.
107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim. *Note: Changed as of 6/03*
108	Payment adjusted because rent/purchase guidelines were not met. *Note: Changed as of 6/02*
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
112	Payment adjusted as not furnished directly to the patient and/or not documented. *Note: Changed as of 2/01*
113	Payment denied because service/procedure was provided outside the United States or as a result of war. *Note: Changed as of 2/01; Inactive for version 004060. Use Codes 157, 158 or 159.*
114	Procedure/product not approved by the Food and Drug Administration.
115	Payment adjusted as procedure postponed or canceled. *Note: Changed as of 2/01*
116	Payment denied. The advance indemnification notice signed by the patient did not comply with requirements. *Note: Changed as of 2/01*
117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care. *Note: Changed as of 2/01*
118	Charges reduced for ESRD network support.
119	Benefit maximum for this time period or occurrence has been reached. *Note: Changed as of 2/04*
120	Patient is covered by a managed care plan. *Note: Inactive for 004030, since 6/99. Use code 24.*
121	Indemnification adjustment.
122	Psychiatric reduction.

123 Payer refund due to overpayment.
Note: Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals.

124 Payer refund amount - not our patient.
Note: Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals.

125 Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.
Note: Changed as of 2/02

126 Deductible -- Major Medical
Note: New as of 2/97

127 Coinsurance -- Major Medical
Note: New as of 2/97

128 Newborn's services are covered in the mother's Allowance.
Note: New as of 2/97

129 Payment denied - Prior processing information appears incorrect.
Note: Changed as of 2/01

130 Claim submission fee.
Note: Changed as of 6/01

131 Claim specific negotiated discount.
Note: New as of 2/97

132 Prearranged demonstration project adjustment.
Note: New as of 2/97

133 The disposition of this claim/service is pending further review.
Note: Changed as of 10/99

134 Technical fees removed from charges.
Note: New as of 10/98

135 Claim denied. Interim bills cannot be processed.
Note: New as of 10/98

136 Claim Adjusted. Plan procedures of a prior payer were not followed.
Note: Changed as of 6/00

137 Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
Note: New as of 2/99

138 Claim/service denied. Appeal procedures not followed or time limits not met.
Note: New as of 6/99

139 Contracted funding agreement - Subscriber is employed by the provider of services.
Note: New as of 6/99

140 Patient/Insured health identification number and name do not match.
Note: New as of 6/99

141 Claim adjustment because the claim spans eligible and ineligible periods of coverage.
Note: Changed as of 6/00

142 Claim adjusted by the monthly Medicaid patient liability amount.
Note: New as of 6/00

143 Portion of payment deferred.
Note: New as of 2/01

144 Incentive adjustment, e.g. preferred product/service.
Note: New as of 6/01

145 Premium payment withholding
Note: New as of 6/02

146 Payment denied because the diagnosis was invalid for the date(s) of service reported.
Note: New as of 6/02

147 Provider contracted/negotiated rate expired or not on file.
Note: New as of 6/02

148 Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.
Note: New as of 6/02

149 Lifetime benefit maximum has been reached for this service/benefit category.

	Note: New as of 10/02
150	Payment adjusted because the payer deems the information submitted does not support this level of service. *Note: New as of 10/02*
151	Payment adjusted because the payer deems the information submitted does not support this many services. *Note: New as of 10/02*
152	Payment adjusted because the payer deems the information submitted does not support this length of service. *Note: New as of 10/02*
153	Payment adjusted because the payer deems the information submitted does not support this dosage. *Note: New as of 10/02*
154	Payment adjusted because the payer deems the information submitted does not support this day's supply. *Note: New as of 10/02*
155	This claim is denied because the patient refused the service/procedure. *Note: New as of 6/03*
156	Flexible spending account payments *Note: New as of 9/03*
157	Payment denied/reduced because service/procedure was provided as a result of an act of war. *Note: New as of 9/03*
158	Payment denied/reduced because the service/procedure was provided outside of the United States. *Note: New as of 9/03*
159	Payment denied/reduced because the service/procedure was provided as a result of terrorism. *Note: New as of 9/03*
160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion. *Note: New as of 9/03*
161	Provider performance bonus *Note: New as of 2/04*
162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. *Note: New as of 2/04*
163	Claim/Service adjusted because the attachment referenced on the claim was not received. *Note: New as of 6/04*
164	Claim/Service adjusted because the attachment referenced on the claim was not received in a timely fashion. *Note: New as of 6/04*
165	Payment denied /reduced for absence of, or exceeded referral *Note: New as of 10/04*
166	These services were submitted after this payers responsibility for processing claims under this plan ended. *Note: New as of 2/05*
167	This (these) diagnosis(es) is (are) not covered. *Note: New as of 6/05*
168	Payment denied as Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan *Note: New as of 6/05*
169	Payment adjusted because an alternate benefit has been provided *Note: New as of 6/05*
170	Payment is denied when performed/billed by this type of provider. *Note: New as of 6/05*
171	Payment is denied when performed/billed by this type of provider in this type of facility.

	Note: New as of 6/05
172	Payment is adjusted when performed/billed by a provider of this specialty *Note: New as of 6/05*
173	Payment adjusted because this service was not prescribed by a physician *Note: New as of 6/05*
174	Payment denied because this service was not prescribed prior to delivery *Note: New as of 6/05*
175	Payment denied because the prescription is incomplete *Note: New as of 6/05*
176	Payment denied because the prescription is not current *Note: New as of 6/05*
177	Payment denied because the patient has not met the required eligibility requirements *Note: New as of 6/05*
178	Payment adjusted because the patient has not met the required spend down requirements. *Note: New as of 6/05*
179	Payment adjusted because the patient has not met the required waiting requirements *Note: New as of 6/05*
180	Payment adjusted because the patient has not met the required residency requirements *Note: New as of 6/05*
181	Payment adjusted because this procedure code was invalid on the date of service *Note: New as of 6/05*
182	Payment adjusted because the procedure modifier was invalid on the date of service *Note: New as of 6/05. Modified on 8/8/2005*
183	The referring provider is not eligible to refer the service billed. *Note: New as of 6/05*
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. *Note: New as of 6/05*
185	The rendering provider is not eligible to perform the service billed. *Note: New as of 6/05*
186	Payment adjusted since the level of care changed *Note: New as of 6/05*
187	Health Savings account payments *Note: New as of 6/05*
188	This product/procedure is only covered when used according to FDA recommendations. *Note: New as of 6/05*
189	"Not otherwise classified" or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service *Note: New as of 6/05*
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay. *Note: New as of 10/05*
191	Claim denied because this is not a work related injury/illness and thus not the liability of the workers' compensation carrier. *Note: New as of 10/05*
192	Non standard adjustment code from paper remittance advice. *Note: New as of 10/05*
A0	Patient refund amount.
A1	Claim denied charges.
A2	Contractual adjustment. *Note: Inactive for version 004060. Use Code 45 with Group Code 'CO' or use another appropriate specific adjustment code.*
A4	Medicare Claim PPS Capital Day Outlier Amount.
A5	Medicare Claim PPS Capital Cost Outlier Amount.
A6	Prior hospitalization or 30 day transfer requirement not met. *Note:*
A7	Presumptive Payment Adjustment

	Note:
A8	Claim denied; ungroupable DRG
B1	Non-covered visits. *Note:*
B4	Late filing penalty.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded. *Note: Changed as of 2/01*
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty. *Note: Changed as of 2/01. This code will be deactivated on 2/1/2006.*
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. *Note: Changed as of 10/98*
B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.
B9	Services not covered because the patient is enrolled in a Hospice.
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test. *Note:*
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor. *Note:*
B12	Services not documented in patients' medical records. *Note:*
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment. *Note:*
B14	Payment denied because only one visit or consultation per physician per day is covered. *Note: Changed as of 2/01*
B15	Payment adjusted because this procedure/service is not paid separately. *Note: Changed as of 2/01*
B16	Payment adjusted because `New Patient' qualifications were not met. *Note: Changed as of 2/01*
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current. *Note: Changed as of 2/01. This code will be deactivated on 2/1/2006.*
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service *Note: Changed as of 2/01, 6/05*
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider. *Note: Changed as of 2/01*
B22	This payment is adjusted based on the diagnosis. *Note: Changed as of 2/01*
B23	Payment denied because this provider has failed an aspect of a proficiency testing program. *Note: Changed as of 2/01*
D16	Claim lacks prior payer payment information. *Note: Inactive as of version 5010. Use code 16 with appropriate claim payment remark code [N4].*
D17	Claim/Service has invalid non-covered days. *Note: Inactive as of version 5010. Use code 16 with appropriate claim payment remark code [M32, M33].*
D18	Claim/Service has missing diagnosis information. *Note: Inactive as of version 5010. Use code 16 with appropriate claim payment*

remark code [MA63, MA65].

D19	Claim/Service lacks Physician/Operative or other supporting documentation *Note: Inactive as of version 5010. Use code 16 with appropriate claim payment remark code [M29, M30, M35, M66].*
D20	Claim/Service missing service/product information. *Note: Inactive as of version 5010. Use code 16 with appropriate claim payment remark code [M20, M67, M19, MA67].*
D21	This (these) diagnosis(es) is (are) missing or are invalid *Note: New as of 6/05*
W1	Workers Compensation State Fee Schedule Adjustment *Note: New as of 2/00*