Electronic
Claims
Processing™

Phoenix EDI Module

August 2007

Lytec®

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Preface

Introduction

This program gives you the ability to transmit nearly all of your insurance claims (Medicare Part B, Medicaid, Blue Cross/Blue Shield and Commercials) to the clearinghouse. When you send claims to the clearinghouse, it first formats the claims for each individual insurance carrier's requirements. The clearinghouse then forwards the claims electronically to the carriers.

Depending on the state in which you practice, claims can be submitted by the clearinghouse to Medicare, Medicaid, Blue Cross/Blue Shield, and Commercial carriers throughout the country. For a complete list, go to this link and click **Phoenix Payer List** under the Phoenix Platform heading:

http://www.lytec.com/support/SPT3_Documentation.asp

Requirements

If you are sending claims through the Phoenix Broadband module, you need an active internet connection to send claims. If you are sending claims through the Phoenix module, you need a modem and a phone line.

1. **Modem:** This is a device that links your computer to a telephone line. Its function is to convert data signals to a series of tones that can be sent over a phone line. Your modem can be inside your computer or an external model, but it must be installed on each computer from which you will transmit electronic claims.

    > **Note:** Greater success is sometimes achieved when using external hardware-based modems.

2. **Phone line:** It is best to have a separate line for your modem at the time of transmission, although it is not required. Sharing a line with a fax machine is a popular option. However, do not share it with rollover lines.

Technical Support

Contact your local Value-Added Reseller or technical support at (800) 689-4550. You can also access the Lytec Knowledge Base at www.lytec.com/kb 24 hours a day.

About This Manual

This manual is for use with Lytec 2007. If you have a previous version of Lytec that is not compatible with this program, contact your local Value-Added Reseller or sales at (800) 735-1991.

Chapter 1

Registration

Before you can begin filing electronic claims, you must register with the clearinghouse. Call your local Value-Added Reseller or sales at (800) 735-1991 to register. They will send you an EDI registration packet.

> **Note:** If you are a billing service, you must have contracted with at least one provider before you can register with the clearinghouse.

EDI Customer Contract (ECC)

The first page of the EDI registration packet is the ECC. As you fill in the ECC, be aware of the options for the practice type. Be sure you understand whether the provider files as a single physician or a member of a group practice, or if he or she files as a radiologist or lab. (Check off only one of these items.)

This page also contains an option to receive electronic remittance advice. This allows your computer to actually post payments and adjustments from insurance carriers. If you would like this service, you must also sign up for it through your Value-Added Reseller or your sales representative.

There is also an area for your local Value-Added Reseller's name and identifying numbers. Do not enter anything in this area yourself. If you are working with a Value-Added Reseller, he or she is responsible for this information.

Terms and Conditions

The next pages in the EDI registration packet contain the Terms & Conditions. Make sure the business manager or physician is the one to initial and date both pages.

Billing Information

Exhibit A is the Billing Information form. Please fill in your business name, address, telephone, and fax numbers. Then decide whether you want to use a credit card or have your checking account debited each month for your clearinghouse fees.

Provider Information Sheet

Exhibit B is the Provider Information Sheet. Fill in the information requested.

Statement Processing Registration

Exhibit D is the Statement Processing Registration form. Fill in all required information.

Carrier Approval Tracking Form (CAT)

You are now ready to complete the CAT. The Provider Tax ID should contain the Federal Tax Identification Number (TIN), if one has been assigned to the practice by the IRS. A TIN has two digits followed by a dash and seven more digits. If the provider/practice does not have a TIN, enter the provider's Social Security Number in this field.

Enter information for each provider in the practice, for each location, even if you file as a group. The form has space for up to four providers. Copy the blank form if needed for more providers.

Review

This would be a good time to check over the forms and make sure all necessary items have been completed.

After you have checked over each item in the packet, send the registration information to. You can fax the completed registration forms to Lytec at (480) 635-8271. Please include a coversheet to the attention of Phoenix Registration.

If a fax is not available, you can mail the registration forms to:

Lytec–Attention: Phoenix Registration
5222 E. Baseline Road, Suite 101
Gilbert, AZ 85234

Be sure to make copies of the completed forms before mailing them.

Lytec will receive your forms and process them, which can take up to five business days. When this has been completed, each provider will be assigned the necessary codes for sending electronic claims. Once these codes have been received, you can start sending most of your commercial carrier claims. The setup portion of this manual will explain how to enter the codes into your Lytec program.

FAQs

When can I actually send claims?

Most commercial claims can be sent after you get your provider codes. This will take about five business days from the date your enrollment forms are sent to Lytec. Allow a minimum of an additional 25 days for your government carriers and any other carriers that require special provider agreements. Some carriers may take longer. Keep in mind that we will follow up on the status of these agreements. You do not need to contact the carrier yourself. Doing so may cause confusion and delays.

How much does it cost to send claims?

The charges for electronic claims filing are broken down by services rendered. Contact your Value-Added Reseller or sales at (800) 735-1991 for the current prices.

Chapter 2

Setting Up

Approximately five days after the Registration department receives your registration forms, you will receive a fax with the necessary information to send claims electronically. Once you receive this fax, you can start setting up Lytec to send electronic claims.

Broadband

If you are sending claims through the Phoenix Broadband module, you must have an active internet connection on your computer.

EDI Receivers

You must first set up the Phoenix EDI receiver. To set up the EDI receiver, go to the **Lists** menu and select **EDI Receivers**. In the **EDI Receivers** window, click **New.**

Address Tab

In the **Name** field, enter **Phoenix**. This in the only required information in this tab.

Modem Tab

Open the **Modem** tab. You do not need to enter information in this tab if you are sending through the Phoenix Broadband module.

If you are sending through the Phoenix module, enter the following information in the tab:

  Data Phone—Leave this field blank.

  Dialing Prefix-- If you are using an in-house phone system, you may need to enter a 9 or a 7 first to get an outside line.

  Serial Port—This field has four selections: **COM1**, **COM2**, **COM3**, and **COM4**. Enter the port that houses your modem.

  Baud Rate—Enter the fastest speed your modem can use up to **28.8k**.

  Transmit Protocol—Select **Z-Modem**.

  Dialing Attempts—You can enter any number up to **99** for the dialing attempts, but **20** is usually sufficient.

> **Transmission Mode**—Select **Active** unless sending test files.

You should either leave the other fields blank or leave the default selections.

ID and Extras Tab

Open the **ID and Extras** tab.

Enter the following information in this tab:

> **Submitter ID 1**—Enter the **Client ID Number** you received when you enrolled for electronic claims.

> **Submitter Password 1**—Enter the **Client ID Number** assigned by Phoenix.

> **Program File**—Enter one of the following values:

> | | |
> |---|---|
> | Modem | Enter **NDCPHX.EXE**. |
> | Broadband | Enter **NDCPHXBB.EXE**. |

> **Extra 3**—Enter the name of the contact person in your office who answers electronic claims questions.

> **Extra 4**—Enter a **1** or a **2** depending on whether the practice name consists of a practice name or an individual's name. For example, if the practice name is Centertown Offices, enter **1**. If the practice name is Dr. John F. Centertown, enter **2**.

Extra 5—You only need to fill out this field if you are a billing service or are filing for multiple practices. If you send claims for multiple practices under one client ID and password, enter a unique two-digit code for the receiver (01-99). Do not use alpha or special characters.

Group Practice—Check this box if you are a group practice.

Click **Save**. This completes the EDI receiver setup.

Insurance Companies

You must enter certain information for the insurance companies for which you send claims. To enter that information, follow the steps below.

Go to the Lists menu and select **Insurance Companies**. The **Insurance Companies** window opens. Edit an insurance company for which you send claims.

Name and Address Tab

Open the **Name and Address** tab.

In the **Type** field, select the appropriate type for the insurance company.

Note: If you file any crossover claims, you need to set up two insurance companies--one for regular Medicare claims (**Medicare** type) and one for the crossover company (**Medicare with Crossover** type).

Identification Tab

Open the **Identification** tab. Enter the following information in this tab:

> **Provider ID**—In the **Provider ID** field, select the Provider ID that has been assigned to the insurance company. If you are not sure what number was set up under the Provider ID field, click the ellipsis button to open the **Find Provider** option.

> **Medigap ID**—If billing crossover claims, enter the Medigap ID.

> **Payer ID**—Enter the commercial carrier Payer Number. This number is in the Phoenix Payer List available at http://www.lytec.com/support/SPT3_Documentation.asp#ECP.

> Leave the field blank for insurance companies to which you want to send paper claims.

Claims Tab

Modify this tab only if the practice is billing as a group practice.

> **Group Practice with practice ID**—Enter the group number that has been assigned to the provider or the practice.

EDI/Eligibility Tab

Open the EDI/Eligibility tab

In the **EDI Receiver when Primary** field, enter the EDI receiver you created in the previous section. If you send secondary claims, enter the same receiver in the **EDI Receiver when Secondary** field.

> **Note:** If you do not enter an EDI receiver in the EDI Receiver when Primary field, claims will not be created or sent for this insurance company.

If the insurance company assigned a submitter ID on the clinic/provider level rather than on the clearinghouse level, you need to enter that number in an insurance custom field. See the Insurance Custom Field section below.

Click **Save** and repeat these steps for each applicable insurance company.

Insurance Custom Field

If the insurance company assigned a submitter ID on the clinic/provider rather than on the clearinghouse level, you need to create an insurance custom field for the ID named **SUB:**. To create this field, follow the steps below.

1. Go to the **Settings** menu and select **Custom Fields.**

2. Open the **Insurance** tab.

3. In the first available line, enter **SUB:** as the **Description**. You can leave the defaults in the other fields.

4. Click **OK** to save the custom field.

Then when you go into the insurance company's record, open the **Custom Fields** tab and enter the appropriate submitter ID in the **SUB:** field.

Providers

You must enter information for each provider whose claims you send. You will normally enter most of this information when setting up the provider record. However, if you want to verify that the provider is set up correctly for sending claims, follow the steps below.

Go to the Lists menu and select **Providers**. Edit the first provider whose claims you send.

License Tab

Open the **License** tab. Enter the following information in this tab:

Social Security #—Enter the provider's social security number.

Tax ID—If applicable, enter the provider's tax ID number.

State License—Enter the provider's State License Number.

National Provider ID—Enter the National Provider Identifier for the provider.

Group National Provider ID—If the provider bills some insurance companies as part of a group, enter the group National Provider Identifier in this field.

Specialty License—Enter the Taxonomy code for the provider.

DEA Number—Enter the provider's pharmaceutical DEA number.

UPIN—The Unique Personal Identification Number is issued by Medicare. It is comprised of one alpha plus five numerical characters. Enter the provider's assigned UPIN.

Signature on File—Check this box to include Signature on File on the HCFA 1500 form and on electronic claims.

Other IDs Tab

Open the **Other IDs** tab and enter the following information in this tab

Submitter ID—This field is only applicable to customers sending to through Noridian. Enter the submitter ID assigned to the provider by Noridian.

Mammography Cert Number—This number is assigned to providers licensed to read mammograms. If the provider has a mammography certification number, enter it in this field.

Care Plan Oversight Number—Medicare assigns this number to providers who are authorized to perform covered home health services. If the provider has a CPO number, enter it in this field.

Other ID—Unless instructed in the crosswalk, leave this field blank.

Hospice Employed—Check the box if the provider provides hospice care.

Medicare Participating Provider—This field needs to be checked for the Remittance Processing program to post adjustments.

Allow Eligibility Verification—Check this box if the provider is enrolled for eligibility verification.

Insurance IDs Tab

The **Insurance IDs** tab displays the PINs assigned by an insurance company to the provider.
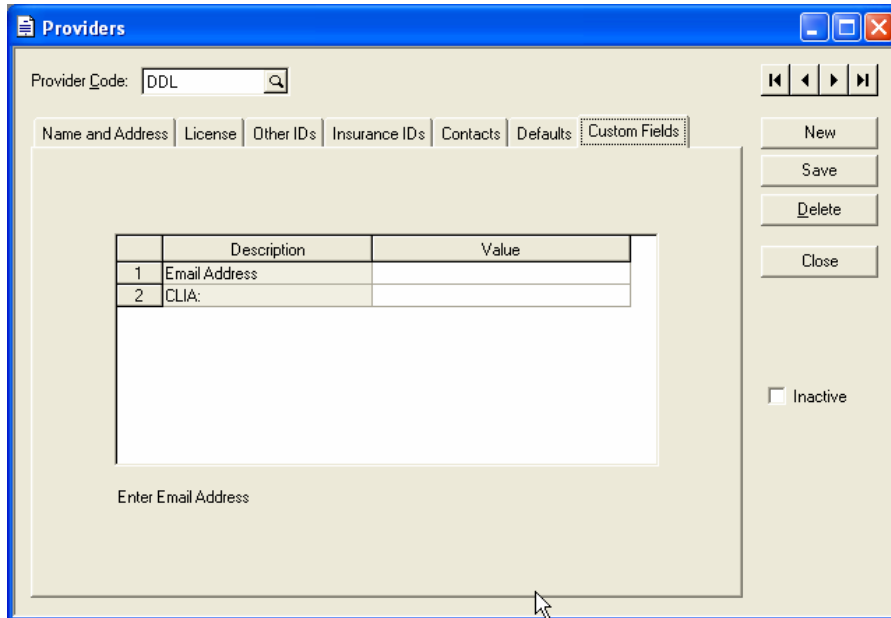

ID Column—Enter the provider's PIN.

Description—Enter the name of the insurance company that assigned the PIN.

ID Qualifier—Click the drop-down arrow and select the ID qualifier for the PIN. The ID qualifier indicates what type of PIN you are sending.

Custom Fields

You may need to enter values in custom fields for the provider. For example, if the provider has a CLIA number, you might need to enter it in his record. You would first create a **CLIA:** custom field in the **Custom Fields** window available from the **Settings** menu. Then you would come in the provider's record, open the **Custom Fields** tab, and enter the provider's CLIA number in the field.

Click **Save** and then repeat these steps for each applicable provider.

Patients

You must enter certain information for each patient for whom you want to send electronic claims. You will normally enter most of this information when setting up the patient record. However, if you want to verify that the patient is set up correctly for sending claims, follow the steps below.

Go to the **Lists** menu and select **Patients**. Edit the first patient for whom you want to send claims.

Patient Information Tab

If the patient has a suffix or prefix (i.e. Jr or Mrs) on his/her insurance card, you must enter the additional information in the patient's name field. To add a suffix or prefix, open the **Patient**

Information tab. If you need to enter a suffix (i.e. Jr), enter it after a comma in the **Last Name** field. For example, enter **Last Name, Suffix**. If you need to enter a prefix (i.e. Mrs), enter it after a comma in the **First Name** field. For example, enter **First Name, Prefix**.

Primary Insurance Tab

Open the Primary Insurance tab and enter the following information in this tab:

Accept Assignment—Check this box if the insured is assigning benefits to the provider.

Relation to Insured—Click the down arrow to select the appropriate option.

Insurance Code—Enter the patient's primary insurance company.

Group Number—Enter the patient's group number.

Insured ID Number—Enter the insured's ID number.

Secondary Insurance Tab

If you are submitting Medigap claims, open the **Secondary Insurance** tab. Make sure the **Bill insurance automatically** check box is not checked. Review the Medigap carrier list received from Medicare to verify its crossover status.

Associations Tab

Open the **Associations** tab and enter the following information in this tab:

Provider—Enter the patient's provider.

Referring Physician—Enter the patient's referring physician. If no referring physician exists, we suggest that you assign the provider as the referring physician. This is required if CPT codes are used for ordering lab work or X-rays.

Note: If the referring physician is listed, the Unique Personal Identification Number (UPIN) is required. Enter the UPIN in the **Insurance Code 1** field of the referring provider's record in the **Addresses** window.

Claim Information Tab

If you need to mark the patient as a non-person (i.e. it is a company), open the **Claim Information** tab. Click the **More Information** button on the tab. The **More Information** window opens. Open the **More Information 2** tab. Go to the **Entity Type** field. Choose **Non-Person** to indicate the patient's entity type. This field is usually used for worker's compensation claims. Click **OK**,

Click **Save** and then repeat these steps for each applicable patient.

Guarantors

If a guarantor is not a patient and is a non-person (i.e. it is a company), you must designate the entity type as such. To make this designation, follow the steps below.

Go to the **Lists** menu and select **Guarantors**. Edit the first guarantor for whom you send claims.

Go to the **Entity Type** field. Choose **Non-Person** to indicate the guarantor's entity type. This field is usually used for worker's compensation claims.

Click **Save** and repeat these steps for each applicable guarantor.

Addresses

A referring provider is required for electronic claims when a referral exists. A referring provider may also be required for selected procedure codes, diagnosis codes, or provider specialties. When a referring provider is required on a claim, an identification number for the referring provider is also required.

A facility is required if the place of service on a claim indicates the service is being billed for procedures that were performed outside of the doctor's office. A facility may also be required on a claim for certain procedure or diagnosis codes.

Referring providers and facilities are both set up in the **Addresses** window. Go to the **Lists** menu and select **Addresses**. Highlight the referring provider's record and click **Edit**.

Type Tab

Open the **Type** tab and enter information in the following field.

> **Entity Type**—Choose **Person** or **Non-Person**, depending on whether the record is for an entire practice or for an individual. For example, if a referring provider bills as a practice, Dr. Doe's Clinic, choose **Non-Person**. If a referring provider bills under Dr. Doe, choose **Person**.

Insurance Codes Tab

Open the **Insurance Codes** tab to designate the address record's information.

> **National Provider ID**—Enter the National Provider ID for the referring provider or facility

> **Insurance Code 1**—Enter the referring provider's UPIN.

> **Insurance Code 2**—For referring physicians, enter the Social Security Number. For facilities, enter the Tax ID.

> **Other ID**—Enter the Tax ID number of the referring provider.

Insurance IDs Section

> **Insurance**—Select the insurance company that assigned the insurance ID to the referring provider or facility.
>
> **Insurance ID**—Enter the ID for the referring provider or facility.
>
> **ID Qualifier**—Click the drop-down arrow and select the qualifier for the ID. This qualifier tells the payer what type of ID is being sent on the claim.

Click **Save** and repeat these steps for each applicable referring provider or facility.

Practice Information

You must designate the entity type under which the practice bills: **Person** or **Non-person**.

Go to the **Settings** menu and select **Practice**. The **Practice Information** window opens.

Go to the **Entity Type** field. Choose **Person** or **Non-Person** depending on whether the practice name consists of a practice name or an individual's name. For example, if the practice name is Centertown Offices, choose **Non-Person**. If the practice name is Dr. John F. Centertown, choose **Person**.

Click **OK** to save the setting.

Medigap/Crossover Claims

Medicare does not always cover all of a patient's healthcare needs. Medigap policies are private insurance companies that can help pay for the "gaps" that Medicare does not cover. When a patient has a secondary insurance that is supplemental insurance to Medicare, Medicare will forward the claims to the secondary insurance company.
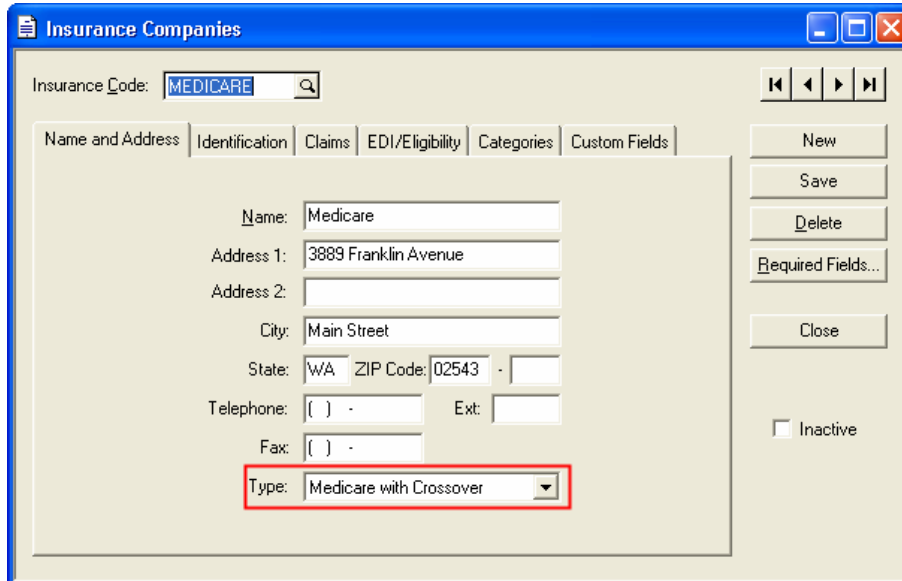
Complementary crossover occurs when Medicare forwards an adjudicated claim automatically to the secondary insurance company. The transfer of adjudicated Medicare claims information is based upon eligibility data supplied to Medicare by the supplemental insurance. Medicare has service agreements with payers for automatic crossover of the claim information.

According to the agreement, the secondary insurance companies provide Medicare with an eligibility file on a weekly or monthly basis that lists all patients eligible for their insurance coverage. If the secondary insurance does not fall under a complementary crossover, Medicare needs the patient's claim to report the secondary insurance information. Medicare assigns each supplemental insurance company a five-digit identification number called a Medigap ID or OCNA number.

Primary Insurance (Medicare) Setup for Medigap/Crossover Claims

Go to **List** menu and select **Insurance Companies**. Click the magnifying glass and select the Medicare insurance company.

The **Type** of insurance company needs to be **Medicare with Crossover**.

Secondary Insurance Setup for Medigap/Crossover Claims

Go to **List** menu and select **Insurance Companies**. Click the magnifying glass and select the secondary insurance company.

Go to the **Identification** Tab. Enter the Medigap /ONCA number in the **Medigap ID** field.

If Medicare automatically forwards claims to the secondary, then type **CC:** into the **Medigap ID** field.

Patient Information Setup for Medigap/Crossover Claims

Under **Patients**, **Policy 1** tab, the Insurance **Type** must be **Medigap**.

Under **Patients**, **Secondary Insurance** tab, the **Type** must be **Supplement**.

Notes

Notes may be required on a claim if information is needed to substantiate medical treatment. A note may also be required if the payer requires information that is not otherwise reported on an electronic claim. Notes can be sent on a claim level or at a transaction level and are reported in an NTE segment.

Entering an Insurance Narrative

Insurance narratives can be added to a claim in two separate ways. The first is in the **Charges and Payment** screen, **Billing** button, **Insurance Narratives**.

The second method is to select **Insurance Narratives** from the **Activities** menu.

If **Insurance Narrative** is selected from the **Activities** menu, then the user will be prompted to select the patient to attach the narrative to.

On the **Insurance Narratives** window, click the **Add** button.
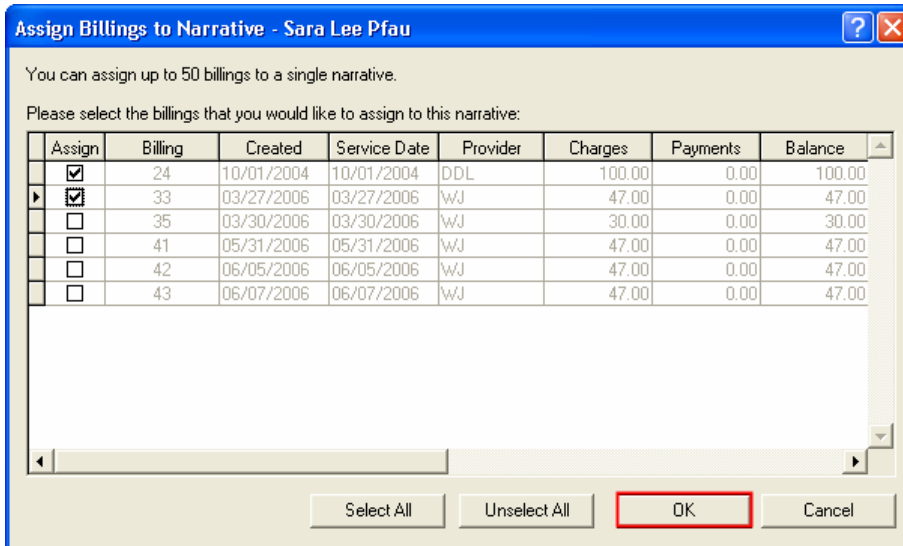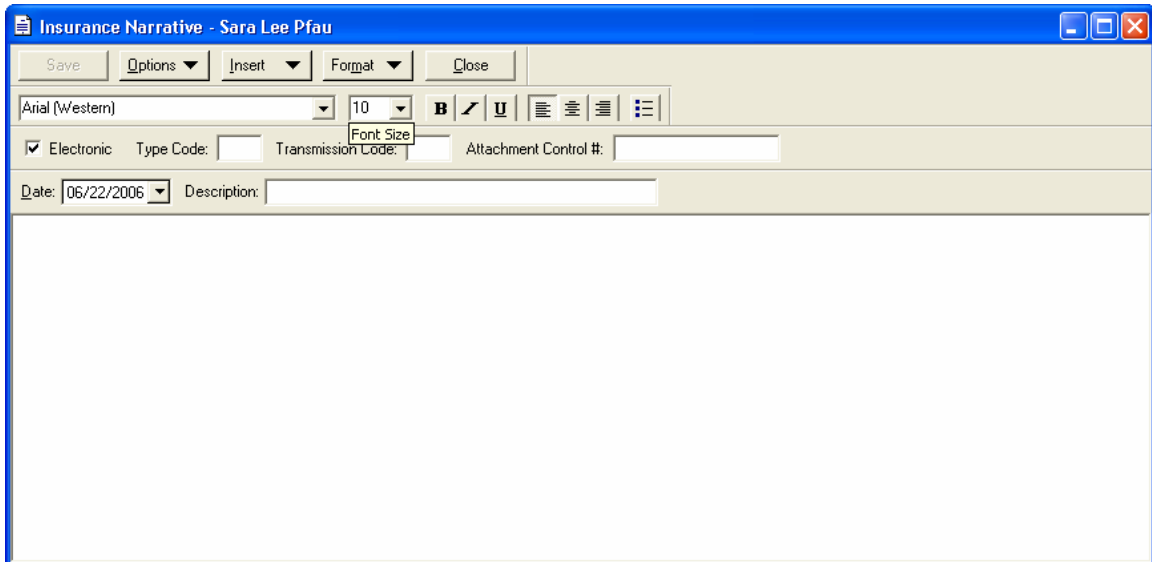
When the **Assign Billings to Narrative** window opens, select the billings to assign the narrative to in the **Assign** column. Clicking the **Select All** button will assign the narrative to all existing billing for a patient. Once the billings have been selected, click **OK**.

The **Insurance Narrative** window will appear.

Save Button—Click this button to save the text in the insurance narrative.

Options Button—Click the **Options** button to print, set up the page layout, import text, and export text.

Insert Button—Click the **Insert** button to enter date and time information automatically.

Format Button—Click the **Format** button to format the text.

Electronic—Click **Electronic** if the narrative is to be included when sending electronic claims.

Type Code—The **Type Code** is a two-character code that indicates the title or contents of a document, report, or supporting item sent with electronic claims.

Transmission Code—The **Transmission Code** is a two-character code that defines the timing, transmission method, or format by which reports are sent with electronic claims.

Attachment Control #—The value you enter in the **Attachment Control #** field is your own unique reference number that is up to seven-digits long. This number is required if you select any Transmission Code besides AA.

Date—Enter the date for which you are entering the narrative. This field will default to the system date.

Description—In order for notes to report on electronic claims at the claim level, the description must begin **@NTE**.

Use the area below the **Date** and **Description** fields to enter the text. Text for claim level notes note can be up to 245 characters long. Text for transaction level notes can be up to 164 characters long.

Once all Information has been filled in, click **Save** and then **Close**.

The **Insurance Narrative** window will reopen with the Insurance Narrative now listed. The **Billings** column will indicate the billings the Insurance Narrative has been assigned to. The **Preview** section will display the contents of the narrative.

Chapter 3

Processing Electronic Claims

Phonebook Entry

When you first send claims, you must create a phonebook entry for your modem. When sending electronic claims, the following message appears to let you know you need to set up the phonebook entry.
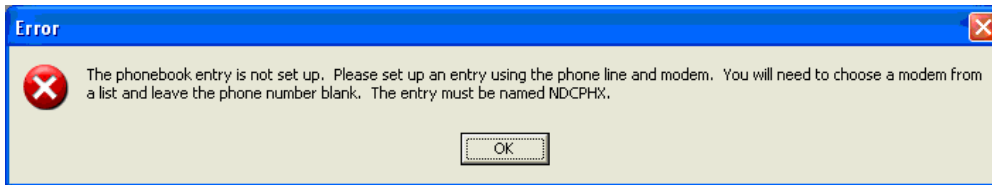
Follow the steps below to set up PHX as a phonebook entry.

1. Click **OK**. The **New Connection Wizard** opens to the **Type of Connection** window.
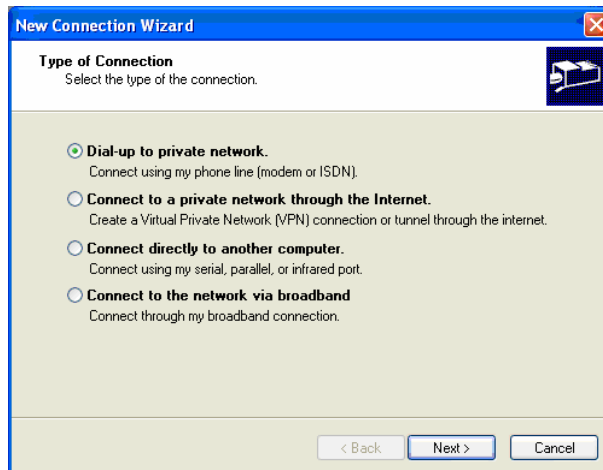
2. Leave **Dial-up to private network** selected and click **Next**. The **Phone Number to Dial** window opens.

3. Because the program pulls the phone number from the EDI receiver settings, leave the phone number field blank and click **Next**. The **Finished** window opens.
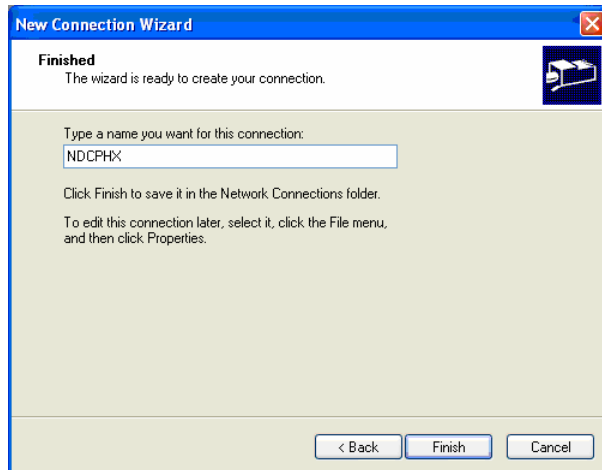
Enter **PHX** as the name of the connection and click **Finish**. The phonebook setup is now complete, and your modem should open, dial, and connect properly.

Sending Primary Claims

To send primary claims , follow the steps below.

> **Note:** For the program to include a billing in the claims file, the **Bill** box in the **Bill To** section of **Charges and Payments** must be checked. The **Print** box in the **Detail Items** section must also be checked for each line item you want to transmit on a claim.

1. Go to the **Billing** menu and select **Electronic Claims**. The **Find EDI Receiver** window opens.
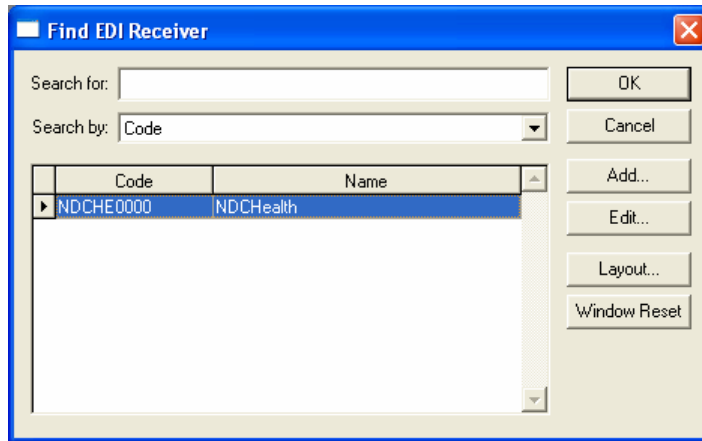
2. Select the Phoenix EDI receiver and click **OK**. The **ANSI X12** window opens.
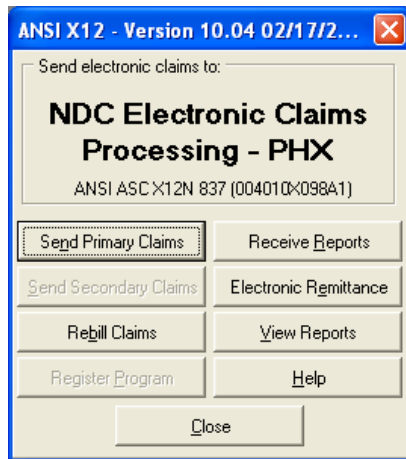
3. Click **Send Primary Claims**. The **Data Selection Questions** window opens.

4. Enter values in the ranges to select specific claims and click **OK**. Leaving all fields blank will batch all unbilled entries that meet the requirements in the claims file.

5. A message appears, asking if you want to view a Verification Report. We strongly recommend that you view and print the Verification Report. Click **Yes** to view the report.

   This report shows which claims were batched in the claims file. It gives you a record of the claims you are about to send. It also lets you check the batch for accuracy of claims and ensure the claims you intend to send are included.

Lytec does not perform any edits on the claims, but it does tell you if certain information is not in the claims. If you see a message like "No facility is set up for this case," it is merely to alert you to that fact. The claim may or may not require a facility. That is for you to determine.

Once you have reviewed the claims, click the Print speed button at the top of the window to print the report. Keep the printed report on file. Once you close the window, you cannot bring it up again.

6. After you print the Verification Report and close the preview window, a window appears asking if you want to continue with the transmission.

7. If you saw errors on the Verification Report, click **No**. Make the necessary changes in Lytec and create the claim file again.

8. If the Verification Report had no errors or you did not view it, click **Yes** to continue.

9. If the claim file is not created, you will probably get an error similar to the following.
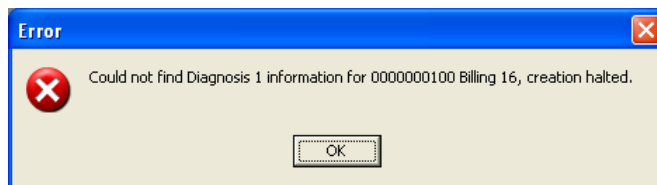
Note down the problem, the chart number, and the billing number and press **OK**. The **Creating Claim File** window opens and tells you no claims were created. Close out of the electronic claims program, go into the billing in question in **Charges and Payments**, fix the problem, and then recreate the claim file. For example, if you got the message above, you would go to billing 16 and add a diagnosis 1 for each applicable charge. Then you would create the claim file again.

10. If the claim file is created successfully, the **Creating Claim File** window opens.
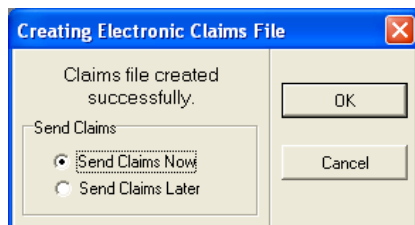
11. You can choose either to send claims now or later. To send claims now, choose that option and click **OK**. The program transmits the file. Once it is finished, a message appears and lets you know if the transmission was successful.

12. To send claims later, choose that option and click **OK**. The **Send Later** window opens.
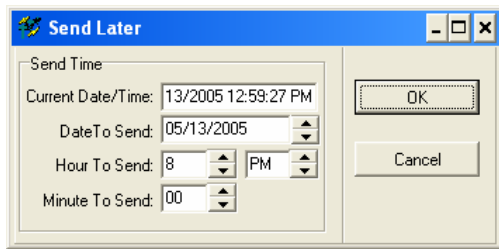
13. Select the time you want to send your claims using the date, hours, and minutes up/down arrow buttons and click **OK**.

YOUR LYTEC PROGRAM WILL BE DISABLED until the file is transmitted or you cancel the procedure.

Sending Secondary Claims

Not every insurance carrier/clearinghouse processes secondary claims electronically. If your carrier/clearinghouse does accept secondary claims electronically, the following conditions must be met before Lytec can send these claims.

▪ You must set up another insurance company record for secondary claims. All other field requirements in the **Insurance Companies** window are the same as for primary carriers. See your electronic claims manual for instructions on setting up insurance carrier records.

▪ You must select the secondary insurance carrier in the **Insurance Code** field **Secondary Insurance** tab in the **Patients** window.

▪ In the **Insurance Companies** window, **EDI\Eligibility** tab, the secondary receiver must be selected in the **EDI Receiver when Secondary** field.

▪ In **Charges and Payments**, the **Bill To** section must be marked for sending to the secondary insurance company.

▪ In the **Billing Options** window, **Secondary Insurance** tab, the **Print Billing to Paper Only** box must be unchecked.

Send secondary claims the same way you send claims, except click **Send Secondary Claims** in the **ANSI X12** window.

Remittance Tracking Information

When you send secondary claims, the **Remittance Tracking Information** window opens. The Remittance Tracking Information feature allows users to store and access information sent back by the primary insurance carrier. This information may be sent in Electronic Remittance Advice (ERA) files or on the Explanation Of Benefits (EOB). When billing a secondary carrier, this information may be necessary in order to get paid the correct amount. Information sent back in ERA files is automatically

posted to the **Remittance Tracking Information** screen when an ERA file is downloaded or viewed through one of Lytec's electronic claims programs. If the information sent in the ERA file is incorrect, you can change the information and then resend the secondary claim. For more information, look up the Remittance Tracking Information – Overview topic in the help file.

Receiving Reports

To receive electronic claims reports, follow the instructions below.

1. In Lytec, go to the **Billing** menu and select **Electronic Claims**. The **Find EDI Receiver** window opens.

2. Select the Phoenix receiver and click **OK**. The **ANSI X12** window opens.

3. Click **Receiver Reports**. The program dials the clearinghouse and collects any available reports for the claim files you transmitted.

Response Report

> **Note:** If a report is word wrapping, change the print format to **Landscape** from **Portrait**.

One of the reports that you might receive is the Response Report. When you transmit a claims file, the clearinghouse edits the claims for errors and returns a Response Report that lists any immediate errors found. This report is available the next day after transmission and is called NDC1.RPT.

When you receive the Response Report, it automatically opens on the screen. You will see the claims that were included in the batch and whether each one was accepted or rejected. If a claim is rejected, the report lists the errors that must be corrected.

You should print this report. Click the **Print** icon to print out a copy of this report and then make any necessary corrections to the claim.

When you receive a new report (after you transmit the next batch of claims), Lytec automatically renames your old report file with an ".OLD" extension, i.e., NDCRPT1.OLD. The program will hold up to twenty .OLD files before overwriting them, and then will start by overwriting NDCRPT20.OLD. If you want a printed copy of these reports, be sure to print them before downloading any new reports or change the document name.

Delayed Response Report

Another report you might receive is the Delayed Response Report. When the claims pass initial clearinghouse edits, they are forwarded to the respective carriers. If a carrier then determines corrections need to be made, it reports the error to the clearinghouse. The clearinghouse then posts the report to your electronic mailbox.

Starting a day or two after sending claims, click **Receive Reports** in the **ANSI X12** window to download any available reports from the clearinghouse. You must continue to check for reports to be

sure you have received them all. We suggest that you check for reports before transmitting any more claims to the clearinghouse. If errors are reported, the claims must be corrected and retransmitted using the same steps as before.

When you receive a new report, Lytec automatically renames your old report file with an ".OLD" extension like it does for the Response Report.

Monthly Verification Report

Approximately the second or third day of each month, you can download the Monthly Verification Report for all daily submissions that occurred in the previous month.

Rebilling the Claims File
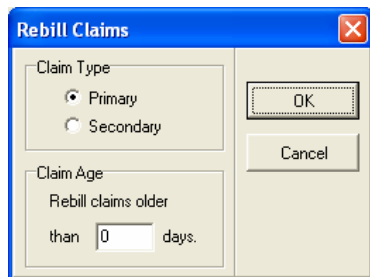
Lytec gives you the opportunity to rebill any unpaid claims that are older than the date you specify.

There are two requirements to rebill these claims:

- The bill has a billing date.

- No insurance payment has been applied to the bill.

To rebill a claim file, follow the instructions below.

1. In Lytec, go to the **Billing** menu and select **Electronic Claims**. The **Find EDI Receiver** window opens.

2. Select the Phoenix EDI receiver and click **OK**. The **ANSI X12** window opens.

3. Click **Rebill Claims**. The **Rebill Claims** window opens.

4. Leave the **Claim Type** as **Primary**. In the **Claim Age** section, enter the number of days that you want to use as your aging period. For example, if you want to rebill all sent but unpaid claims older than 60 days, enter **60**. Click **OK**. The **Data Selection Questions** window opens.

5. Leave all the fields blank and click **OK**. The program rebills all unpaid claims older than the aging period you specified. It also changes the billing date to today's date but leaves the initial billing date as the date the bill was first sent.

Appendix A

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