

Processing Electronic Claims in Lytec

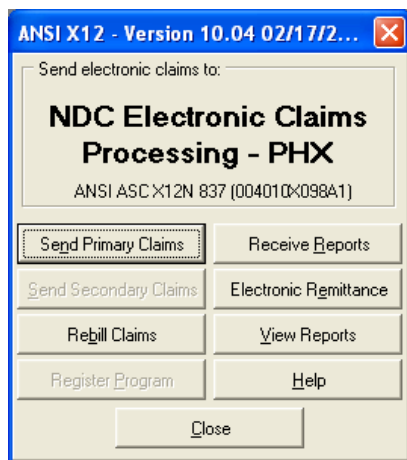
Creating Claims

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 RelayHealth EDI receiver and click **OK**. The **ANSI X12** window opens.



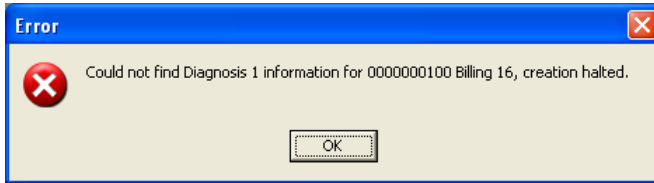
3. Click **Send Primary Claims**. The **Data Selection Questions** window opens.
4. Enter values in the ranges to select specific claims and click **OK**. Leaving all fields blank will batch all unbilled entries that meet the requirements in the claims file.
5. A message appears, asking if you want to 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.

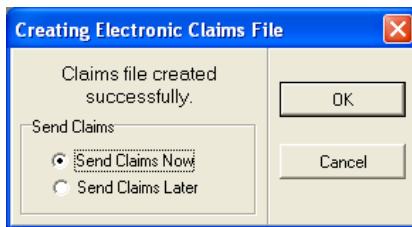
Once you have reviewed the claims, click the Print speed button at the top of the window to print the report. Keep the printed report on file. Once you close the window, you cannot bring it up again.

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.



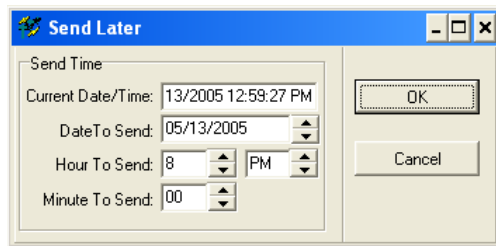
Note down the problem, the chart number, and the billing number and press **OK**. The **Creating Claim File** window opens and tells you no claims were created. Close out of the electronic claims program, go into the billing in question in **Charges and Payments**, fix the problem, and then recreate 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.

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 RelayHealth EDI receiver and click **OK**. The **ANSI X12** window opens.
3. Click **Rebill Claims**. The **Rebill Claims** window opens.

The image shows a screenshot of the 'Rebill Claims' dialog box. It has a blue title bar with the text 'Rebill Claims' and a close button (X). The dialog is divided into two main sections. The top section is labeled 'Claim Type' and contains two radio buttons: 'Primary' (which is selected) and 'Secondary'. The bottom section is labeled 'Claim Age' and contains the text 'Rebill claims older than' followed by a text input field containing the number '0' and the word 'days'. To the right of these sections are two buttons: 'OK' and 'Cancel'.

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.