Introduction

This manual will help streamline and strengthen your office's billing process. You will learn all aspects of Avanta billing defaults, Medicare and Third Party electronic billing, printing HCFA forms, and billing reports such as the Open Insurance Report.

Section One: Defaults/Treatment File

Foreword

Several Practice Defaults within the Avanta system allow you to customize the software to fit your practice's needs. Practice Defaults are just another term for preferences, and may be different for each practice depending on its individual needs. Before beginning or continuing insurance billing, it is a good idea to check your Insurance Billing defaults. Changing the value of certain defaults may PERMANENTLY ALTER data in your practice, so it is a good idea to call Avanta before making any changes to your defaults.

Defaults

To view or edit the Insurance Billing default settings in your practice:

1. Press **[C] Special Functions** from the home screen.
2. Press **[2] Authorized Functions**.
3. Press **[2] Practice Defaults**.
4. **WARNING** - Changing the values of certain defaults may PERMANENTLY ALTER the data in your practice! It is suggested to contact Avanta before making any changes or if you have any questions.
5. Press **[ENTER]** to continue with viewing or editing the Practice Defaults.
6. Press **[5] Insurance Billing**.

This is the Insurance Billing section of your Practice Defaults, containing a total of 17 pages of Insurance Billing defaults. These are a few defaults (which will not permanently alter data in your practice) that may help you more efficiently bill insurance:

Page 1 #1
Should each treating provider print on a separate insurance form?

Answering **[Y]es** will print on one page only procedures with the same treating provider. Procedures with a different treating provider will print on a separate HCFA-1500 form.

Page 1 #3

Should unreferenced diagnoses from a patient's ledger print on insurance forms?

Up to two diagnoses can be referenced to each treatment. However, box 21 on a HCFA form allows for additional diagnoses to be printed. If this default is answered **[Y]es,** all demographic diagnoses (a maximum of four is stored per patient) will print in box 21, even if they are not directly referenced to any of the posted treatments.

Page 3 #1

Should Other Insurance Company information be omitted on HCFA-1500 forms?

Boxes 9 through 9d may be filled in with supplemental insurance information when this default is answered **[Y]es**. Only participating physicians and suppliers may complete these boxes. Information should be entered only if requested by the Medicare beneficiary, as the beneficiary must approve assignment of Medigap benefits.

Page 7 #5

Should the office facility name and address print on insurance forms if there is an office facility associated with the claim?

Box 32 may be filled in with the name and address of the facility of service (separate from place of service), if different than a home or office location. For durable medical equipment, the facility is the location where the order is taken. If the facility providing service is the same as that of the biller listed in box 33, "SAME" is entered in box 32. Complete box 32 for all supplier and laboratory work. Avanta suggests setting this default to **[Y]es**.

Page 8 #1

Should Medicare secondary insurance companies be billed before you have received payment from Medicare?

Allows deferral for patients that have Medicare primary and any other supplemental insurance. Answering **[N]o** will ensure that secondary insurance companies are not billed until a Medicare response is posted to the ledger. Avanta suggests setting this default to **[N]o**.

Page 8 #2

Should Private secondary insurance companies be billed before you have received payment from the primary insurance company?

Allows deferral for patients that have private primary and any other supplemental insurance. Answering **[N]o** will ensure that secondary insurance companies are not billed until a private primary response is posted to the ledger. Avanta suggests setting this default to **[N]o**.

Page 8 #3
Should [Insurance Type 6] secondary insurance companies be billed before you have received payment from the primary insurance company?

Allows deferral for patients that have primary [Insurance Type 6] and any other supplemental insurance. Answering **[N]o** will ensure that secondary insurance companies are not billed until an [Insurance Type 6] response is posted to the ledger. Avanta suggests setting this default to **[N]o**.

Treatment File Settings

The Treatment File in your Avanta System also contains settings and important fields that, if not set correctly or completely, may affect your billing. To view or change the Treatment File in your practice:

1. Press **[8] Edit Practice Files** from the home screen.
2. Press **[5] Treatments/Transactions**.
3. Press **[2] Edit Treatments/Transactions**.
4. Select the Treatment Group that includes the treatment you wish to view or change.
5. Select the treatment you wish to view or change.
   WARNING - Changing any of the fields other than the prices and modifiers will affect all patients who have ever been assigned this treatment
6. Press **[ENTER]** to continue with viewing or editing the treatment.

The treatment profile, comprised of 27 fields, allows you to modify the treatment itself. Most of the treatment profile fields are self-explanatory and must be populated before using the treatment. However, there are some billing-related fields of which you may not be aware:

- **Field [9] Medicare EDI**: This field allows you to choose whether to electronically bill this treatment to Medicare. Avanta suggests answering **[Y]es** to allow this treatment to be billed electronically to Medicare if you use EDI.
- **Field [10] 3rd Party EDI**: This field allows you to choose whether to electronically bill this charge to Third Party. Avanta suggests answering **[Y]es** to allow this charge to be billed electronically to Third Party if you use EDI.
- **Field [14] TOS**: This field allows you to enter the type-of-service (TOS) code for the treatment. The letters A-Z or 1-9 may be entered here.
- **Field [16] DME Item**: This field allows you to choose whether this treatment is a Durable Medical Equipment (DME) charge.
- **Field [17] No $ on Ins**: This field allows you to select whether to bill this treatment with a zero dollar amount to insurance. Avanta suggests answering this item **[N]o** to bill insurance the actual amount of the treatment.

- **Field [18] AA Status**: This field allows you to default the Accept Assignment status of this treatment to **[A]lways**, **[N]ever**, or **[B]y Patient** (demographic setting). The Accept Assignment status, denoted by the letter "a" next to the treating doctor's initials, controls the deferral process when billing an insurance company or patient. Avanta suggests answering **[B]y Patient** so Accept Assignment is decided on a per patient basis.
- **Field [27] CLIA Required**: This field allows you to send with this treatment the CLIA# from the Physician File. This is used if you have a CLIA# and bill for in-house lab charges.

Section Two: Medicare Electronic Billing

Foreword

Medicare electronic billing allows you to submit all your Medicare claims in minutes, without having to print insurance forms. Because errors and incomplete information can prompt Medicare to reject an entire batch of claims, both patient and submitter information are checked for completeness before claims are transmitted.

Setup

Before you can use Medicare Electronic Billing, you must receive a submitter number from Medicare and complete all submitter information in your Avanta system's Physicians/Providers File. This information is required to submit electronic Medicare claims. Please contact Avanta if your practice needs to be set up or changed, or if you have questions regarding Medicare Electronic Billing.

Prepare Claims For Transmission

To ensure that there are no problems submitting electronic Medicare claims, it is recommended that you first prepare a trial run before preparing an actual claim transmission. **[9] Preparing Reports From Trial Run** and **[1] Prepare Claims For Transmission** follow the same steps. However, preparing a trial run does not unflag charges or produce a transmittable claim file, such as occurs when preparing a production transmission.
WARNING: Ledger items are unflagged when claims are prepared, not when they are transmitted to Medicare. Therefore, claims should not be prepared for transmission until completing a trial run with no billing reject messages.

1. Press **[6] Insurance Billing/EDI** from the Home Screen.
2. Press **[2] Medicare Electronic Billing**.
3. Press **[9] Prepare Reports From Trial Run**.
4. Press **[Y]es** to continue with the trial run.
5. Select **[1] Process Current Group**, or **[2] Process All Patients**.
6. Select or de-select the Insurance Types to include.
7. Select whether to transmit Accept Assignment items only. Selecting **[Y]es** will send only charges marked with an accept assignment flag (the lower case "a" next to the MD initials) on a ledger. Selecting **[N]o** will send all charges.
8. Mark the Condition Codes for the patients to be included or excluded. If no Condition Codes are selected, all patients will be included. A **[+]** will result in only those patients being included. A **[-]** will result in only those patients being excluded. All patients with at least one **[*]** will be included. Condition Codes marked with a **[.]** have no effect on the selection process.

9. Select or de-select the treating providers whose patients are to be included.
10. Select or de-select the place of service to be included.
11. Select starting and ending dates for treatments to be included. Only treatments with a date of service in this range will be included. Avanta suggests not setting a starting date in order to include all flagged charges.
12. Select **[Y]es** to use the treating physician as the referring source for patients that have no demographic referring source. Avanta suggests selecting **[Y]es** for Medicare claims.
13. Enter the beginning record number to print, if you wish to limit the patients to be included. If you are printing all patients, the system will automatically begin with patient **<1>**. If you are printing a group of patients, the system will automatically begin with the first patient in your group.
14. The system will now build a test transmission without unflagging ledger items.

Once the trial run has finished building, you can examine the billing reject messages. If problems are found during the trial run, the system will prompt you with the following message:
WARNING: Some claims cannot be submitted to Medicare because of data errors.
If this message appears:

1. Press **[2] Examine Billing Reject Messages** from the Medicare Electronic Billing screen.
2. Select the number or letter of the transmission you want to examine. The Transmission Log list is sorted from most recent to oldest, so the test claim you just built will be the first item on the list.
3. Select **[1] View Messages On Screen**, or **[2] Print Messages**, and follow the printing instructions as you normally would.

The patient's record number and name are provided, as well as an explanation or reason for rejection. For example, "Missing or Invalid Medicare #" or "Missing Birthdate" are common error messages that can easily be corrected on the patient's demographic screen. The Avanta system checks for completion of all required demographic, ledger, and Physicians/Providers File fields. However, it does not check the accuracy of this information; even after a clean trial run, Medicare may still reject claims if the claim information is complete, but incorrect. After making the appropriate corrections, it is suggested that you prepare another trial run to ensure a clean final claim transmission.

If there are no reject messages or errors in your transmission, the system will prompt you with the message:
No Reject Messages On File =>
Press **[ENTER]** to continue and prepare claims for transmission.

Transmit Claims

After preparing a trial run to detect and fix any errors, Medicare claims need to be prepared for transmission. To prepare claims for electronic transmission to Medicare:

1. Press **[6] Insurance Billing/EDI** from the home screen.
2. Press **[2] Medicare Electronic Billing**.
3. Press **[1] Prepare Claims For Transmission** to build transmittable claims, unflagging ledger items in the process.
4. Follow the same steps for preparing claims for transmission as you did for preparing the trial run.

Once claims have been prepared for transmission, they are ready to be transmitted to Medicare. To transmit claims to Medicare:

1. Press **[8] Transmit Claims To Medicare** from the Medicare Electronic Billing screen.
2. Select the number or letter of the transmission that you wish to send (normally transmission #1, which is your most recent transmission file).
   NOTE: Make sure to check that the transmission is a production file (denoted by "Prod" under the "Mode" column) and to verify the integrity of the claim file (denoted by a "Y" under the "OK" column).
3. When you select the transmission number or letter, the system will initialize the modem, dial Medicare's phone number, and transmit the claim file to Medicare.
4. Once the transmission is completed, the system will display the unique transmission filename, which is automatically posted in the Transmission Log.
5. Press any key to return to the Medicare Electronic Billing screen.

Examine/Print/Delete

After claims have been prepared for transmission, you can examine or print several claim transmission reports, either before or after your claim file has been transmitted. To examine and/or print reports, or examine and delete transmissions:

Claim Detail Report

This report includes the patient's name and record number, treatment date, HCPCS code, description, diagnosis, and amount billed per patient. This report also provides summary totals for number of patients, claims, procedures, and amount billed.

1. Press **[3] Examine Claim Detail Report** from the Medicare Electronic Billing screen.

2. Select the number or letter of the transmission to: **[1] View Claim Detail On Screen**, or **[2] Print Claim Detail Report**.

Patient Totals Report

This report includes the patient's name and record number, number of procedures, and amount billed per patient. This report also provides summary totals for number of patients, claims, procedures, and amount billed.

1. Press **[4] Examine Patient Totals** from the Medicare Electronic Billing screen.
2. Select the number or letter of the transmission to: **[1] View Totals On Screen**, or **[2] Print Patient Totals**.

Provider Totals Report

This report includes the respective claims, procedures, and amount billed per provider. This report also provides summary totals for number of claims, procedures, and amount billed.

1. Press **[5] Examine Provider Totals** from the Medicare Electronic Billing screen.
2. Select the number or letter of the transmission to: **[1] View Totals On Screen**, or **[2] Print Provider Totals**.

Transmission Log

The Transmission Log screen provides a list of test and production transmission files. Included in this screen are:

Transmission number; date and time of claims file preparation; date and time of claims file transmission to Medicare; transmission mode (production, trial, or test); destination (four letter abbreviation of your Medicare fiscal intermediary); status of file integrity; and file size in blocks

Selecting the number or letter of a transmission will allow the user to view or print the confirmation number (unique filename) for the transmitted claim file:

1. Press **[6] Examine Transmission Log** from the Medicare Electronic Billing screen.

Delete Transmissions

The Transmission log holds a maximum of 99 Medicare electronic claims transmission files. When 99 transmission files are being stored, the oldest file is automatically deleted when building an electronic claims transmission file. To manually delete a Medicare electronic claims transmission file:

1. Press **[7] Delete Old Transmissions** from the Medicare Electronic Billing screen.
2. Select the number or letter of the transmission to delete. Old transmission files are typically deleted after payment has been received and posted.
3. Answer **[Y]es** if you are sure you wish to delete this transmission.

Received Reports

The received reports screen displays the type of report, and the date and time the reports were published on Medicare's Bulletin Board. The Error Summary Report (ESR) includes summary information regarding how many claims are being processed and rejected for a given claim file, while the Acknowledgement file (ACK) includes confirmation information that a specific transmission was received by Medicare.

1. Press **[8] Examine Received Reports** from the Medicare Electronic Billing screen.
2. Select the number or letter of the report to examine.

Receive Pending Reports

When choosing to receive pending reports, the system will automatically initialize the modem, dial Medicare's number, and receive any pending files, such as Medicare Electronic EOBs (835), Error Summary Reports (ESR), or Acknowledgment files (ACK).

1. Press **[9] Get New Files from Medicare** from the Medicare Electronic Billing screen.

Section Three: Medicare Electronic EOB Posting

Foreword

Avanta's Automatic Medicare EOB Posting Program is effective and easy to use. The Medicare EOB posting module automatically and intelligently posts electronic EOB information to each patient. The Automatic Medicare EOB Posting Program references each payment by date and treatment code, saving you time and effort.

Medicare sends electronic EOB information in the form of "835" files, which are then received by your Avanta system. Be aware that Medicare does not coordinate electronic with paper EOB information. This means that electronic "835" files may contain different EOB information than is printed on paper EOBs that you receive. Therefore, it may be difficult to balance your daily Medicare posting with the Daily Deposit Slip.
EXAMPLE: an electronic "835" file that is posted contains EOB information from three separate paper EOBs, which you have not yet received. Because of this, you will not be able to balance your posted items with Medicare check(s) on hand.

Previewing Medicare Electronic EOBs

It is recommended that you first preview before actually posting a Medicare electronic EOB. Previewing a Medicare electronic EOB proceeds exactly as actual posting, except that none of the changes are written to the practice files and patient ledgers are NOT CHANGED. Previewing creates a report that shows which EOB information is contained in the electronic file, how the electronic EOB payments will be applied, and if payments will be rejected during actual posting. If you are balancing against your checks on hand, this process is helpful in determining whether you should post your Medicare EOB.

The Automatic Medicare EOB Posting Program, whether previewing or posting, will not apply payments to ledgers unless the information matches exactly.
EXAMPLE: a payment, with a HIC number that is different than the patient's demographic HIC number, will not be posted. This is not true for HIC numbers that vary only with the last letter.

1. Press **[3] Post Payments/View Ledger** from the home screen.
2. Press **[9] Post Medicare EDI Remittance**.
3. Press **[1] Get New Files From Medicare** to receive new files from Medicare's electronic Bulletin Board. The system will initialize the modem, dial Medicare's number, retrieve any available files, and return you to the **[9] Post Medicare EDI Remittance** menu.

4. Press **[2] Preview 835 Remittance Contents**.
   WARNING: This function provides a preview of what will happen when you post an ANSI 835 remittance file. Everything proceeds exactly as it will during actual posting, except that none of the changes are written to the patient ledgers. The resulting report shows you what will happen when the file is actually posted. Is this what you want to do, **<Y>** or **N**?
5. Press **[Y]es** to continue with previewing a Medicare electronic EOB file, or **[N]o** to not preview a Medicare electronic EOB file and return to the previous screen.
   NOTE: there are three types of 835 files displayed, "Previewed on [date]," "[date]," and "Not Yet Posted!" files (denoted under the "POSTED" column). "Previewed on [date]" files have already been previewed and "[date]" files have already been posted; viewing or printing these previewed files will be explained in step 7. To continue with previewing a file, we are only interested in the "Not Yet Posted!" files.
6. Press the number or letter of the "Not Yet Posted!" file to preview the file. The Avanta system will now preview the Medicare electronic EOB, scrolling on-screen the information as it is processed and generating a report to be viewed on-screen or printed.
   NOTE: remember the date of the file being previewed (found under the "PUBLISHED" column). You will view or print the previewed file from a different screen, and will use the date to select the file.
7. Press **[4] Examine Remittance Posting Reports** to view or print the previewed file that has just been processed.
8. Select the number or letter of the desired "Previewed on [date]" file to view on-screen or print this previewed file.
   NOTE: use the date of the previewed file that was just processed (denoted under the "PUBLISHED" column) to choose the correct file to view or print.

Posting Medicare Electronic EOBs

After previewing a Medicare electronic EOB, you may now decide to move ahead with posting the file.

1. Press **[3] Post Payments/View Ledger** from the home screen.
2. Press **[9] Post Medicare EDI Remittance**.
3. Press **[3] Post 835 File To Patient Ledgers**.
   NOTE: there are three types of 835 files displayed, "Previewed on [date]," "[date]," and "Not Yet Posted!" files (denoted under the "POSTED" column). "Previewed on [date]" files have already been previewed and "[date]" files have already been posted.

4. Select the number or letter of the 835 file to be posted. Typically, it will be one that has been previewed already. The Avanta system will now post the Medicare electronic EOB, scrolling on-screen the information as it is processed and generating a report to be viewed on-screen or printed.
   NOTE: remember the date of the file selected for posting (denoted under the "PUBLISHED" column). You will view or print the posting report file from a different screen, and will need the date to select the file.
5. Press **[4] Examine Remittance Posting Reports** to now view or print the file that has just been posted.
6. Select the number or letter of the desired 835 file (denoted under the "POSTED" column) to view on-screen or print this posted file.
   NOTE: use the date of the file that was just posted (denoted under the "PUBLISHED" column) to choose the correct file to view or print.

Section Four: Third Party Electronic Billing

Foreword

Third Party electronic billing allows you to submit all your third party claims in minutes without having to print insurance forms. Because errors and incomplete information can prompt third parties to reject an entire batch of claims, both patient and submitter information are checked for completeness before claims are transmitted.

Setup

Before you can use Third Party Electronic Billing, you must receive a submitter number from your third party clearinghouse, complete all submitter information in your Avanta system's Physicians/Providers File, and identify all participating insurance companies in your Insurance Company File. This information is required to submit electronic Third Party claims. Please contact Avanta if your practice needs to be setup or changed, or if you have questions regarding Third Party Electronic Billing.

Prepare Claims For Transmission

To ensure that there are no problems submitting electronic Third Party claims, it is recommended that you first prepare a trial run before preparing an actual claim transmission. **[C] Prepare Reports From Trial Run** and **[1] Prepare Claims For Transmission** follow the same steps. However, preparing a trial run does not unflag charges or produce a transmittable claim file, such as occurs when preparing a production transmission.
WARNING: Ledger items are unflagged when claims are prepared, not when they are transmitted to Medicare. Therefore, Avanta recommends that claims not be prepared for transmission until completing a trial run with no billing rejects.

1. Press **[6] Insurance Billing/EDI** from the Home Screen.
2. Press **[3] Third Party Electronic Billing**.
3. Press **[C] Prepare Reports From Trial Run**.
4. Press **[Y]es** to continue with the trial run.
5. Select **[1] Process Current Group**, or **[2] Process All Patients**.
6. Select or de-select the Insurance Types to Include.
7. Select whether to transmit Accept Assignment items only. Selecting **[Y]es** will send only charges marked with an accept assignment flag (the lower case "a" next to the MD initials) on a ledger. Selecting **[N]o** will send all charges.

8. Mark the Condition Codes for the patients to be included or excluded. If no Condition Codes are selected, all patients will be included. A **[+]** will result in only those patients being included. A **[-]** will result in only those patients being excluded. All patients with at least one **[*]** will be included. Condition Codes marked with a **[.]** have no effect on the selection process.
9. Select or de-select the treating providers whose patients are to be included.
10. Select or de-select the place of service to be included.
11. Select a starting and ending date for the treatments to be included. Only those treatments with a date of service in this range will be included. Normally, no starting date is entered so that all charges are included. This allows for charges that may have been reflagged to be included.
12. Select **[Y]es** to use the treating physician as the referring source for patients that have no referring source on file.
13. Enter the beginning record number to print, if you wish to limit the patients to be included. If you are printing all patients the system will automatically start with patient **<1>**. If you are printing a group of patients, the system will automatically begin with the first patient in your group.
14. The system will now build a test transmission without unflagging ledger items.

Once the trial run has finished building, you can examine the billing reject messages. If problems are found during the trial run, the system will prompt you with the following message:
NOTE: Some claims were rejected because of data errors. Please see the electronic billing reject messages and correct all errors before attempting to submit these claims.
If this message appears:

1. Press **[2] Examine Billing Reject Messages** from the Third Party Electronic Billing screen.
2. Select the number or letter of the transmission you want to examine. The Transmission Log list is sorted from most recent to oldest, so the test claim you just built should be the first item on the list.
3. Select to **[1] View Messages On Screen**, or **[2] Print Messages**, and follow the printing instructions as you normally would.

The patient's record number and name are provided as well as an explanation or reason for rejection. For example, "Missing or Invalid Group #" or "Missing Birthdate" are common error messages that can easily be corrected in the patient's demographic screen. The Avanta system checks for completion of all required demographic, ledger, and Physicians/Providers File fields. However, it does not check the accuracy of this information; even after a clean trial run, insurance companies may still reject claims if the claim information is complete, but incorrect. After making the appropriate corrections, it is suggested that you prepare another trial run to ensure a clean final claim transmission.

If there are no reject messages or errors on your transmission, the system will prompt you with the message:
No Reject Messages On File =>
Press **[ENTER]** to continue and prepare claims for transmission

Transmit Claims

After preparing a trial run to detect and fix any errors, Third party claims need to be prepared for transmission. To prepare claims for electronic transmission to the Third Party clearinghouse:

1. Press **[6] Insurance Billing/EDI** from the home screen.
2. Press **[3] Third Party Electronic Billing**.
3. Press **[1] Prepare Claims For Transmission** to build transmittable claims, unflagging ledger items in the process.
4. Follow the same steps for preparing claims for transmission as you did for preparing the trial run.

Once the claims have been prepared for transmission, they are ready to be transmitted. To transmit claims to the Third Party clearinghouse:

1. Press **[7] Transmit Claims** from the Third Party Electronic Billing screen.
2. Select the number or letter of the claim transmission that you wish to send (normally transmission #1, which is your most recent transmission file).
   NOTE: make sure to check that the transmission is production file (denoted by "Prod" under the "Mode" column), and to verify the integrity of the claim file (denoted by a "Y" under the "OK" column).
3. When you select the transmission number or letter, the system will automatically initialize the modem, dial the clearinghouse's number, and transmit the claims.

Examine/Print/Delete

After the claims have been prepared for transmission, you can examine or print several claim transmission reports, either before or after your claim file has been transmitted. To examine and/or print reports, or examine and delete transmissions:

Claim Detail Report
The Claim Detail Report screen provides a list of transmitted claims, listing the following information:

Transmission number; date and time of claims file preparation; date and time of claims file transmission; transmission mode (production, trial, or test); status of file integrity; and file size in blocks.

Selecting the number or letter of a transmission will allow the user to view or print the patient's name and record number, treatment date, CPT code, description, diagnosis, AA status, and amount billed. This report also provides summary totals for number of patients, claims, procedures, and amount billed.

1. Press **[3] Examine Claim Detail Report** from the Third Party Electronic Billing screen.
2. Select the number or letter of the transmission to: **[1] View Claim Detail On Screen**, or **[2] Print Claim Detail Report**.

Patient Totals Report

This report includes the patient's name and record number, number of procedures, and amount billed per patient. This report also provides summary totals for number of patients, claims, procedures, and amount billed.

1. Press **[4] Examine Patient Totals** from the Third Party Electronic Billing screen.
2. Select the number or letter of the transmission to: **[1] View Totals On Screen**, or **[2] Print Patient Totals**.

Provider Totals Report

This report includes the respective claims, procedures, and amount billed per provider. This report also provides summary totals for number of claims, procedures, and amount billed.

1. Press **[5] Examine Provider Totals** from the Third Party Electronic Billing screen.
2. Select the number or letter of the transmission to: **[1] View Totals On Screen**, or **[2] Print Provider Totals**.

Delete Transmissions

The Transmission log holds a maximum of 99 Third Party electronic claims transmission files. When 99 transmission files are being stored, the oldest file is automatically deleted when building an electronic claims transmission file. To manually delete a Third Party electronic claims transmission file:

1. Press **[6] Delete Old Transmissions** from the Third Party Electronic Billing screen.
2. Select the number or letter of the transmission to delete. Old claims may be deleted after payment has been received and posted.
3. Answer **[Y]es** if you are sure you wish to delete this transmission.

Received Reports

The received reports include the report number, date and time received, and type of report ("Monthly" or "Daily"). The "Monthly" Report includes EOB-type information from the payor (insurance company), while the "Daily" Report includes acknowledgement and claim rejection information from the Third Party clearinghouse.

1. Press **[8] Examine Received Reports** from the Third Party Electronic Billing screen.

2. Select the number or letter of the report to examine.

Receive Pending Reports

When choosing to receive pending reports, the system will automatically initialize the modem, dial your Third Party clearinghouse's number, and receive any pending "Monthly" or "Daily" reports.

1. Press **[9] Receive Any Pending Reports** from the Third Party Electronic Billing screen.

Delete Received Reports

The Delete Received Reports screen provides you with the report #, date and time the report was received, and type of report ("Monthly" or "Daily").

1. Press **[A] Delete Received Reports** from the Third Party Electronic Billing screen.
2. Select the number or letter of the report you wish to delete.

Section Five:
HCFA 1500 Insurance Billing

Foreword

Insurance billing using the red HCFA-1500 forms is applicable to most insurance types. After all Practice Defaults and Treatment Files have been set correctly, there remain several run-time questions that may affect your paper billing.

Primary/Secondary Insurance Billing

To bill insurance via the HCFA-1500 form:

1. Press **[6] Insurance Billing/EDI** from the home screen.
2. Press **[4] Red HCFA-1500 Forms (Medi-Cal OK)**.

To process a single patient:
1. Select **[1] Process [current patient]**, **[2] Select Patient By Name**, or **[3] Select Patient by Record Number**.

OR

To process a group of patients or all patients:
1. Select **[4] Process Current Group**, or **[5] Process All Patients**.
2. Select **[1] Change Insurance Flags While Printing**, or **[2] Don't Unflag Ledger - Print Primaries Only**.
   NOTE: select **[2]** if you would like to print duplicate copies of your HCFA-1500 forms before running electronic claims.
3. Select or de-select the Insurance Types to be included.
4. Select whether to print forms by insurance company. Selecting **[Y]es** prints HCFA forms by insurance company.
   NOTE: Answering **[Y]es** to step 4 adds processing time, so printing your insurance forms will take significantly longer.
5. Select whether to print forms in Alphabetical Order. Selecting **[Y]es** prints HCFA forms by patient last name.
6. Select whether to print accept assignment items only. Selecting **[Y]es** will send only charges marked with an accept assignment flag (the lower case "a" next to the MD initials) on a ledger. Selecting **[N]o** will print all charges.
7. Select the Condition Codes for patients to be included or excluded. If no Condition Codes are selected, all patients will be included. A **[+]** will result in only those patients being included. A **[-]** will result in only those patients being excluded. All patients with at least one **[*]** will be included. Condition Codes marked with a **[.]** have no effect on the selection process.

8. Select or de-select the treating providers whose patients are to be included.
9. Select a starting and ending date for the treatments to be included. Only those treatments with a date of service in this range will be included.
10. Select whether to use the treating physician as the referring source for patients with no referring source on file.
11. Select **[Y]es** or **[N]o** to choose whether to: **[1] Print Primary Insurance Forms** and **[2] Print Secondary Insurance Forms**.
15. Enter the beginning record number to print, if you wish to limit the patients to be included. If you are printing all patients, the system will automatically start with patient **<1>**. If you are printing a group of patients, the system will automatically begin with the first patient in your group.
12. Follow the printing instruction as you normally would. Details on the alignment form and laser printer adjustments are explained in the next section.
13. Select whether to **[1] Generate Insurance Billing Summary** to be displayed on-screen or printed, or **[2] Generate Detailed Billing Report** to be printed.

Printer Alignment

It is possible that your laser printer may begin printing out of alignment, making it necessary to realign the text to print within the various HCFA-1500 fields. To check alignment of a laser printer, answer **[Y]es** to print an alignment form before printing your HCFA-1500 forms.

1. Press **[Y]es** to Print an alignment form.
2. The system will print rows of "X"s into all HCFA-1500 fields. Make sure all Xs fit within each field. If all Xs are contained within the designated fields, press **[N]o** to print another alignment form. The system will now continue to process and print your HCFA-1500 forms.

OR

1. Press **[Y]es** to print another alignment form, if the Xs do not fit within the fields. **NOTE**: the Align Red HCFA-1500 Forms screen allows you to correctly align the data to be printed on your forms. It will continue to print alignment forms as long as you answer **[Y]es** to print another alignment form. The units are noted in 1/36^{ths} of an inch.
2. Enter the desired amount to move the text up or down: entering a value less than the number within the "< >" brackets will move the text up the page. Entering a larger value will move the text down the page.
3. Enter the desired amount to move the text left or right: entering a value less than the number within the "< >" brackets will move the text to the left. Entering a larger value will move the text to the right.

Section Six: Open Insurance Report

Foreword

The new Open Insurance Report offers powerful features that allow you to report outstanding items to which insurance has not responded. This information will allow you to take specific measures, such as rebilling charges or contacting an insurance company, for collecting on these items. A key feature of this report is choosing to show open insurance items for both primary and supplemental insurance companies. The user may also choose to automatically reflag items included on the report, making it even easier to rebill non-responded to charges.

The Open Insurance Report employs a new convention for choosing report parameters: Now all parameters for running the report are displayed on a single screen, making the reporting process faster and easier.

The Open Insurance Report will print the patient's record number, name, address, phone number, date of birth, Social Security number, insurance type, primary and supplemental insurance company name, insurance ID number, insurance group number or name, and relationship to insured. For every open item, the report will print the item's date of service, CPT or HCPCS code, description, treating provider, amount charged, amount paid, date of billing, insurance type, days without insurance response, primary and secondary diagnoses, and summary information for amount charged, paid, and balance. The report will also include header information on the first page, displaying all parameters for how the report was run.

Open Insurance Report Setup Screen

1. Press **[7] Reports** from the home screen.
2. Press **[2] Ageings and Balances Due**.
3. Press **[4] Open Insurance Report**.
4. To set a parameter, move the cursor into that parameter's field and press **[ESC]** to view your options. For several parameters, pressing **[SPACE BAR]** from the Open Insurance Report Setup screen will toggle to the next value. Navigation keys are displayed at the bottom of each parameter's options screen. After selecting your options, press **[END]** to return to the Open Insurance Report Setup screen.
   NOTE: While the user may choose to modify only certain parameters, all parameters for running the Open Insurance Report are explained below. Also, the Avanta system will remember your parameter choices the next time you run this report.
5. When finished setting your report parameters, press **[END]** to compile and print the report, or press **[CTRL-X]** to exit and not run the report.

All Patients Or Group

- Select to consider **[1] All Patients**, **[2] Current Group**, or the number or letter of the desired saved group.
- ➢ **NOTE**: press **[PAGE DOWN]** to view saved groups on the next screen, or press **[PAGE UP]** to view saved groups on the previous screen.

Assigned Providers

- Select **[Y]es** to consider, or **[N]o** to not consider specific assigned providers.
- ➢ **NOTE**: you may press **[CTRL-Y]** to select all, or **[CTRL-N]** to select none of the assigned providers.

Insurance Types

- Select **[Y]es** to consider, or **[N]o** to not consider specific Insurance Types.

Condition Codes

- Select the Condition Codes to be considered. If no Condition Codes are selected, all patients will be considered. A **[+]** will result in only those patients being considered. A **[-]** will result in only those patients not being considered. A **[*]** will result in all those patients being considered. Condition Codes marked with a **[.]** have no effect on the selection process.

Plan Types

- Select **[Y]es** to consider, or **[N]o** to not consider **[1] Patients With No Plan**, **[2] Patients With A Plan Of Type HMO**, **[3] Patients With A Plan Of Type PPO**, or **[4] Patients With A Plan Of Type "None."**

Patient Balance Types

- Select **[Y]es** to consider, or **[N]o** to not consider patients with a **[1] Debit Balance**, **[2] Zero Balance**, or **[3] Credit Balance**.

Treating Providers

- Select **[Y]es** to consider, or **[N]o** to not consider treating providers.
- ➢ **NOTE**: you may press **[CTRL-Y]** to select all, or **[CTRL-N]** to select none of the treating providers.

Include Unresponded Items Billed To

- Select **[Y]es** to consider, or **[N]o** to not consider unresponded items that have been billed to **[1] Primary Insurance** or **[2] Supplemental Insurance**.

Companies To Include

- Select **[Y]es** to consider, or **[N]o** to not consider insurance companies.
- ➢ **NOTE**: you may press **[CTRL-Y]** to select all, or **[CTRL-N]** to select none of the insurance companies.

Primary Sort Order

- Select the primary sort order for your report by: **[1] Ins. Co. Amount Owed** (sorted by insurance companies that owe the greatest to least amount), **[2] Ins. Co. Name**, **[3] Ins. Co. Number**, **[4] Treating Provider Number**, **[5] Patient Name**, or **[6] Patient Number**.

Secondary Sort Order

- Select the secondary sort order for your report by: **[1] Ins. Co. Amount Owed** (sorted by insurance companies that owe the greatest to least amount), **[2] Ins. Co. Name**, **[3] Ins. Co. Number**, **[4] Treating Provider Number**, **[5] Patient Name**, or **[6] Patient Number**.
- ➢ **NOTE**: If one of the insurance company-related options (**[1]**, **[2]**, or **[3]**) is selected as the primary sort order, these options will be dimmed and unavailable as the secondary sort order. Similarly, if the treating provider-related option (**[4]**) or one of the patient-related options (**[5]** or **[6]**) is selected as the primary sort order, these options will be respectively dimmed and unavailable as the secondary sort order.

Event Detail Per Ledger Line

- Select to include **[1] None**, **[2] Partial (Only Pertinent Events)**, or **[3] All** event detail per ledger line.
  [1] None includes no event detail.
  [2] Partial (Only Pertinent Events) includes only billing event detail.
  EXAMPLE: `01/15/02 Billed 1st ins via HC1500    Ins 182: Quality Ins. Co.`
  [3] All includes all event detail, which may create a very long report.

Reflag Services Included On Report

- Select **[Y]es** or **[N]o** to reflag services that appear on the report.
- ➢ **NOTE**: this parameter is important to select correctly. Choosing **[Y]es** indicates that you want all services compiled by the report to be reflagged for rebilling at a later time.

Exclude patients who have appeared on report within the last ...... days.

- Enter the number of days in the **[……]** field to exclude patients who have appeared on the Open Insurance Report within this period of time.
- ➢ **EXAMPLE**: entering a value of "30" will exclude patients who have appeared on the report within the last 30 days.

Only include services not responded to by insurance for a period greater than or equal to …… days and less than or equal to …… days.

- Enter the number of days in the first **[……]** field to only include services not responded to by insurance for a period greater than or equal to this period of time.
- ➢ **EXAMPLE**: entering a value of "60" will only include services not responded to by insurance for 60 or more days.
- Enter the number of days in the second **[……]** field to only include services not responded to by insurance for a period less than or equal to this period of time.
- ➢ **EXAMPLE**: entering a value of "365" will only include services not responded to by insurance for 365 or fewer days.

Omit services with a balance due of less than $ ……

- Enter the dollar amount in the first **[……]** field to omit services with a balance due of less than the entered amount.
- ➢ **EXAMPLE**: entering a value of "5" will omit services with a balance due of less than $5.