What’s New in MedicalDirector Blue Chip 2.11
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Summary of the 2.11 Release

- Online Eligibility Check (OEC)
- Eclipse In Hospital Claiming (IHC)
- Permissions added for managing the adding, editing, and deleting of letters in patient records
- User password expiry management
- Modification to the invoicing process for Assistant surgeons
- Banking History Report enhancements
- Windows 10 compatible

Eclipse In Hospital Claiming (IHC) and Online Eligibility Checking

In Hospital Claiming

In Hospital Claiming (IHC) allows public and private hospitals, and day facilities, the ability to submit a claim in relation to the patient’s hospital stay;

- Creation of the estimate for the hospital stay
- Online eligibility checking using the hospital estimate
- Invoice creation using the hospital estimate
- In Hospital Claim creation for the hospital episode
- In Hospital Claim submission to the health fund via Department of Human Services
- In Hospital Processing report
- In Hospital Payment report
- Banking/Reconciliation

Online Eligibility Checking

Online Eligibility Check lets you check the eligibility of a patient with the Department of Human Services or private health insurers to estimate out-of-pocket expenses and benefits payable for medical services.
Prerequisites for IHC and OEC

- Register for Eclipse In Hospital claiming with Department of Human Services and obtain a PKI certificate.
- Create separate fee lists for Hospital and Providers for each health fund (e.g., IHC BUPA with hospital fees and IMC BUPA / BUPA with provider fees).
- Before creating an Estimate, you must configure your various Company Groups with their appropriate Address Types via Setup > Lists > Company Groups. For example, a company group called ‘Health Funds’ has to be created in order to send claims to various health funds. Health funds used in patient details are sourced from the ‘Health Funds’ company group list.
- Diagnostic Related Group (DRG) code is mandatory for the submission of In Hospital Claims.
  - Another term also used is AR-DRG (Australian Refined Diagnosis Related Groups), refers to an Australian admitted patient classification system, providing a clinically meaningful way of relating the number and type of patients treated in a hospital (i.e. case mix) to the resources required by the hospital.
  - MedicalDirector Day Surgery integrates with 3M Group application.
    - Day Surgery does not integrate with other types of Grouper software.
    - Not all Practices will need to purchase this application.
    - Dependent on the procedural items used, it is possible to manually code the episode to the related DRG (i.e. use a summary of items and related DRG codes).
    - Most health fund contracts will have the DRGs listed even when the fees are not based on the DRG code. Contact your Health Funds to enquire about the DRG, in most cases they will be able to help by providing you with a list of DRG’s, relevant to your contract that can be used to manually code the episode.
- MedicalDirector Blue Chip Day Surgery requires MS Access 2007 and above.
- Editing the template letterheads for new IHC classes
In Hospital Claiming

New: Create and Configure the Batch

Practices can create an IHC (In Hospital Claiming) batch for sending In Hospital claims to the health fund.

1. Select **Setup > Practice > Batch Types**. The **Batch Setup** window appears.

2. From the Batch Setup window, click **New...** The **New Batch Type** window appears.

3. Enter a name, and select the **ECLIPSE-IHC (In Hospital Claiming)** method, as shown below.

4. Click **OK** to confirm your selection. You are returned to the Batch Setup window, where the IHC Batch Type is now available.
5. To configure the IHC (In Hospital Claiming) batch type, click The Eclipse IHC Setup window appears with the Patient Verification tab selected.

6. Within the Patient verification prior to invoicing through Medicare ECLIPSE section, select whether you wish to conduct a patient verification for every claim ('Always'), or only for those patients for whom you have indicated a verification must take place ('When required for patient'). This latter setting is made via the ‘Patient Details’ window.

7. Within the Patient verification prior to invoicing through Medicare ECLIPSE section, indicate the type of verification you wish to make, from the following options:
   - Medicare/DVA only: verifies the Medicare/Veteran details of the patient.
   - Medicare/DVA and Fund: verifies both the Medicare/Veteran and the Health Fund details of the patient.
   - Fund only: verifies the Health Fund details of the patient.
8. Ensure the **Enable Health Fund capability validation**... check box is ticked, as shown below. This checks whether the Health Fund selected for the claim participates in Medicare ECLIPSE.

9. Select the **IHC Insurers** tab. Click **Update**... to have MedicalDirector Blue Chip automatically update the insurers list (requires an active Internet connection), after which all insurers who participate in IHC and OEC will be flagged as such.
10. Eclipse In Hospital Claiming requires all the prosthesis items to have a prefix (PX00) for all health funds except Department of Veterans’ Affairs.

NOTE: During the upgrade to 2.11, prosthesis codes for health funds are set by default. You can edit the prosthesis code by typing a new code. Change the prosthesis code for a specific healthfund by going to Setup > Lists > Company Groups.

Click [Change Prosthesis Code]. Prosthesis codes for the various health funds (e.g. CBH for CBHS HealthFund Limited) can be edited by typing a new one.
11. In the **Medicare Australia System** tab, the URL listed below must be set for ‘Server’ and ‘Recipient’ for you to send claims;
   - **Server**: test.mcoe.humanservices.gov.au/ext
   - **Recipient**: ebus.test@medicareaustralia.gov.au

12. Select the **Network** tab to define your network information. This is used when sending claims to Medicare Online Claiming over a network.

13. Select the **Location and Authentication** tab. It is at this time you must enter the Location ID, Passphrase and Crypto Store Location for your encryption certificate. This information will be supplied to you by Medicare. It may be that you already have this information recorded if you have already configured MedicalDirector Blue Chip for Medicare Online claiming.
14. Click **Setup Wizard**. The **IHC Setup Wizard** appears. In this step of the wizard, we need to indicate which Company Groups from our database are health funds for In Hospital Claiming.

   - The left section of this window lists our Company Groups to select from.
   - The right section lists the Company Groups that are health funds for IHC. Initially this section will be empty.

15. Within the **Company Groups** section, locate and double-click the group(s) you wish to add to the Health Fund Groups section. Alternately, you can select a group, and then click to move them into the Health Fund Groups section.

16. Click **Next >**. You are presented with Step 2 of the wizard. In this step of the wizard, you need to indicate for each of the Health Funds(Companies) from our selected Company Group(s);

   - Their Insurer Code.
   - The Hospital Fee List to use when billing.
   - Whether they have an EPM (Equitable Payment Model) contract. Equitable Payment Model (EPM) is a contracting model used by the Australian Health Services Alliance (AHSA) Health Funds.

   a. Double-click within the **Insurer Code** field to reveal a drop-down list of options to select from.

   b. Double-click within the **Fee list** field to reveal a drop-down list of Hospital fee list options to select from.

   Alternatively, you can also link the Health Fund with the Hospital Fee List it uses, as shown below. This is important for In Hospital claiming and estimates. This can be done via the ‘Company Details’ window for the Health Fund. See “Health Funds (Adding and Editing)” for more information (press F1 to open the Blue Chip Help).
c. Tick the **EPM check box** for companies that offer Equitable Payment Models.

17. Click **Next**. You are presented with Step 3 of the wizard. In this step of the wizard, we need to indicate for each of the Health Funds (Companies), which practitioners have Equitable Payment Models.

   a. Select a health fund from the **Health Fund** section. The **Practitioners in Non-EPM** section will become populated with the practitioners associated with the selected health fund. It is initially assumed that none of the practitioners have EPM (Equitable Payment Model) contract.

   b. Within the **Practitioners in Non-EPM** section, locate and double-click each practitioner who has EPM (Equitable Payment Model) contract with the Health Funds. They will be moved to the **Practitioners in EPM** section.
New: Create the Class

1. Select Setup > Practice > Classes. The Class Setup window appears.

2. Click New. The Copy window appears. Enter a name and abbreviation for In Hospital Claiming, an example of which is shown below. Because you are creating a new class, leave the 'Copy from Class' selection as 'none'.

3. Click OK to continue. You will be returned to the Class Setup window.

4. Select the IHC Account Class and then Payment Options tab.
5. On the **Payment Options** tab;
   - Locate the **Batch Type** dropdown list, and select **IHC** batch type you created in the Step 1.1.
   - Locate the **Addressee** dropdown list, and select **Health Fund (from membership)**.
   - Locate the **Company Groups for Health Fund** dropdown list, and select **Health Funds**.

![Class Setup window](image)

6. Click **OK** to save the IHC Class setting and close the Class Setup window.

7. **Configuring Day Surgery for In Hospital Claiming (IHC):** Select **Setup > Practitioner > Practitioner Details**. The **Practitioner Setup** window appears.

![Practitioner setup window](image)

8. Within the **Practitioners** section select your Day Surgery. Select the **Class Usage** tab. Tick the check box for the IHC class you created in the previous step.
9. Select the Class Options tab.
   a. Within the Class section, select the IHC claiming class. The Options for IHC section will populate with all Service Item Lists.
   b. Within the Options for IHC section, enable each of the Service Item Lists that you want to use IHC with, by ticking their associated check boxes.

   ![Practitioner Setup Window]

   Repeat steps a) and b) for each practitioner who wishes to use IHC.

10. Click **OK** to save your changes and close the Practitioner Setup window.
New: In Hospital Claim Service Items Setup

Before you can claim via Eclipse In Hospital Claiming, all Day Surgery Service Items must be assigned the appropriate service type required for creating invoices and claim submission, keeping in mind the following conditions;

- Each Service Item you wish to bill for IHC needs to be configured with a service type.
- The ‘Procedure Type’ applies to MBS, MBS Case Payment, and DVA Case Payment only.
- The ‘Theatre Band’ setting is mandatory for ‘MBS’ service types. The process of configuring each Service Item needs to be performed only once. This can be done in two ways;
  - **Method 1:** Click to update all the properties of the items in the Service Item list.
  - **Method 2:** Update each item in the Service Item List separately.

**Method 1: Via the ‘Update IHC Items’ Button**

MedicalDirector Blue Chip provides a master list of standard MBS, Prosthesis, and Miscellaneous items and their associated properties. This list can be used to update the Service Item list of the practice in MedicalDirector Blue Chip. Any custom items, including case payments, need to be updated by the practice.

**NOTE: ONLY MBS, PROSTHESIS, and MISCELLANEOUS SERVICE ITEMS CAN BE UPDATED USING THE MASTER FILE PROVIDED BY MEDICALDIRECTOR BLUE CHIP.**

1. Select **Setup > Lists > Service Items.** The **Service Items List** window appears.

2. Select the service item list you wish to update. We have selected DS MBP.

3. Click **Update IHC Items**. The **Fee Import** window appears.
4. Click Open. The Select Fee File window appears.

5. Select the master file (e.g. Service Item import), as shown above.

6. Click Open. You are returned to the Fee Import window.

7. Tick the Apply to More Fee Lists check box to apply it to multiple service item lists. DS MBP will be selected already. Select other multiple service item lists as desired (e.g. DS DVA, Test BUPA)

8. Click Process. The Fee Import window shows all the items that are updated with the properties for multiple service item lists (e.g. DS MBP, DS DVA, Test BUPA).

NOTE: Only those Service items from the practice service items list (e.g. DS MBP, DS DVA and Test BUPA) that match Service Items in the master list (e.g. Service Item import) are updated.
9. You can view which service items get updated by accessing the Service Item List. Select Reports > BC Reporter. Login with your username and password. The Blue Chip Custom Reporter appears. Select Services and then IHC Service Item List.

![Image of Blue Chip Custom Reporter]

You can view which service items get updated by accessing the Service Item List. Select Reports > BC Reporter. Login with your username and password. The Blue Chip Custom Reporter appears. Select Services and then IHC Service Item List.

10. Select the Input tab. The exact name of the service item list (e.g. DS MBP) must be entered in the ‘Value’ field.

![Image of Blue Chip Custom Reporter Input Tab]

Select the Input tab. The exact name of the service item list (e.g. DS MBP) must be entered in the ‘Value’ field.

11. Select Output tab. The ‘Selected Fields’ section should display the fields ITEM, Service Type, Theatre Band, and Procedure Type.

![Image of Blue Chip Custom Reporter Output Tab]

Select Output tab. The ‘Selected Fields’ section should display the fields ITEM, Service Type, Theatre Band, and Procedure Type.

12. Click [Execute] Microsoft Excel will attempt to open the report, and you will be prompted that the file you are trying to open appears to be in a different format to what Excel expected. Ignore this prompt by clicking Yes.

**NOTE:** ONLY MBS, PROSTHESIS AND MISCELLANEOUS SERVICE ITEMS CAN BE UPDATED USING THE MASTER FILE AS LONG AS THESE ITEMS ARE PRESENT IN PRACTICE SERVICE ITEM LIST.
13. The report opens in Microsoft excel with matching items updated and the items that do not match are blank.

14. You can now view the report, and update the custom Service Items (e.g. ACC1, 30473C) with missing properties (blanks/none) by entering the appropriate properties.

15. Once any custom service items with missing properties are updated, save the file with the format of .csv...

16. ...and then re-import it to update all the service items with missing properties (by following the same steps outlined above).

17. Repeat this process for all your Service Item lists for use with In Hospital claiming.
Method 2: Update Each Service Item in the Service Item List Separately.

1. Select Setup > Lists > Service Items. The Service Items List window appears.

2. Select the service item list you wish to update. We have selected DS MBP.

3. Click Items... The Service Items window appears.

4. Select the item you wish to configure IHC settings for, and then click the IHC Service Type button. The Edit IHC Item Details window appears.

5. Indicate the Service Type, Theatre Band, and Procedure Type for this service item as required.

6. Click OK to confirm the changes.

7. Perform Steps 4-6 for each service item in the Service Item List.

8. Click Close to exit the Service Items window.
New: Importing Prosthesis/Miscellaneous Service Item List into a Health Fund Service Item List

An estimate created for in hospital online eligibility checking requires the prosthesis and miscellaneous items to be in the health fund service item list. This can be achieved by importing the prosthesis and miscellaneous service item lists (DS Prosthetics) into Health fund service item lists (e.g. DS MBP, Test BUPA).

1. Service item fee list for Prosthesis and Miscellaneous must be created in excel file (.csv) and saved.
2. Select Setup > Lists > Service Items. The Service Items List window appears. Select a Service item list and then click User Defined Fee Update…

   ![Service Items List Window](image)

3. The Fee Import window appears. Select the service item file (e.g. DS Prosthetic).

   ![Fee Import Window](image)
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4. Tick the **Apply to More Fee Lists** check box. DS prosthetic list can be imported into multiple Health Fund service item lists (e.g. Test BUPA). Click **Process**.

5. Prosthetic items are now added into Health fund service item lists (e.g. DS MBP and Test BUPA)
New: Linking MedicalDirector Blue Chip to Day Surgery

In Hospital claim generation in MedicalDirector Blue Chip requires that a related Day Surgery Episode be created. Before this can occur, a link between Blue Chip and Day Surgery must be established, through which the Episode data will be extracted from Day Surgery.

Before setting the link in Blue Chip for extracting the data, you must create an ‘Output’ folder in your DS (Day Surgery) folder. This folder is where the episode extract is stored. Also, the Day Surgery Extractor (DS IHC) provided by MedicalDirector must be placed in the DS (Day Surgery) folder, and the paths for Episodes, Data, and Output must be configured.

Step 1: Preparing the Day Surgery Extractor, and Episode Paths in Microsoft Windows.

1. Locate your Day Surgery program folder.
2. Within the DS folder, create a new folder called Output.
3. Grab the DSIHC (Day Surgery IHC extractor) file provided by MedicalDirector, and drop it into the DS folder.
4. Double-click the DSIHC file. The **DS File Locations** window appears.

![DS File Locations window](image1)

5. Locate the **Episodes** text box, and click its associated button. The **Browse** window appears.

![Browse window](image2)

6. Locate and select the **DS Episodes** file in your DS folder.

7. Click **OK**. You are returned to the **DS File Locations** window.

8. Select also the paths for both the **Data** and **Output** folders.

![DS File Locations window](image3)

9. Click **to save.**
Step 2: Configuring Day Surgery within Blue Chip

1. Within Blue Chip, select **Setup > Practice > Links > Day Surgery**. The **Day Surgery Setup** window appears.

2. Tick the **Enable IHC Extract** checkbox.

3. Locate the **Day Surgery IHC Output Folder** path, and click **Browse**. The **Browse for Folder** window appears. The Output folder you created earlier should be selected automatically. If it is **not**, locate and select it now.

4. Click **OK**. The link to your **Output** folder now appears within the **Day Surgery IHC Output Folder** path, as shown in the example below.

5. Click **OK** on the **Day Surgery Setup** window to save these settings. This concludes the steps necessary for configuring Day Surgery for IHC.
New: Create Estimate for Private Billing and In Hospital Stay

In MedicalDirector Blue Chip, Estimates are created prior to performing an eligibility check. Before creating the Estimate, the Service Items setup must be completed, as described earlier. Estimates are created by the practice to provide a quote to the patient for their out-of-pocket expenses.

Estimate for In Hospital Care

1. An Estimate is created for the patient’s stay at your day surgery by opening the patient’s record, and selecting the Estimates entry in the menu on the left.

2. With the Estimates window active, click New... The ‘New Estimate of Fees’ window appears.

   a. As this is an estimate for In Hospital Claiming, you must select the hospital the claim relates to. Tick the In Hospital Services check box, and then click the button to select the desired hospital from your database.

   b. Tick the Health Fund check box. You can then indicate which Fee list the H/F Rebate is based on via the associated drop-down list.

   c. Ensure the Practitioner e.g. Day Surgery is selected.

   d. Ensure the Class selected is your Day Surgery class.

   e. Ensure that Issue to is Health Fund (from membership).

   f. Enter service items (e.g. 32093 for colonoscopy).

   g. Specify the expiration date for this estimate.

   h. Name the estimate, for future reference.

3. Click OK to save the Estimate. This in hospital Estimate can be used to check the eligibility.
Estimate for a Private Billing Account

1. An estimate is created for the practitioner (Dr Bevan Ayers) by opening the patient’s record, and selecting the ‘Estimates’ entry in the menu on the left.

2. With the Estimates window active, click New. The ‘New Estimate of Fees’ window appears.

   a. Select the practitioner who is performing the procedure
   b. Select the day surgery or the hospital where the surgery is performed. Tick the In Hospital Services check box, and then click the ... button to select the desired hospital from your database.
   c. Ensure the Class selected is the class that is setup for In Hospital Claiming
   d. Ensure that Issue to is Health Fund (from membership).
   e. Tick the Health Fund check box. You can then indicate which ‘Fee list’ the H/F Rebate is based on via the associated drop-down list.
   f. Enter service items (e.g. colonoscopy: 32093).
   g. Specify the expiration date for this estimate.
   h. Name the estimate, for future reference.

3. Click OK to save the Estimate. The inpatient medical estimate can be used to check eligibility (medical benefits) for this procedure.
New: Online Eligibility Check

Practices can perform an online eligibility check prior to the arrival of the patient on the day of the appointment.

An online eligibility check report will have details about the patient’s out-of-pocket expenses, and medical benefits payable by Department of Human Services and the Health Fund, assisting the patient with providing informed financial consent.

For instance, an eligibility check can be performed for a patient who has booked an appointment for procedure (e.g. colonoscopy) in your day surgery.

You can select from the 3 types of Online Eligibility Checks in Eclipse;

- **Hospital-only check (ECF)** determines whether the patient is eligible for the selected presenting illness or condition on the admission date. It provides the out-of-pocket expenses for excess, exclusions, and co-payments associated with the patient’s hospital episode.
- **Medicare-only check (ECM)** determines whether the patient is covered by Medicare, and what benefits are payable for in-patient medical services.
- **Hospital and medical checks at both Medicare and the private health insurers (OEC)** determines whether the patient is eligible for a presenting illness or condition on the admission date. It provides the out-of-pocket expenses for excess, exclusions, and co-payments associated with the patient’s hospital Episode, and the Medicare and the private health insurer benefits payable for the medical services.

In order to perform the eligibility check to determine the out-of-pocket expenses associated with the hospital episode, the estimate (Example Estimate) created for the patient’s hospital stay in the previous section is selected.

1. Within the patient’s record, select the Estimates menu, and then the in hospital estimate (Example Estimate) to perform the check.

![Estimates menu screenshot](image)

2. Click OEC. The Online Eligibility Checking window appears.

![Online Eligibility Checking window](image)

The ‘Both (OEC)’ option is selected by default so that you can check both the out-of-pocket expenses such as excess, exclusions, and co-payments associated with the patient’s hospital episode, and the Medicare and private health insurer benefits payable for the medical services.
3. At this point you can continue with the default ‘Both (OEC)’ option, or select the Fund (ECF) option to check the out-of-pocket expenses such as excess, exclusions, and co-payments associated with the patient’s hospital episode (stay).
   - If you wish to continue with the default ‘Both (OEC)’, proceed now to Step 7.
   - If you choose to select ‘Fund (ECF)’, any pre-populated data and item numbers (e.g. colonoscopy: 32093) from the estimate and patient details will be deleted, as indicated in the prompt that appears. Click OK to continue.

   ![Image of the warning prompt to delete pre-populated data]

   The ‘Online Eligibility Checking’ window will appear with Fund (ECF) selected. Proceed to Step 7.

   ![Image of the ‘Online Eligibility Checking’ window]

   If you wish the Fund (ECF) option to default so you can check the out-of-pocket expenses such as excess, co-payments, and exclusions with the associated hospital stay, an estimate with only the prosthesis and miscellaneous items used during the patient’s episode at your day surgery is created.

   ![Image of the new estimate of fees]

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Select ‘Example Estimate 3’ and click OEC.

The Online Eligibility Checking window appears. Proceed now to **Step 7**.

In order to perform the eligibility check to determine the benefits payable from Department of Human Services and the health fund, the estimate (Example Estimate 2) created for practitioner (Bevan Ayers) performing the procedure is selected.

4. Within the patient’s record, select the **Estimates** menu item. Select the estimate (for e.g. Example Estimate).
5. Click **OEC**. The **Online Eligibility Checking** window appears. The **Both (OEC)** option is selected by default, so that you can check both the out-of-pocket expenses such as excess, exclusions, and co-payments associated with the patient’s hospital episode, and the Medicare and private health insurer benefits payable for the medical services.

6. At this point, you can continue with OEC, or you can choose Medicare (ECM) to find only the benefits payable by Medicare.
   - If you wish to continue with Both (OEC), proceed now to **Step 7**.
   - If you select 'Medicare (ECM)', pre-populated data from estimate and patient details will be deleted. You will be prompted to confirm this action. Click **OK** to continue.

   The **Online Eligibility Checking** window appears. Proceed now to **Step 7**.
7. Mandatory fields for all 3 eligibility options are marked in **bold** and an asterisk (*), and differ for each option.

- Most of the patient data (Patient Name, Gender, Patient Alias Name, Date of Birth, Medicare No., Fund Membership No., and ORG Fund Payee ID) is sourced from the patient’s record (Patient Details window). The default membership number in the patient details is used as the Fund Membership no. If there is no default membership number recorded, the latest fund membership number in the patient details is used. If there is no fund membership number in patient details, it must be entered manually.

- Some of the fields (Service Type, Compensation Claim, Pre Existing Ailment and Accident Indicator) are populated by default. Ensure this data is checked and all the other mandatory fields (Principal Provider number, Servicing Provider Number, Admission Date, Discharge Date, Presenting Illness Item Number or Presenting illness code, Accident indicator) has been entered.

- Most of the services data is populated from the estimate. E.g. item 32093 is populated in the online eligibility form.
Based on the service type (MBS, Prosthesis, and Miscellaneous), each service item will have mandatory fields (Service Date, Service Quantity, Service Rate) that must be completed. For example, Service Date is mandatory for Service Type MBS.

8. Upon attempting to submit the form by clicking Submit, you will be prompted to provide any mandatory data you have missed.
9. The (OEC) – Processing OEC window appears. Online Eligibility Check is sent to Medicare and health fund for processing.

10. After submitting the eligibility check processing, you will be returned to the Estimates window. Notice in the example below that the estimate is now assigned an OEC ClaimID. The status of the check is displayed. In our example, the claim’s status is ‘Awaiting Process Report’

11. Click Practice Explorer located at bottom-right of your screen, and then select Medicare Australia from the margin menu window to retrieve the Online Eligibility Check process report.

12. In the Medicare Australia window, choose the claim type Online Eligibility Checking OEC and the online eligibility claim appears.
13. Select the claim and click **Transmit**. The Medicare Australia – Processing Claim(s) window appears. Online Eligibility Check (OEC) report is downloaded.

![Medicare Australia - Processing Claim(s)](image1)

14. Click **Close**. The claim status is changed to ‘Process Report Received’ after the process report is downloaded.

![Medicare Australia - Online Claims](image2)

15. Select the claim with the ‘Process Report Received’ status and click **Open** to view the result (Accepted/Rejected) of the online eligibility check.

![Online Eligibility Check](image3)
16. Click **Finalise** to finalise the OEC claim. You will be prompted to print the Online Eligibility Check Report.

17. Click **OK** to print. The **Print Online Eligibility Check (OEC) Report** appears.

18. Choose the printer to print to, and click **Next**. The Online Eligibility Check report provides a detailed explanation of the out-of-pocket expenses, and the benefits payable from Medicare and the Health Fund. The information can differ based on the type of check performed. The OEC report opens in Microsoft word and can be printed.

If you click **Cancel** instead, you can print the Online Eligibility Report by returning to the Estimates window, selecting the Estimate, and clicking **Print OEC**.
Resubmitting an Online Eligibility Check (OEC) Claim for an Existing Estimate

There are instances where an online eligibility check (OEC) request is performed multiple times for the same episode without creating a new estimate. This can be achieved by resubmitting Online Eligibility check (OEC) claim for an existing estimate by deleting the OEC claim.

1. An estimate is created, OEC claim is submitted and the OEC report is retrieved. If the same estimate is to be used again for another OEC, the OEC claim is deleted by clicking on ‘Delete’. The reason has to be entered and click ‘OK’.

2. Uncheck ‘Exclude Finalised claims’ to view the deleted OEC claim which is highlighted with a strike-through.
3. In the Estimate window, the estimate has ‘Finalised (Deleted)’ status which indicates that estimate is no longer associated with the claim.

4. The OEC request can now be resubmitted by highlighting the estimate and clicking the ‘OEC’ button.

5. The ‘Online Eligibility Checking’ window appears. The data from the previous OEC claim is populated. The data can be modified and submitted by clicking on ‘Submit’.

6. The submission and retrieval process is same as regular OEC claim and is done in Medicare Australia window.
New: Create the Invoice

After the online eligibility check is performed and informed financial consent is received from the patient, an estimate created for the hospital stay is used as the basis for the invoice to claim for In Hospital services.

1. Open the patient’s record, and select the Estimates margin menu. Select the Estimate and click Create Invoice.

2. Via the Select Account window, select the account for which an invoice must be created. Click OK to continue.

At this time you may be prompted to verify the patient if you have not previously done so, or if you have ‘patient verification’ configured under the In Hospital Claiming Batch Setup to conduct the check before invoicing. Patient verification ensures that claims can be made for bona fide patients. Click OK to initiate the verification process. Alternatively you can ‘ignore’ the verification process for now.
3. The **New Invoice** window appears. The items (e.g. 32093) from the estimate are populated in the invoice.

![New Invoice Window](image)

- Additional Service Items (Accommodation – ACC1, Case payment) can be added to the invoice. For each item, you can:
  - Modify the date the service was performed.
  - Enter the service item number (by clicking into the item field, and then either typing the number or pressing Enter to search for items). *As this invoice is specifically for IHC, only IHC items are available (see section 1.3 In Hospital Claim Service items Setup)*
  - Modify the fee (if you want to alter the default fee value).
  - Modify the Item Description (if you want to alter the default).

- Optional:
  - Add an invoice message.
  - Indicate the hospital where hospital services were performed.

4. Click **Issue** to issue the invoice. You will be prompted to indicate whether this invoice is associated with a referral for the patient. Select a referral, or choose the Not Applicable option, and then click ‘Select’ to continue.
5. The **Issue Invoice** window appears, prompting you to enter the date on which the invoice was issued (with the current date being the default).

![Issue Invoice Window]

6. Click **OK** to confirm. You are returned to the patient's record, where the new invoice is now visible on the Invoices tab for the account.

7. Before you can submit this invoice for processing, you must first record the episode in **Day Surgery**. Select the invoice and click **Open**.

![Record Episode in Day Surgery]

8. Once the invoice window appears, click **Create Day Surgery Episode**.

![Create Day Surgery Episode Window]
9. The **Day Surgery Module** window appears. You will be prompted to create a new Episode. Click **Yes** to continue. 
   *Note: Refer to *How to Link an Invoice to an Existing Day Surgery Episode* if you want to link the invoice to an existing episode.*

![Image of Day Surgery Module window with prompt to create a new Episode]

10. The **Day Surgery Module** opens. Episode details can be recorded by entering information in all the tabs.

![Image of Day Surgery Module interface with episode details]

Once the episode is completed, the Day Surgery module can be closed. You are returned to the patient’s record.

![Image of HIC Submission button in the Day Surgery module]

11. Click **IHC Submission** to continue the claim creation.
12. Once the ‘IHC Submission’ is clicked, you will be prompted that a Day Surgery episode must be completed:
   - Click Yes if the Day Surgery episode is completed.
   - Click No if it is not completed. Complete the Day Surgery Episode before proceeding.

13. The New In Hospital Claiming (IHC) form appears. All relevant data from the Day Surgery Episode and MedicalDirector Blue Chip is pre-populated on this form.

The New In Hospital Claiming (IHC) form consists of seven tabs of information:
   - Claim / Patient
   - Episode
   - Accommodation/SVB
   - Services
   - DRG Morbidity
   - Certificates / Transfers
   - Remarks

Important:
   - All fields marked in bold with * are mandatory, and must be completed in order to submit the In Hospital Claim.
   - Some fields are pre-populated. Check these fields to ensure the correct data is present.

Note: The following section provides a brief overview of each of the tabs presented on the New In Hospital Claiming window. If you wish to skip this information, you can proceed directly to Step 14.
New: New In Hospital Claiming Window Overview

Claim/Patient Tab
- Displays both Patient Details and the Claim Summary.
- Most patient data is sourced from the patient’s details in MedicalDirector Blue Chip. The patient’s Medical Record ID is sourced from Day Surgery.
- In the Claim Summary section, Total Hospital Charge amount and Total charge amount must reflect the total invoice amount.

Episode Tab
Displays most of the Episode data sourced from Day Surgery.
Accommodation/SVB Tab
Displays the accommodation details of the Episode. If the accommodation is charged as per diem, bundled, or DRG case payment, the accommodation fee from the invoice is displayed in the Charge Amount field. The day band of the Episode is also sourced from Day Surgery.

Services Tab
This tab is divided into Principal Services, Multiple Services, and Miscellaneous. The Service Code field displays Service Items of type ‘MBS’.
DRG Morbidity
The DRG code, Principal and Additional diagnosis is displayed here.

Certificates/Transfers
Displays certificate and transfer information.
Remarks

General/additional notes regarding the claim to be sent to Medicare can be entered in the Remarks section.

14. At this point, you have the following options;
   - Click Save to save the claim information now, and send it later.
   - Click Send to send the claim information. If any mandatory fields are missing information, you will be prompted to complete them before proceeding. Only completed forms can be sent to Medicare.
   - Click Recreate IHC Submission to reload Episode information if any is changed for any reason.
Claim Submission

1. Click Send to submit the claim. The In Hospital Claiming (ECLIPSE) – Processing IHC window appears. If there is a validation error, the client adaptor will display the claim error, and the claim will not be submitted and will show as status of ‘Awaiting Submission’ in Medicare Australia window. If there is no error, the claim is submitted, and will show a status of ‘Awaiting Process Report’ in the Medicare Australia window.

   **Example 1: Claim Error when submitting.**
   You can modify the data to rectify the error. In the example below, the ‘from’ date should be before the ‘to’ date, or is missing. Once this is rectified, the claim can be submitted successfully.

   ![Claim Error Example Image]

   **Example 2: No Claim Error when submitting.**
   Claim will be submitted successfully.

   ![No Claim Error Example Image]

2. Once the Claim ID is generated, click Practice Explorer at the bottom-right to continue the retrieval of processing and payment reports.

   ![Practice Explorer Image]
3. In the practice explorer window, select **Medicare Australia** from the margin menu. The submitted claim appears at the top of the list, with a status of ‘Awaiting Process Report’.

**NOTE:** Some claims may have a status of ‘Awaiting Submission’. Claims with this status would have failed the Client Adaptor validation, and will have to be edited to ensure successful submission.

4. Click **Transmit** to retrieve the processing report. When the processing report is being retrieved, the response sent by the fund can be ‘rejected’ or ‘interim’ or ‘final report’.

**Handling rejected reports with a status of ‘Ready to Finalise(R)’:**

a. The rejected claim can be viewed by double clicking it. Within the In Hospital Claim (IHC) Results window that appears, the results of processing (such as the rejection code and description) can be viewed. Click **Close** to return to the ‘Medicare Australia’ window.
b. In the ‘Medicare Australia’ window, click **Rejected** to process the rejected claim.

c. The **In Hospital Claim (IHC) – Rejected Items** window appears. Rejected Items can be left unpaid or written-off. Click **OK**.

d. You will be prompted to continue processing the rejected claim. Click **Yes**.
The rejected claim is now Finalised and status is changed to **Finalised (Rejected)**.

Handling Interim Processing Reports with a status of ‘Awaiting Process Report (Interim)’: If the interim processing report is available after the Transmit button is clicked, the status changes to ‘Awaiting Processing (Interim)’. The health fund will transmit the interim report to inform you of the reason that processing of the claim is not yet complete. The fund will then transmit a final report (which will overwrite any interim reports) once processing has been completed for the claim. After the final processing report is retrieved, the payment report can be retrieved (proceed now to **Step 5**).

Handling Final Processing Reports with a status of ‘Awaiting Payment Report’: If the final processing report is available after the Transmit button is clicked, the Medicare Australia – Processing Claim(s) window appears, and the final Processing Report is downloaded.
5. After the final processing report is retrieved, the status of the claim changes to ‘Awaiting Payment Report’, and the claim can now be viewed by double-clicking it to see the result (Accepted/Rejected) of the claim submitted. The Processing report will consist of invoice details, and service item details of the retrieved claims, which may assist you with any troubleshooting. Click Transmit to download the payment report.

6. The Medicare Australia – Processing Claim(s) window appears, and displays the downloading messages. You will be prompted that a Payment Report is available for download. Click Yes to download the payment report.

7. The downloaded Payment Report can be saved by clicking Save to File. Alternatively, click Close to return to the Medicare Australia window. Payment report will consist of the summary of health fund payments which will help the practice reconcile payments with the bank statement. It also consists of additional payment details on the paid claim.
8. In the Medicare Australia window, the claim’s status changes to Ready to Receipt. Click the Receipt button.

9. The In Hospital Claim (IHC) Receipt window appears. Choose the option ‘Write-off or ‘Leave Unpaid’ to receipt and Click ‘OK’.

Example Scenarios:

Scenario 1

In the scenario below, the Claim Total was $475.00, but the Total Benefit Paid was only $425.00.

$100 is automatically allocated to item ACC2, to cover its claim amount of $100. Notice that the Option column reads ‘Accept’, to indicate that we will accept this allocation.

The remaining $325 is allocated to item 42738. Note however, that the fee for this item is $375, which is $50 more than the benefit we have received. Therefore, we must also indicate what to do with the remaining co-payment amount of $50; we can either leave it unpaid, or write it off, as selected via the Option drop-down list.
Scenario 2

In this scenario, we are claiming two prosthesis service items (PX00AL005 for $110. and PX00G007 for $698).

Note that the health fund paid a benefit of $808 for the first prosthesis item, although its fee is $110. This is because, in this example, this particular health fund did pay a benefit to cover both prosthesis items, but allocated the payment to the first item only. If this happens, you must manually adjust the receipt allocation.

Using the example above, we would;

1. Take note of the Outstanding Balance ($2012.00) and the Receipt Amount ($1,762). The receipt amount needs to be allocated in the Receipt allocation against the items.

2. Take note of the Claim Amounts and Receipt Allocation values for the service items being claimed.
   a) The first item is claimed at $948, and its receipt allocation is also $948. This item requires no adjustment.
   b) The second item is claimed at $256, and its receipt allocation is also $256. Again, this item requires no adjustment.
   c) The third item is claimed at $110, but its receipt allocation is $808. This value must be modified manually. Click within the Receipt Allocation field, and change the value to $110.
   d) This leaves us with a paid benefit balance of $448. We allocate this to the last service item. Note that this service item’s claim value was $698, not $448, and hence we have an excess $250. In our example, we have selected the option to Leave Unpaid. Alternative you could Write Off this value.
**Print In Hospital Claim Processing Report**

1. Via the Medicare Australia window, the processing report can be printed by selecting the claim and clicking the icon located at the of MedicalDirector Blue Chip.

2. The Print Report window appears. Select In Hospital Claim Processing Report and click Next.
3. In the **Print In Hospital Claim Processing Report** window, you will be prompted to select options for the printed report.

   **NOTE:** If you choose to include deleted claims, they will be printed in *italics*.

![Print In Hospital Claim Processing Report](image)

4. Click **Next** to continue. You will be prompted to select print options for the report.

   **NOTE:** The first time you print this report on any given computer, you will have to specify the printer and print tray. Thereafter, MedicalDirector Blue Chip will remember your settings.

![Print In Hospital Claim Processing Report](image)
Print In Hospital Claim Payment Report

1. In the Medicare Australia window, processing report can be printed by selecting the claim and clicking on the print icon on the top.

2. The Print Report window appears. Select In Hospital Claim Payment Report and Click Next.
3. In the **Print In Hospital Claim Payment Report** window, you will be prompted to select options for the printed report.  
**NOTE:** If you choose to include deleted claims, they will be printed in *italics*.

![Print In Hospital Claim Payment Report window](image)

4. Click **Next** to continue. You will be prompted to select print options for the report.  
**NOTE:** The first time you print this report on any given computer, you will have to specify the printer and print tray. Thereafter, MedicalDirector Blue Chip will remember your settings.

![Set print options](image)
New: Banking / Reconciliation

After the payment report is downloaded, health fund payments listed in the payment report can be used to reconcile payments with your bank statement. It is recommended that the practice settles its banking transactions to ensure correct reconciliations are maintained.

1. Via the Practice Explorer, select the Banking margin menu. Select your bank account, and click Open.

![Practice Explorer with Banking selected](image1)

2. Select EFTPOS from the margin menu, and then select the EFTPOS Type of Direct Debit to view the amount paid for the claim by Medicare and the Health Fund.

![EFTPOS screen with Direct Debit selected](image2)

3. Click Settle to settle the Direct Debit amount using your bank statement.

![Settle button highlighted](image3)
4. Enter the Settlement No. and click **OK**.

![Debit EFTPOS settlement](image)

5. The **Print EFTPOS** window appears. You can print the debit settlement.

![Print EFTPOS](image)

![DIRECT DEBIT SETTLEMENT, 14/01/2016](image)

6. To print the **Banking History Report** can be printed by clicking the icon located at the top of MedicalDirector Blue Chip.
7. Practice can view the banking history report which has a list of finalized bank slips and banking slip receipts.

- Select the report detail as **Summary** to get the summary of the banking history report.

- Select the report detail as **Detail** to get the detailed banking history report.
Other Changes to MedicalDirector Blue Chip

New: Changes to the Printed Invoice (Assistant)

Assistant Name now appears on the printed invoice.

1. To create an invoice for assistant items, enter the surgical item number (e.g. 32093) and the assistant item number (e.g. 51303) in the Item field of the New Invoice window.

2. Upon pressing Tab, the Assistant Item window appears. Select the invoiced items. Click OK.
3. Click **Issue** to issue the invoice.

The Assistant’s name now appears on the printed invoice.

4. Once the invoice is issued, click **Open**, and then **Print** to print the invoice.

The Assistant’s name now appears on the printed invoice.
New: Changes to the WP fields

Previously in MedicalDirector Blue Chip, the default address in the patient details would never appear in templates (WP, Recalls, Reports, Letterheads) even though the ‘Default Address’ checkbox was ticked.

The WP field has been renamed from ‘Full name and address’ to ‘Full name and default address’ to populate the default address, dependant on the status of the check box.

In addition to this, two other WP fields have been renamed to help practices use the WP fields efficiently. The two ‘Full address’ WP fields have been renamed ‘Residential full address’ and ‘Postal full address’.

NOTE: The old WP fields can be replaced by the new WP fields in all the relevant existing templates to ensure population of the correct address

1. In patient details screen, the default checkbox is checked for residential address.

2. Select Setup > Templates > WP > Recalls, select the template, and click Edit to access the WP Fields in the template.
3. Via the WP Fields menu, select **Full name and default address** (the new WP Field). This field appears as '[PatNameAddr]' in the Follow up letter.

![Image of WP Fields menu showing 'Full name and default address' field]

4. Select the **Recalls** margin menu, and then click **Contact/print** to print the Recall Letter.

![Image of Recall Letter window with 'Contact/print' button highlighted]

- The patient’s residential address appears as shown below.

![Image of Recall Letter with patient's residential address highlighted]
The two ‘Full address’ WP fields have been renamed to ‘Residential full address’ and ‘Postal full address’. These WP fields will print only the residential address or postal address irrespective of the ‘default address’ being checkbox being ticked in patient details screen.
New: Changes to the Banking History Report

- Medical Director Blue chip can now print a ‘Banking History Report (Detailed)’ for banked receipts which were reversed. This report can also be printed in .csv format.
A new Sort By option is added to the Print Banking History Report screen for sorting your banking slips by 'Banking Slip Type' or 'Banking Date'. This applies for both summary and detail bank history report.

The Banking History Report now sorts content based on the ‘Banking Slip Type’. All banking slips with a banking slip type of ‘Cheque’ will appear first, followed by type ‘Cash’.
What’s New in MedicalDirector Blue Chip 2.11

- The Banking History Report (Summary and Detail) can be printed in .csv format.

- Previously, when printing the deposit slip in the ‘Bank deposit’ screen, the Show GST Details check box had to be ticked before printing the deposit slip. The check box is now ticked by default, whenever the deposit slip is printed.

- BC Secure Help topics can be accessed from the BC Secure menu, and a new Help topic for the banking history enhancements is provided.
New: Permission to Add, Edit, and Delete Correspondence

Medical director Blue Chip now provides **Correspondence** permissions in BC Secure for, so that the practice can provide appropriate access to users for to adding, editing, and deleting correspondence.

In BC Secure, select the **Permissions** margin menu. The **Correspondence** section is located at bottom-right. It provides three permissions options; Add Correspondence, Edit Correspondence and Delete Correspondence.

![Permission Menu Screenshot]

If **Add Correspondence** permission is granted, the following options are enabled for the user.

![Correspondence Permissions Screenshot]

If **Add Correspondence** permission is **not** granted to a user, the above options will be unavailable (greyed-out).
If **Edit Correspondence** permission is granted;

- The **Edit Letter** option is available where the correspondence can be edited.

- The **Edit** button is available in the deferred printing screen.

If the **Edit Correspondence** permission is not granted, all the above options are unavailable (greyed-out). Correspondence can still be viewed, but no changes are saved.

If **Delete Correspondence** permission is granted, the **Delete** button is enabled.

If **Delete Correspondence** permission is not granted, the **Delete** button is unavailable (greyed-out).

BC Secure Help topics can be accessed from the BC Secure menu, and a new Help topic for the updated correspondence functionality is provided.
New: Password Expiry

The practice can now set a password expiry for users via the new **User Password Expiry** section in BC Secure.

If the practice needs to enforce changing of password, tick the **Force User Password Expiry** checkbox, and indicate a desired password expiry interval days (30, 60, 90...360) can be set. Click **Apply**.

Once the expiry interval period (e.g. 30 days) is reached, the user will be alerted to expiry of their current password, and prompted to change it.
The user’s new password must be different to their previous password.

You can click **OK** after the new password is entered.

You will also be notified of the password expiry (based on the interval set) when you use the ‘Delete patient Records Wizard’ utility.
New: Changes to the Item Number Field

Medical Director Blue Chip has increased the item number field from 8 to 11 characters. Practices can send miscellaneous items (11 characters) to health funds for In Hospital Claiming. Most of the relevant sections and reports in MedicalDirector Blue Chip have been modified to incorporate this change.

Service Items Window

New Invoice Windows
Once the invoice is issued, the invoice window is updated.

Invoice printout
Receipt window

Estimate window
Estimate printout

Estimate of Fees

In addition to various windows in MedicalDirector Blue Chip, the following reports have been changed:

- Medicare Australia DB4 form
- Allocation Detail Item Report
- Deferred Invoices
- Income Analysis Detail Report
- Income Analysis Report
- Invoices Detail Items Report
- Locum Report
- Service Items Detail Report
- Service Items Summary Report
- Statement
- Practitioner Service Count Report
New: Changes to the Assistant Item Billing

Previously, Surgeons (Practitioners) claiming on behalf of their Assistant had to send a single claim consisting of both the Surgeon’s and the Assistant’s Service Items. This process has been modified in order to prevent such claims being rejected by Department of Human Services.

From version 2.11, the Surgeon’s Service Items are sent first, in their own claim, and then the Assistant Service Item is sent in a separate claim.

1. Create an invoice for the Surgeon (e.g. Bevan Ayers) under an IMC account. Include the Surgeon’s Service Items with surgeon as the principal and servicing provider.

2. Once the invoice is issued, the claim for the surgeon is submitted first.
3. Now that the surgeon’s claim is submitted, an invoice is created for the Assistant Service Item with the surgeon (Bevan Ayers in our example) as the principal provider, and the Assistant (Grant Kong) as servicing provider.

![Invoice Image]

4. The Assistant Item (51303) is in the invoice, along with the Assistant’s provider number in the ‘Service Text’ as shown below.

![Invoice Image]

5. Once the invoice is created, the claim for the Assistant is sent as a separate claim (and after the claim for the surgeon is processed).

![Claim Image]

New: Disk Space Check before Installing

Medical Director Blue Chip now checks the amount of available disk space before installation commences, and indicates if there is too little disk space than what is required for the installation.
New: Changes to the Fund Payee (ORG) ID in Inpatient Medical Claim

Previously, the IMC claim types tab of the IMC batch setup window provided only one ORG ID to be saved for each practitioner for each Health Fund. This limitation did not account for some Health Funds that assign a different ORG (fund payee) ID to each bank account used by the practitioner. Version 2.11 has been enhanced to incorporate the saving of more than one Fund Payee (ORG) ID.

1. Select Setup > Practice > Batch Types > Eclipse > Configure Eclipse. A new IMC ORG (Fund Payee) ID tab is available. The ORG ID column from the IMC Claim Types tab has been relocated to the new tab, where the Bank Account and Health Fund information is also located.

NOTE: Different bank accounts can be setup in BC Secure and linked to the appropriate locations.

2. In the IMC ORG (Fund Payee) ID tab, users can enter different ORG (Fund Payee) IDs issued by the health fund (BUPA) for different bank account numbers (King Ayer Pty Ltd – RBA, St Leonards, Different King Ayer Pty Ltd – RBA, North Sydney) for a practitioner (Bevan Ayers).

3. Once the IMC ORG (Fund Payee) IDs are recorded, and an invoice is generated, the ORG (Fund Payee) ID recorded for the relevant bank account is populated during IMC claim submission.
New: Changes to the Waiting List

Previously, the waiting list could only be filtered by practitioner. Changes have been made to be able to filter by location. Sorting functionality is also added to all the columns of waiting list which will help you sort by date, patient duration, practitioner, type, location, urgency and comments.

Select Practice Explorer > Waiting List. Location Filter and column is added.

You can now select ‘Location’ while adding a patient to the waiting list.
You can filter by location for a practitioner (e.g. for Prof Bevan Ayers filter by ‘Chatswood’ or ‘Crowsnest’)

Sort by the fields (Date, Patient, Duration, Practitioner, Type, Location, Urgency and Comments) in waiting list. (E.g. Date in this scenario)

Waiting list can be printed by clicking on “Print”. It can be printed in Microsoft Excel (.csv) and Rich Text Format (.rtf)
How to Link an Invoice to an Existing Day Surgery Episode

This is existing functionality, but we have included it here, as there is some confusion as to link an invoice to a Day Surgery episode that you have already created.

Scenario 1: Where you have already created a Day Surgery episode, but have not yet completed it.

1. Create an invoice and open the invoice to link it to the existing episode.

2. Click Day Surgery opens. You will be prompted as to whether you wish to update items for this episode.

3. Click Complete the episode as normal. Notice that the invoice number is brought over to the episode, and recorded automatically:
Scenario 2: Where you have already created and completed a Day Surgery episode.

1. Create an invoice and open the invoice to link it to the existing episode.

2. Click **Create Day Surgery Episode**. Day Surgery opens. You will be prompted as to whether you wish to create a new episode.

3. Click **No**.

4. Use Day Surgery’s **Find** feature to locate the episode you wish to associate with this invoice.
5. Select the **Notes** tab.

6. Because this episode is already complete, it cannot be updated i.e. you cannot update an episode that is in a ‘completed’ state. However, in order to link the invoice to this episode, it needs to be in an **incomplete** state.

So, to **force** the episode into an incomplete state, locate the **Date Coded** field, and **delete** the contents of this field. This will flag the episode as **incomplete**.

7. Now return to the invoice window in MedicalDirector Blue Chip.

8. Click again. Day Surgery opens. You will be prompted as to whether you wish to update items for this episode.

9. Click **Yes** Complete the episode as normal.