Eastern Bay
Primary Health Alliance

Healthy Whānau, Healthy Lives

Medtech

Practice Manager User Guide

March 2021

Govt Funding – Processing the Claims

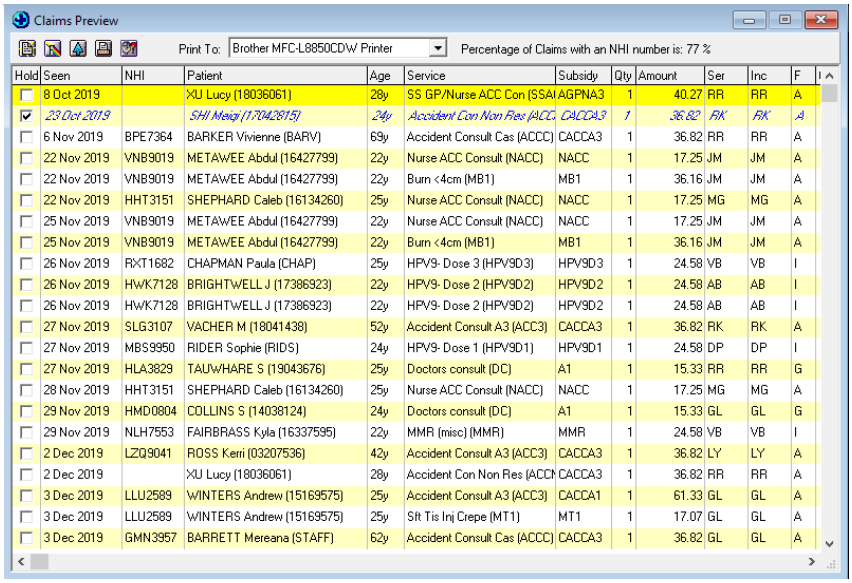
Claims Preview MOH/ACC Claims (MUST be done no more than 2 monthly, they will NOT pay for anything older than 2 months)

This MUST be done on the Healthlink computer (back desk, left hand side, remote desktop)

Claims Preview – ACC, GMS, IMMS, MATY

You must "preview" all claims in the first instance to ensure they are correct before finalising to send through for claiming. Not completing this process will mean potentially claims will be declined due to errors, and we may miss out of funding that we are entitled to. This process minimises the chance of errors and missing out on funds being claimed.

In Medtech go to Module > Claims > Preview > leave tick in "Include invoices On-Hold" click OK



Hold	Seen	NHI	Patient	Age	Service	Subsidy	Qty	Amount	Ser	Inc	F
☐	8 Oct 2019		XU Lucy (18036061)	28y	SS GP/Nurse ACC Con (SSA	AGPNA3	1	40.27	RR	RR	A
☑	23 Oct 2019		SHI Meiqi (17042815)	24y	Accident Con Non Res (ACC	CACCA3	1	36.82	RK	RK	A
☐	6 Nov 2019	BPE7364	BARKER Vivienne (BARV)	69y	Accident Consult Cas (ACCC)	CACCA3	1	36.82	RR	RR	A
☐	22 Nov 2019	VNB9019	METAWEE Abdul (16427799)	22y	Nurse ACC Consult (NACC)	NACC	1	17.25	JM	JM	A
☐	22 Nov 2019	VNB9019	METAWEE Abdul (16427799)	22y	Burn <4cm (MB1)	MB1	1	36.16	JM	JM	A
☐	22 Nov 2019	HHT3151	SHEPHARD Caleb (16134260)	25y	Nurse ACC Consult (NACC)	NACC	1	17.25	MG	MG	A
☐	25 Nov 2019	VNB9019	METAWEE Abdul (16427799)	22y	Nurse ACC Consult (NACC)	NACC	1	17.25	JM	JM	A
☐	25 Nov 2019	VNB9019	METAWEE Abdul (16427799)	22y	Burn <4cm (MB1)	MB1	1	36.16	JM	JM	A
☐	26 Nov 2019	RXT1682	CHAPMAN Paula (CHAP)	25y	HPV9- Dose 3 (HPV9D3)	HPV9D3	1	24.58	VB	VB	I
☐	26 Nov 2019	HWK7128	BRIGHTWELL J (17386923)	22y	HPV9- Dose 2 (HPV9D2)	HPV9D2	1	24.58	AB	AB	I
☐	26 Nov 2019	HWK7128	BRIGHTWELL J (17386923)	22y	HPV9- Dose 2 (HPV9D2)	HPV9D2	1	24.58	AB	AB	I
☐	27 Nov 2019	SLG3107	VACHER M (18041438)	52y	Accident Consult A3 (ACC3)	CACCA3	1	36.82	RK	RK	A
☐	27 Nov 2019	MBS9950	RIDER Sophie (RIDS)	24y	HPV9- Dose 1 (HPV9D1)	HPV9D1	1	24.58	DP	DP	I
☐	27 Nov 2019	HLA3829	TAUWHARE S (19043676)	25y	Doctors consult (DC)	A1	1	15.33	RR	RR	G
☐	28 Nov 2019	HHT3151	SHEPHARD Caleb (16134260)	25y	Nurse ACC Consult (NACC)	NACC	1	17.25	MG	MG	A
☐	29 Nov 2019	HMD0804	COLLINS S (14038124)	24y	Doctors consult (DC)	A1	1	15.33	GL	GL	G
☐	29 Nov 2019	NLH7553	FAIRBRASS Kyla (16337595)	22y	MMR (misc) (MMR)	MMR	1	24.58	VB	VB	I
☐	2 Dec 2019	LZQ9041	ROSS Kerri (03207536)	42y	Accident Consult A3 (ACC3)	CACCA3	1	36.82	LY	LY	A
☐	2 Dec 2019		XU Lucy (18036061)	28y	Accident Con Non Res (ACC	CACCA3	1	36.82	RR	RR	A
☐	3 Dec 2019	LLU2589	WINTERS Andrew (15169575)	25y	Accident Consult A3 (ACC3)	CACCA1	1	61.33	GL	GL	A
☐	3 Dec 2019	LLU2589	WINTERS Andrew (15169575)	25y	Slt Tis Inj Crepe (MT1)	MT1	1	17.07	GL	GL	A
☐	3 Dec 2019	GMN3957	BARRETT Mereana (STAFF)	62y	Accident Consult Cas (ACCC)	CACCA3	1	36.82	GL	GL	A

There are four types of funders (the F column). In previewing the transactions you are looking at the following –

G = GMS claims (Doctor's visits)

The SER and INC columns **MUST** be a Doctor's initials (INC will be where the income is paid to for your Practice
A1 will have a $ amount to be claimed (usually Casuals you have seen – FFS)
A3 will have a $0.00 amount. (usually your enrolled patients)

I = Immunisations (given and lodged by the nurses)

The Ser and Inc columns can be either a Doctor or Nurses's intials
You can only claim ONE immunisation per patient per day

A = ACC claims (can be Dr's or Nurses or combined visits)

If a dressing has been done in the notes make sure that there is a claim code for the actual dressing/procedure performed (ie: MB1 etc) on the bill for the day
That all Dr/Nurse consults on the same day are claimed as an AGPN (and the nurse consult is not using another ACC code – use a non claiming nurse code)

M= Maternity Must be a Doctors intials (service code will be "not in use")

Service Codes - Check the service codes that are “not in use” ones, especially immunisations (as they will not pay on ones no longer in use) and get the nurse to change the code to the right one by inactivating the incorrect one and relodging the correct one (ie: HPV-Q “not in use” SHOULD be HPV9-D – usually this means the nurse will need to inactivate the current “not in use” one and relodge under the correct vaccination code. It is usually because they have used an old immunisation schedule (prior to 2005) immunisation.

If you are happy that all claims look OK and ready to send you can finalise the claims.

If you have claims that need to be corrected, you can put these on hold by putting a tick next to them on the claims preview window. This will mean they will not be finalised and sent for claiming. You will need to come back and sort these claims out once they have been fixed (see below – Troubleshooting errors)

Finalise the Claims

Always do this on the Healthlink Computer in the remote desktop.
(back reception/admin computer on the left)

Once the claims are finalised it is very complicated to undo this process, so you need to be confident the claims are as correct as can be at the time of finalising.

Click on **Module** – then **Claims** – then **Finalise**
Click on **OK** and this will give a finalised status message.
If there are any that have not finalised, take a note of the details to check & fix
any errors. (usually a nurse with a GMS claim!)

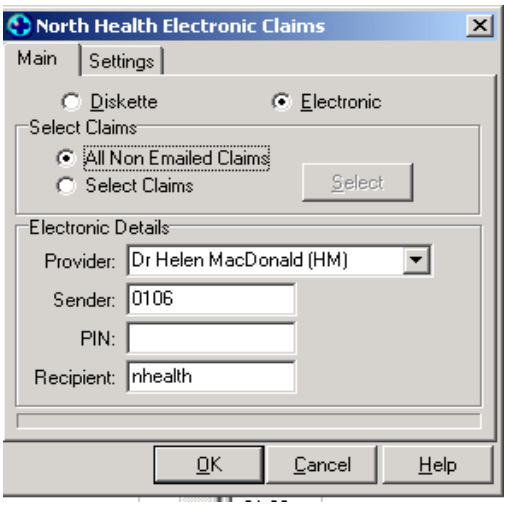
Send the Claims

(*You must be on the Healthlink computer)*

Sending GMS & IMMS Claims

To send the GMS & IMMS claims click on

- **Utilities** – then **Health Benefits** – then **HL7 Electronic Claims**
- Click on **Select Claims** – leave the dot in *All non-emailed claims*
- Click on the Settings tab and change the printer to report manager
- Enter the pin
- Click OK to send the claims. The report will show in your report manager.



MATY – Invoicing on the Patient

Generating Maternity Invoices

Reminder: Eligibility - we can only claim maternity government subsidies if patients are enrolled with our PHO & are NZ residents or eligible

100% NHI numbers – NEEDED

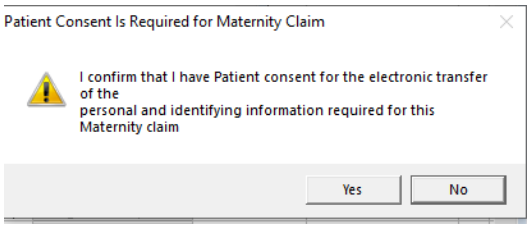
Reception to process the invoice no charge to the patient and send a task to the staff member who is processing the MATY claims.
You MUST wait until the pregnancy is confirmed before loading a MATY claim for services.

NOTE: You can only claim **one** lump sum per patient for their first visit ONLY unless there is an emergency related to the pregnancy. This cannot be processed until the pregnancy is confirmed and a decision has been made about it.

To Claim Maternity

This process is done once the doctor has confirmed the dates and decision about of pregnancy.
To claim – first make sure you have the LMP date/ EDD/ Doctor they saw/ type of claim (eg TOP, normal etc. (EDD is taken from the scan result)

Click on 'female symbol'  > SE > confirm > yes
Bring up appropriate patient (must have NHI & be an eligibale patient)
Click: **Module – Accounts – Maternity**
SE (new single service episode)
A message prompt will come up -



Click Yes
Enter the correct medical provider
Enter the LMP & EDD dates
Click on **'Service'**, e.g. *First trimester claim without miscarriage or termination
(basic uncomplicated normal pregnancy visits)
* First trimester claim with miscarriage (threatened) or TOP
(complicated pregnancy)

For terminations wait until the TOP has been completed and then send the claim (Clinic letter has been received!)

Enter the number of visits in first trimester (usually 1)
Click on 'Service is for" and select Mother (would never be for baby)
Click on **'Reason for Service Completed'**, e.g. Transferred to LMC, had miscarriage or Termination
Click OK.

If you have lodged a claim for say, termination, and the patient changes their mind you can email claims on claims@health.org.nz and have the claim reversed – once it has been reversed you can then re-claim with the correct details.

MATY

(*You must be on the Healthlink computer)*

Sending the Maternity claims

To send the maternity claims click on

- **Utilities – Health Pac – Electronic Maternity Claim Section 88 – 2007**
- Click **'Select claims'** – then click Select
- Put a tick against any schedules awaiting submission, click OK
- Click on the Settings tab and change the printer to report manager
- Sender & recipient fields should automatically be populated
- Click OK to send the claims. The report will show in your report manager.

Go to your Report Manager and print ONLY the first page of each report and file in the front of the PHO Claims folder for the person who processes the BCTI's to match them up.

ACC

(*You must be on the Healthlink computer)*

Sending the ACC Claims

To send the ACC Claims click on

- Tools > Message Transfer > Electronic e-sSchedule Claims (ACC47e)
- Check under the setting tab it is set to Report Manager
- Click select claims and put a tick in any that have not already been sent (haven't got a tick in the sent column.)
- Click OK.

Progress of the upload is shown in the Unload screen. If the invoice is rejected by ACC during the upload, this will show in red in the Unload screen. Scroll to bottom to check "Upload process completed" is showing.

- Click Close.

To view the status of ACC e-schedule claims –

Go to Module > Accidents > Claim Status > Success = claim has been sent (Todays date only)

If the message reads rejected, you will need to unfinalise the claim, correct what is wrong with it and resend it again. (See troubleshooting)

Go to your report manager and select the Electronic claims report and print ONLY the first page to give to the person who processes the payments when they are received.

Troubleshooting Errors in Finalising Claims/ Already finalized claims

If you have a claim that error's up when you are finalising the claims, record the claim # and details. If it is a provider such as a nurse or counsellor with a GMS claim, this is harder to find but see if you can find it by looking through the daybook. Otherwise follow the instructions below -

- In Medtech, open the account the claim relates to ie: ACC, GMS, IMMs.
- Under the patient transactions tab in the Patient Manager, find the claim number that had the error.
- Open this claim and unfinalise the item that has the error.
- Now go to Module > Claims Preview.
- Highlight the claim you have just unfinalized and select > Preview Claims > Delete. This will take it out of the claims to preview AND the patient invoice.

NOTE: Make sure you unfinalise the actual individual claim item first!! (In the funder account) If you don't do this before fixing it, the original claim will keep sending through and causing an error.

GMS claims are ONLY paid if the patient is **not** enrolled and funded with us, but DOES hold a Community services card (A1) (FFS) - A3's DO NOT get paid for GMS funding.

Accounts Receivable - Processing Funding Receipts (Payment Notifications/Remittance)

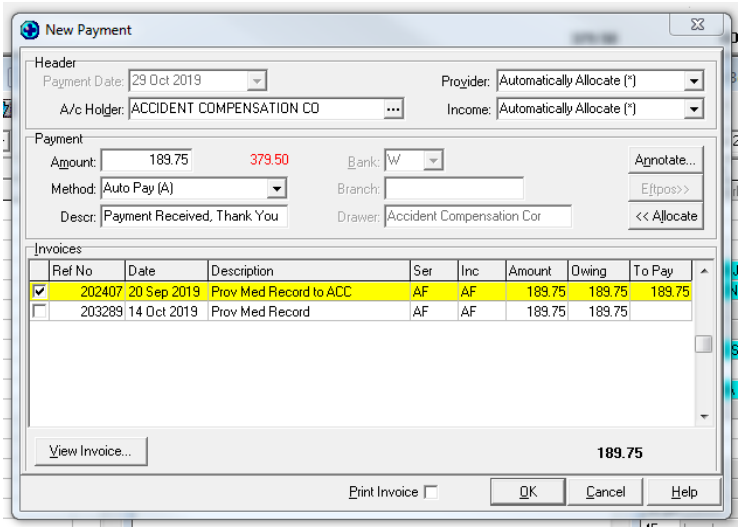
Once the claims have been finalised and sent, the MOH will process them all and send remittance advice for all claims that have been accepted for funding. The payment advice will usually arrive in the mail approximately one week later.

ACC/GMS/IMMS/MATY Receiving payments.

Once the Payment Advice Summary (ACC) or Payment Notification (MOH) has arrived in the mail, these need to be paid off in the respective accounts in Medtech.

To do this, follow the below steps:

- Bring up the claim type in the F2 screen (ACC/GMS/IMMS/MAT)
- Click 'New Payment' (F8)
- Find the claim number you want to make a payment for. Check the payment amount matches the claim. If so, tick the box, enter the amount being paid, and change the method to 'Auto Pay'. If the claim amount does not match highlight the provider claim and click "view invoice". Put a tick in each person that has been paid until there is $0.00 to apply to the payment amount. Click OK and then OK again to make the payment.



If the claim amount is not the same as the payment amount, you will need to unfinalise any items that have not been paid, and go back to the patient to correct the error. This could be, fixing the claim if it is incorrect or deleting the claim if it has been sent through in error. You will not be deleting the invoice to the patient – only the claiming part – this may involve redoing the original transaction but the invoice to the patient should not change.

Once you have finished processing the payments in the Medtech accounts, you will need to send a copy of the payment notifications to Accounts so they can match the payments received in the bank account. Your goal is to pay off all amounts owing from sending the claims.

Scan a copy of the Payment Notification into each account ie: GMS, IMMS, ACC and annotate as "CLAIM PD #KS invoice number" File paper copy as required.

MOH/ACC Subsidy Rejection/ Troubleshooting

If there are any issues with the payment amounts being different or zero (quite often ACC), you need to Troubleshoot why at our end. (see Troubleshooting)

If you cannot resolve the why, you will need to contact the supplier to find a solution.

If you need to alter the original claim, you **MUST**:

- **Unfinalise the single claim first** and then delete/alter or reclaim it on the patient account.

(If the claim is not unfinalized in the Account Holder (ie: GMS) account first, it will continue to re-claim in the back end of the claims and cannot be removed).

If the Government Funder has rejected a claim you will not have allocated a payment to it yet. On the payment advice, there should have been given a reason for rejection. Below is how to process these to correct them and send again for claiming.

If it is a rejected claim that can be AMENDED because it was an error at our end
e.g. incorrect NHI

- In Med tech bring up GMS then click on red dollar sign $
- Double click on the specific invoice that the funding rejection relates to
- Click on appropriate patient –they will show up highlighted in yellow
- Click on "Un-finalise Item" and this will put it back into the claiming system for correction and will show in next batch of bulk billing –
- Go into invoice and correct data. Eg. Missing NHI or wrong provider or duplication, or delete the claim if completely incorrect.
- If it was a duplicate claim and our error it will need to be zero'ed out written off.

This is the same process for ACC rejected subsidy claims – but you may need to alter the provider or the ACC 45 number. Just bring up ACC account & view the claim under the red dollar sign. Highlight the patient and click on 'Un-finalise Item'. This will put it back into the next batch of claims, so correct the error and then it will be ready for next claims finalisation.

The only times claims now need to be written off is when we have over-claimed ACC subsidies or if no actual injury or force occurred.

ACC as an example

- ✓ Reinstate the claim – in the funding account ie: ACC (account holder) open claim with the issue
  Click on the patient name – unfinalise item – (goes back to be claimed again next time)
  ALWAYS CHECK ACC45 BEFORE RESUBMITTING
  (to unfinalise the claim – module/accounts/account holder/select by double clicking on claim/transfer to patient/ finalise it. Sort the claim to a correct state according to the instruction as to why it was rejected and it will be ready for submitting again once corrected.

- ✓ Before submitting to ACC
  Utilities/ACC45/ACC45 status tab at bottom

- ✓ To check if parked – Utilities/ etc… then go to the patient's daily record – find ACC45 then click parked (at bottom)

Procedure if claim is rejected by ACC:

- ✓ You will see if a claim has been rejected on payment advice summary
- ✓ Patient and practice will also receive a letter detailing rejection
  On ACC screen bring up claim – click on patient 'transfer to patient' – ok
  On patient's screen – change amount to whatever the shortfall is
  Add **alert** re outstanding balance
  Send patient a letter advising ACC has rejected the claim and attach a copy of the invoice for the patient to pay.

To view outstanding ACC claims (Unpaid)

ACC as account holder/ red $ (account tab) 'rainbow'/ unpaid transactions only

ACC 45 Failings

Example: if the provider number (i.e. “SH’/ __ - ACC45 ref) is not registered. This means that ACC info was not ‘picked up’ on the ACC45 ‘select’ screen – does not appear at all on the ACC45 listing even though ACC45 info does show on MedTech.
SOLUTION: On MedTech /F6/outbox/select ACC45

- Tick box that says ‘send electronically’
  Now it should show on list under ACC45 – tick to load
  Resend on next finalisation as per usual process

***Seldom need this but if a new provider is entered – sometimes they fail as ACC don’t have them updated yet and we send in a claim. To resend this type of claim – (not registered due to provider number being wrong) – make sure you have correct details in the staff setup for this provider first. Then find patient/ outbox/ find failed ACC45 – open it and change providers name to another provider…save. Now go back on to that ACC45 and change it back to the correct (new) provider.
This will input correct details for them and will be successful when next lodged

Accounts Receivable Process (Income)

PHO Monthly/Quarterly Payments (Reconciliation)

These financial reports are sent to us each month by your PHO/PHA advising the total amount they’ve paid your Practice for each period of bulk funding.

Advise accounts receivable of all payments (income) to be received.

If you have any queries about the payments to be received please contact you Practice Improvement Liaison or Accounts person at your PHO/PHA

Capitation (CBF)

They include the monthly capitated funding amount for your enrolled and funded patints.

FFS Clawbacks/ FLS Payments

There will also be a monthly claw-back page “First Level Health Services Deduction Details: – these relate to people who have gone somewhere else e.g. Accident & Medical or Alternative Doctor visit and we will be deducted $15.33 per person.

Place an Alert **“PHO Seen Elsewhere”** on these patient with an annotation of the date of visit elsewhere and check with them at next visit if they still wish to be enrolled at your Practice. (the report does not show where they went elsewhere, just the date of visit).

Likewise, you will receive an FFS report which details any casual patients you have seen, and the clawback has been made as a payment to you.