medisoft®

Medisoft® Version 17 *Beta Release Notes*

Enhancement: Electronic Transaction Reporting

Medisoft® Version 17 (v17) includes four new reports to help you manage electronic transactions related to verifying your patients' insurance eligibility and submitting claims to insurance providers.

The reports include:

- Appointment Eligibility Analysis - Detail
- Appointment Eligibility Analysis - Summary
- Electronic Claims Analysis - Detail
- Electronic Claims Analysis - Summary

Each of these reports offers several filters for controlling the information that shows. In addition, several summary values appear on each report so that you can see the information at a glance.

Enhancement: Audit Reports

Medisoft v17 includes a feature that allows you to track the reporting and exporting of data when you generate audit reports. A new option on the Audit tab in Program Options allows you to turn this feature on or off. It is turned on by default. Certain reports or grids that are printed or saved to disk will be audited. Note: Previewed reports will not be audited.

The following types of information are included as part of the audit reports:

- Data grids
- Custom reports, including claims and statements

When printed from either Transaction Entry or Statement Management, but not the Report menu or Report Designer, the audit reports include.

- Medisoft reports
- Office Hours data
- Final Draft reports or data printed or saved to disk
- Internal reports
- Statements
- Eligibility information

Enhancement: BillFlash Integration

BillFlash integration applies to the Medisoft Advanced and Network Professional programs.

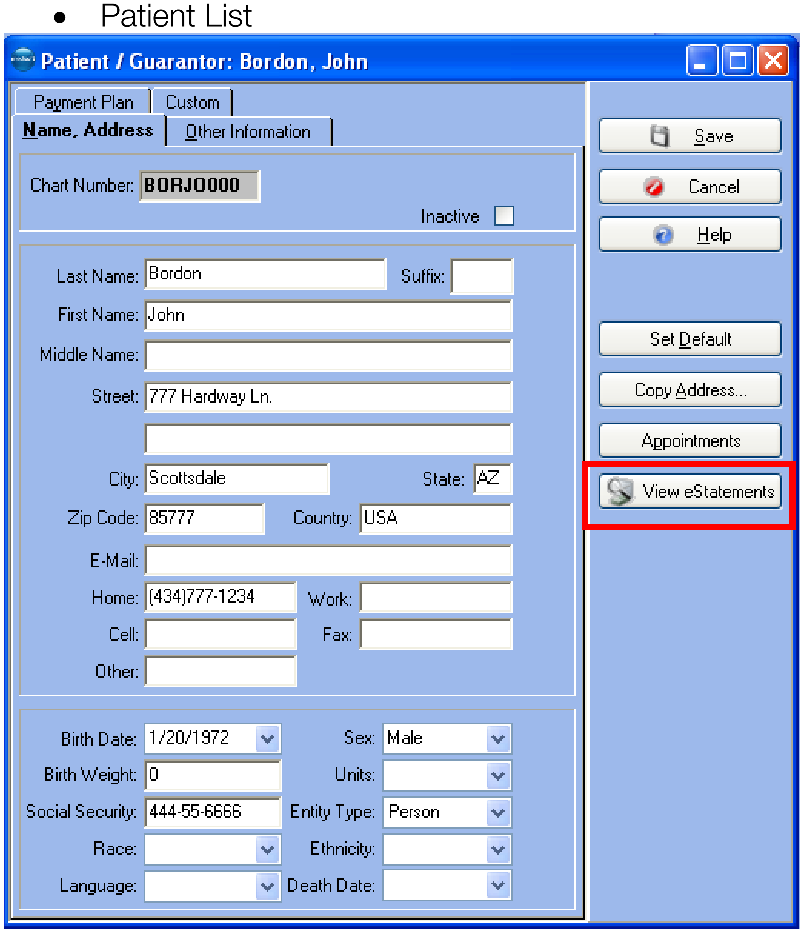
Medisoft now uses BillFlash to print and mail patient statements. With Medisoft v17, you can enroll in BillFlash directly from within Medisoft, as well as upload your statement files directly from Medisoft automatically. You can view and approve statement uploads to BillFlash by clicking links from within Medisoft. For more information on BillFlash and to learn how to enroll, go to www.BillFlash.com.

Within Medisoft, you can control several aspects of what prints on your statements, including which credit cards you accept, service messages you want to print, printing of account summaries and aging, and printing up to six messages to appear on statements. For more information, go to the Program Options - BillFlash tab.

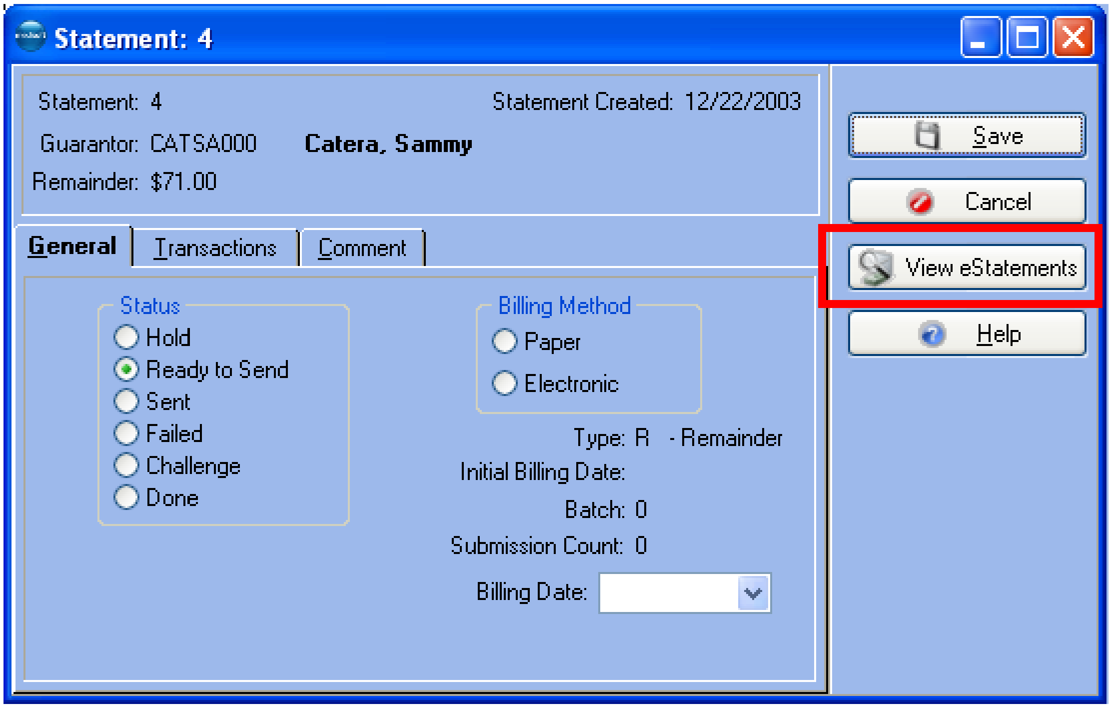
Options on the Activities, BillFlash menu allow you to enroll with BillFlash, view and approve statements that have uploaded to BillFlash, see your account settings at www.BillFlash.com, and view reports such as the Disposition report. Each one of these menu options will open a different page on the BillFlash website.

The following windows in Medisoft have quick access to the eView page of the BillFlash website via a new **View eStatements** button. (In addition, when a patient is selected and **Ctrl + F7** is clicked, the eView page will open for any statements for that patient.)

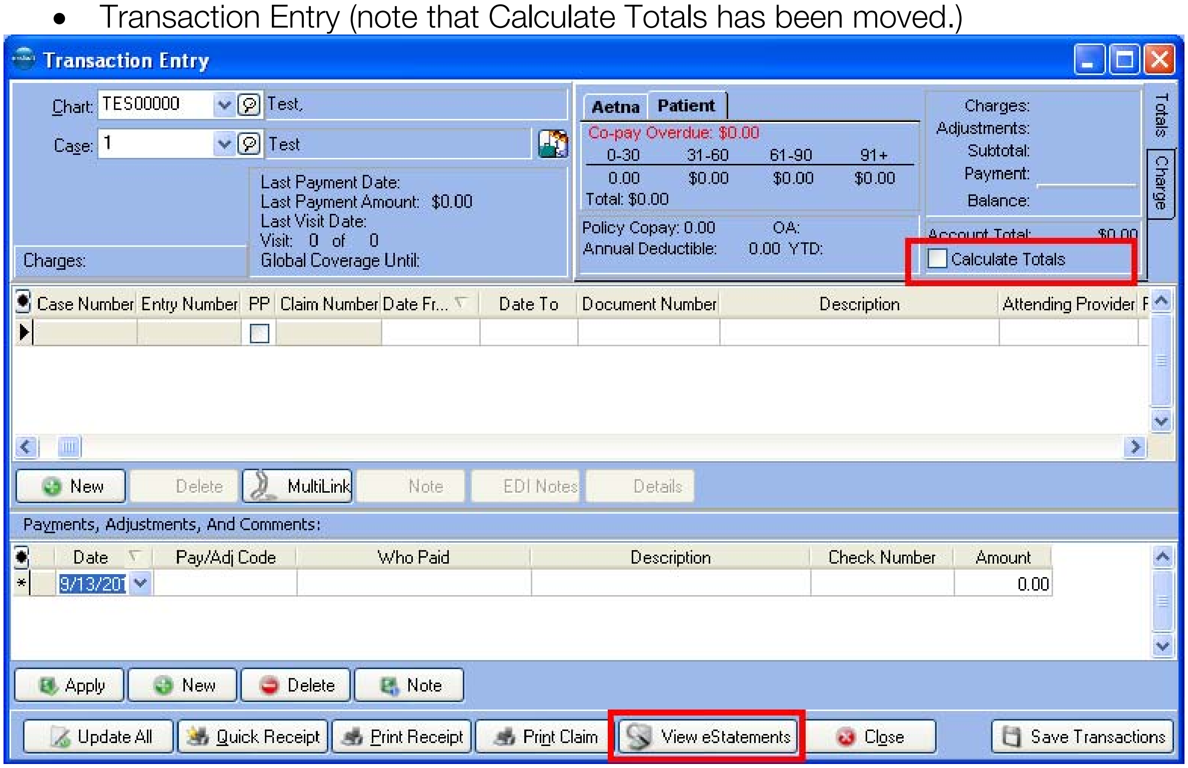
- Patient List



- New/Edit Case
- Quick Ledger
- Guarantor Ledger
- Apply Payments (through Transaction Entry)
- Collection List/Tickler
- Edit Statements



- Deposit List
- Apply Payments
- Transaction Entry (note that Calculate Totals has been moved.)



HIPAA X12 Version 5010 (ANSI 5010)

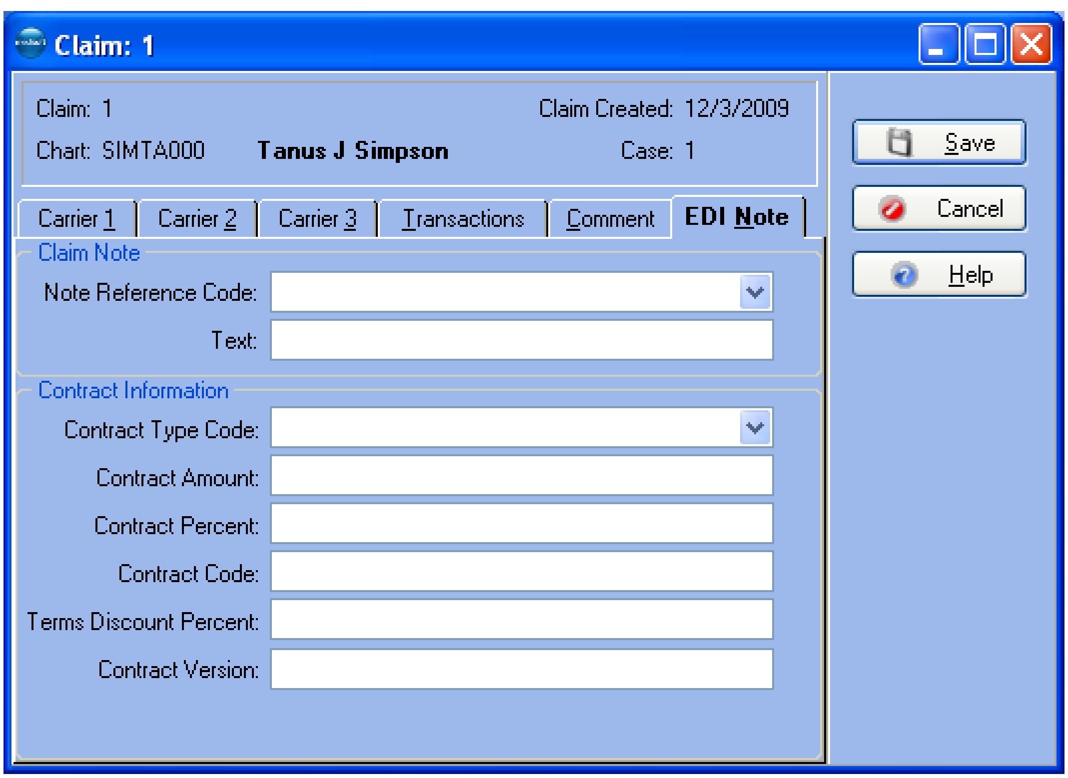
The following are changes made to Medisoft v17 to accommodate the upcoming change from the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 version 4010A1 to ASC X12 version 5010 (referred to as ANSI 5010), as well as the National Council for Prescription Drug Programs (NCPDP) version 5.1 to NCPDP version D.0.5010. ANSI 5010 and NCPDP version D.0.5010 are new sets of standards that regulate the electronic transmission of specific healthcare transactions, including eligibility, claim status, referrals, claims and remittances. Covered entities, such as health plans, healthcare clearinghouses and healthcare providers, are required to conform to ANSI 5010 standards.

These changes include new windows/tabs, restructured windows or moved fields, menu changes, new fields, additional options, and other changes.

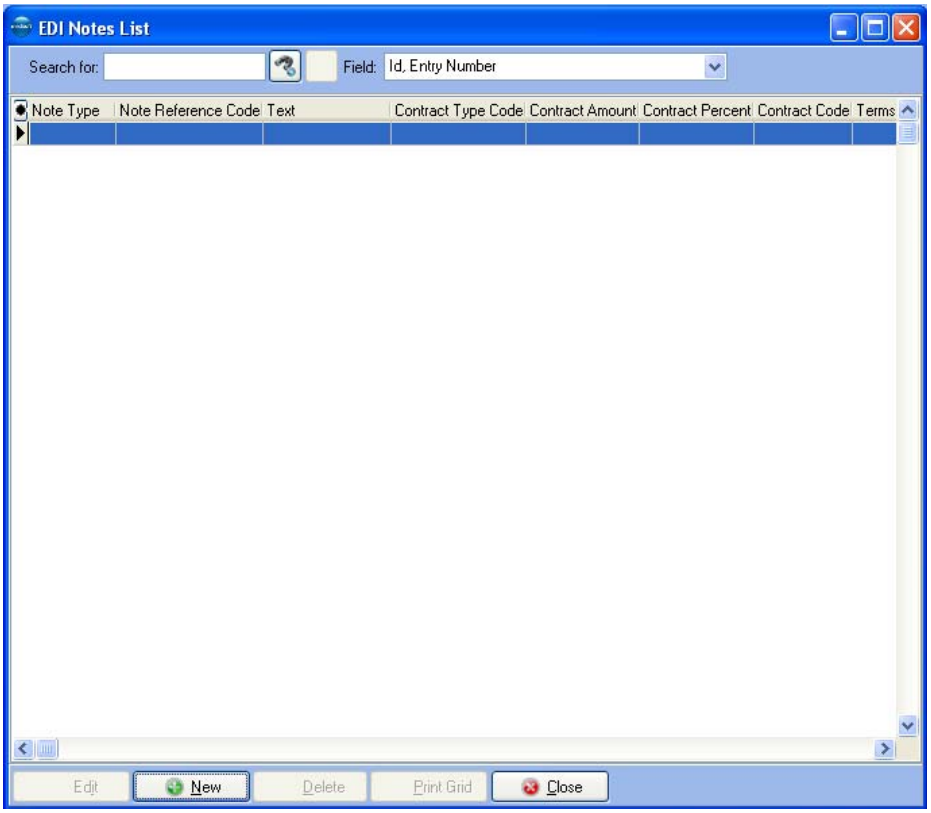
New Windows or Tabs

There are three new windows or tabs.

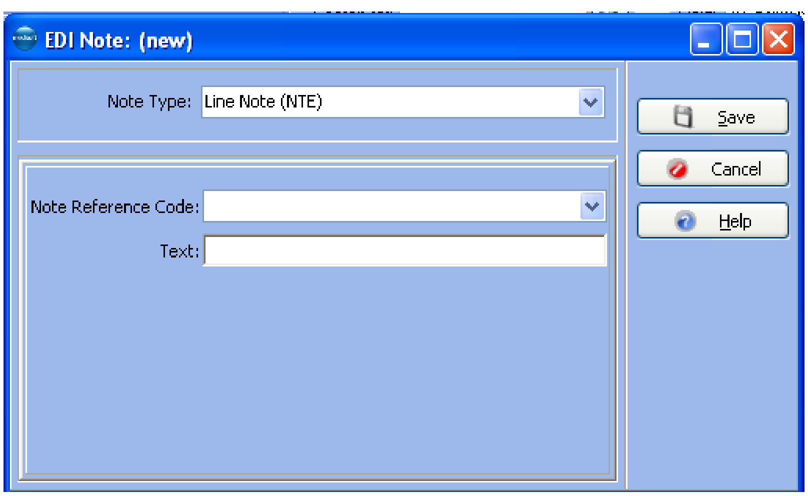
Edit Claim window, new EDI Note tab (for Claim level notes)
The **EDI Note** tab has been added to the Edit Claim window. Information on this tab is pulled from the Case Window, Comment tab. This tab allows you to change various note information at the claim level so it does not affect the data in the case record itself. For more information on this tab, see the EDI Note tab.



EDI Notes and List windows (for Transaction Line Item notes)
A new EDI Notes window will allow you to enter notes of various types for electronic transmission. The corresponding List window will open when the new EDI Notes button is clicked during Transaction Entry, Patient or Guarantor Ledger, or Unprocessed Transactions.



From this window, you can create or edit EDI Notes using the EDI Note window.



You can use the EDI Note window to enter four different types of notes. Depending on your selection in the Note Type field, the fields will change. For more information, see EDI Notes. This change eliminates the need to type notes with delimiters in the Transaction Documentation window.

On the Transaction Entry and Patient Ledger windows, you can see if there is an EDI note associated with a particular line item by adding the EDI Notes column, using the Grid Columns window.

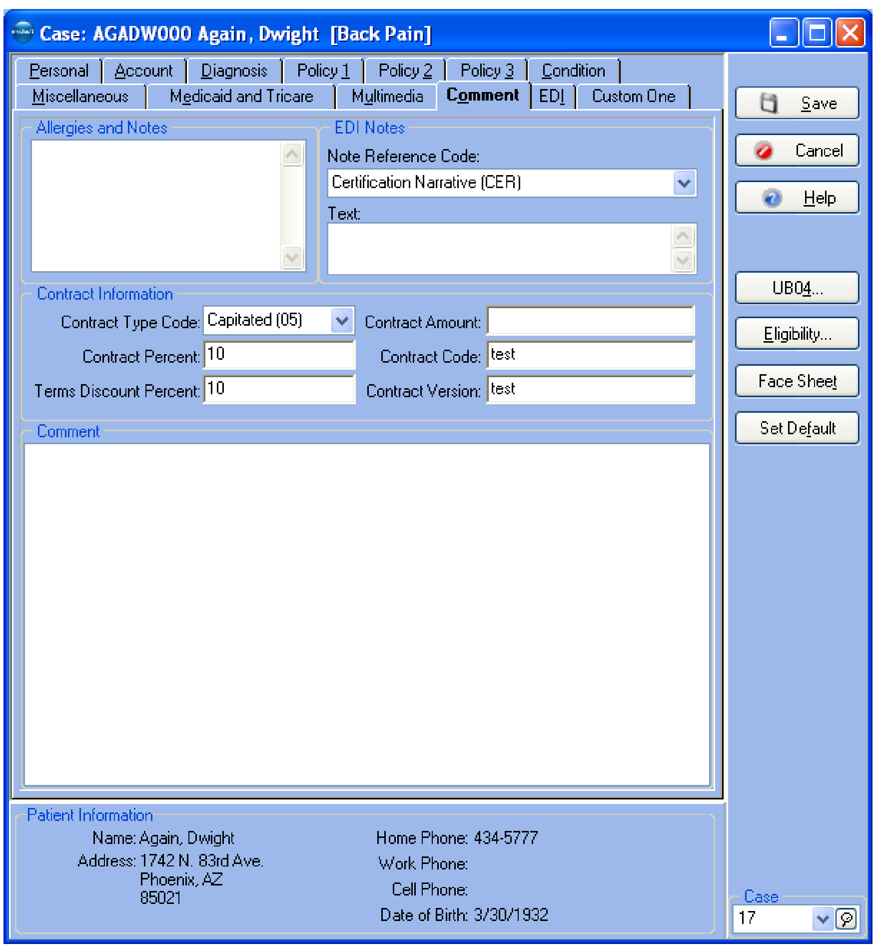
> Note: This column will NOT display by default. When you add it, the Caption will be EDINotes and the Width will be 4; however, after clicking it, the Caption will simply be E with a width of 2. If you attempt to change it back to EDINotes, it will return to E automatically.

> Warning: You must close any open EDI Notes windows before you can return to Transaction Entry, Unprocessed Transactions, or the Ledger windows.

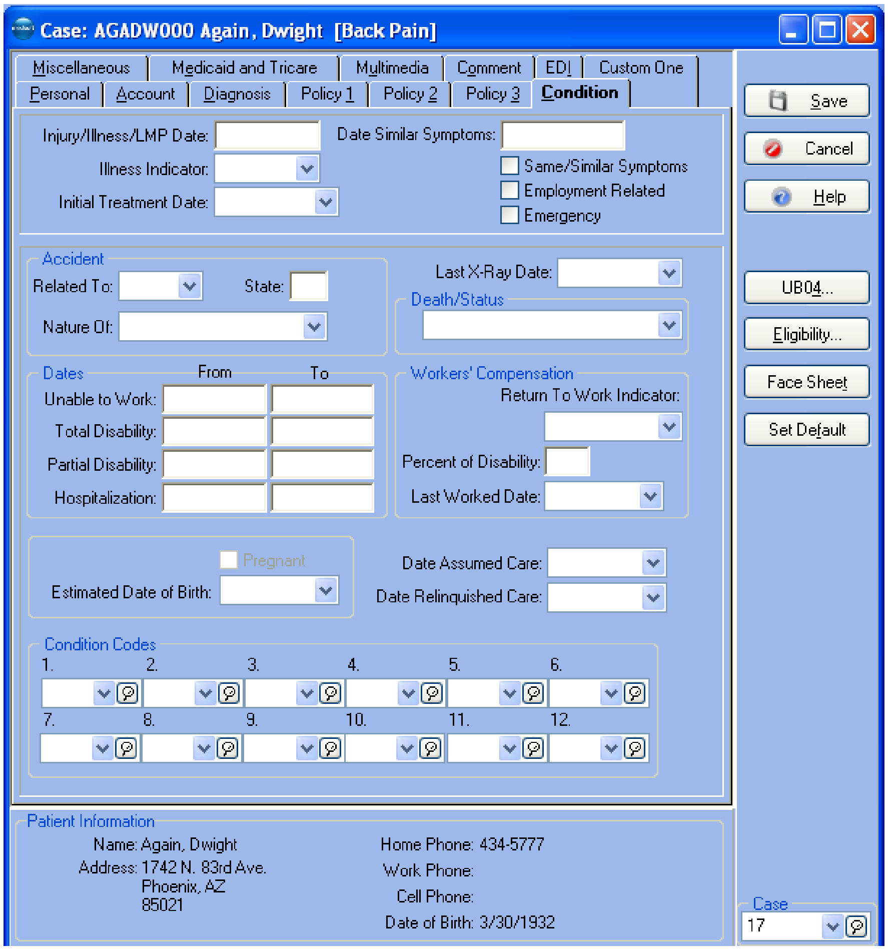
Restructured Windows and Moved Fields

Several fields have been moved, and windows have been restructured and rearranged to accommodate the moved fields.

- Allergies and Notes, as well as EDI Notes, have been moved to the Comments tab of the Case window.



- Condition Codes have been moved from the UB04 window, FL 4 to 41 tab to the Condition tab of the Case window to accommodate changes that allow condition codes to be used in professional claims. Condition Codes will not be copied if the user uses Copy Case.



New Fields Added

Several new fields have been added throughout the program. Below is a table describing the window where the new field is located, the field name and its purpose.

Window where the field is located	Field Name	Purpose
Practice Information, Practice Tab	Email	Enter the general email address for the practice.
Case Window, Case Policy 2 Tab	Medicare Secondary Reason	Allows you to specify the reason why Medicare coverage is secondary. Visible only if an insurance with Type of Medicare is selected.

Patient/Guarantor, Name, Address Tab	Date of Death	Enter the date on which the patient died, if necessary.
Patient/Guarantor, Name, Address Tab	Suffix	Allows you to enter a suffix for the patient's name, such as Jr. Windows that show the patient's name will now display the suffix as well.
Patient/Guarantor, Name, Address Tab	Race	Select the patient's race.
Patient/Guarantor, Name, Address Tab	Ethnicity	Select the patient's ethnicity.
Case Window, Medicare and Tricare Tab	Special Program Code	Allows you to select any special program from the drop-down list.
Provider Window, Address Tab	Middle Name	Allows you to enter the middle name of the provider.
Referring Provider Window, Address Tab	Middle Name	Allows you to enter the middle name of the referring provider.
Case Window, Policy 1, 2, and 3 Tabs	Group Name	Enter the group name for the insurance plan.
Procedure/Payment/Adjustment Window, General Tab	Purchase Service Amount	Use this field to enter amounts you pay a lab or other vendor for technical services they performed for you for the procedure, such as lab testing. This amount will appear on the Transaction Entry window and a summary total of these amounts on the Claim window.
Procedure/Payment/Adjustment Window, General Tab	NDC Unit Price	Use this field to enter the unit price of a drug or biologic.
Transaction Details	Reference ID Qualifier	Use this field to specify a qualifier for the Rx#/Reference ID.
Procedure/Payment/Adjustment Window, General Tab	NDC Unit of Measurement	Use this field to enter the unit of measurement that is used for the drug or biologic.

Menu Changes

The option for UB-04 Condition Codes has moved from the UB04 Code Lists menu to the main Lists menu.

Additional Options

- Additional Diagnosis Codes: The program now allows you to have up to 12 diagnosis codes for a case. The following fields and windows are affected:
  - Program Options, Data Entry tab: Number of diagnosis codes can now be set from 4-12.
  - Transaction Entry: You can now have columns for up to 12 diagnosis codes, as well as up to 12 column check boxes to specify if the code is being used for that procedure.
  - Unprocessed Transactions: You can now have up to 12 columns for diagnosis codes on the List window, as well as the Edit window.
  - Case Window, Diagnosis Tab: You can now have up to 12 default diagnosis fields.
- Patient/Guarantor, Name, Address Tab, Sex Field: Added the option Unknown
- Case Policy 1, 2, and 3 tabs: Relationship to Insured has several new options.

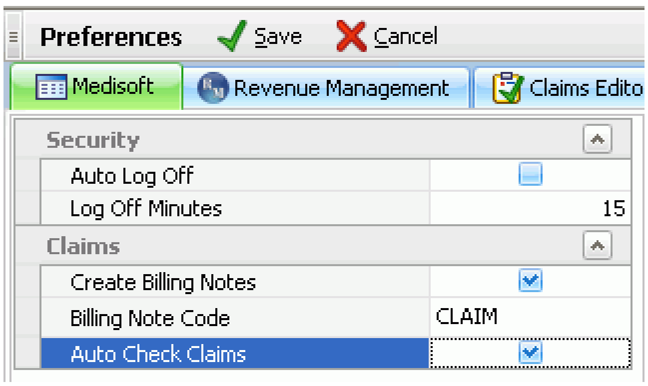
Other Changes

- Medicaid Referral Access # field is now called Referral Access #.
- Case Window, Condition Tab: First Consultation Date field is now called Initial Treatment Date.
- Case Window, EDI Tab: Timely Filing Indicator field is now a drop-down instead of a free-form text field.
- Case Window, EDI Tab: The EPSDT Referral Code field is now a drop-down.
- Insurance Type Code: Removed this field from the EDI tab on the Case window.
- Claim Filing Indicator Code: Added four new items to the drop-down:
  - Dental Maintenance Organization
  - Federal Employees Program
  - Other Federal Program
  - Commercial Insurance Co
- Relationship to Insured: Items in the list have been rearranged so that values valid for ANSI 5010 are on top and legacy values for ANSI 4010 are on the bottom.
- Timely Filing Indicator: This is now a drop-down with preset values, to ensure that a valid value is always selected.

Enhancement: Revenue Management Click Reduction

Several changes have been made to the functionality and workflow of Revenue Management to reduce the number of times that the user must click to achieve the desired result. Among these changes are:

- Claims will be auto-checked so that the user does not need to click Check Claims. There is a new option on the Medisoft tab in Revenue Management Preferences called Auto Check Claims. Selecting this option will enable the program to auto check the claims when the user selects Process > Claims.



- Claim edit checks and Implementation Guide (IG) edit checks have been combined into one step and executed when you select Claims from the Process menu. Errors are displayed on the Claims Preview report, as well as under each individual claim.
- One click removal of all claims marked with a red X has been added, eliminating the need to click Remove Claim many times. A red X icon appears next to the Remove Claim button on the Claim Preview window. Clicking this icon will remove all claims marked with a red X.
- A Failed Claim report has been added that will be displayed when the Send button is selected from the Claim Preview window. This report will display all claims that were removed, eliminating the need to preview this report separately.
- Claims that fail any edit and are removed from the transmission file will be written back to Medisoft and the status in Medisoft changed to Alert. Denial information will be written to the History tab in Revenue Management and the Comments tab on the Claim window in Medisoft.
- The OK button that is displayed after clicking Send from the Claim file saved message has been removed. The Transmission Has Been Received button that displayed after the file was sent/received has been removed.

Revenue Management ERA Changes to Meet ANSI 5010

Changes have been made to Revenue Management electronic remittance advice (ERA) processing to handle the upcoming switch to ANSI 5010. Among these are the following:

- Updates to the 5010 RelayHealth IG. These updates include:
  - For the 835 IG, the TRN02 element has increased size to a maximum of 50 characters.
  - The N407 element (Country Subdivision Code) in Loop 1000A AND Loop 1000B has been added to the 835 IG. It is situational and has a maximum length of 3 characters. It is required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc.
  - Several new elements for Loop 1000A (Payer Identification) in the 835 IG that are not active yet but must be added. In this way, if they are received, the ERA will not be discarded. These are the following:

		POS#	ID	Min/Max	Usage Req	Values
PER	Payer Technical Contact Information	1300		>1	R	
PER01	Contact Function Code		ID	2--2	R	BL
PER02	Payer Technical Contact Name		AN	1--60	S	
PER03	Communication # Qualifier		ID	2--2	S	EM, TE, UR
PER04	Payer Contact Communication #		AN	1-256	S	
PER05	Communication Number Qualifier 2		ID	2--2	S	EM, EX, FX, TE, UR
PER06	Payer Technical Contact Communication #		AN	1--256	S	
PER07	Communication Number Qualifier 3		ID	2--2	S	EM, EX, FX, UR
PER08	Payer Contact Communication #		AN	1--256	S	
PER09	Contact Inquiry Reference		AN	1--20	N/U	

PER	Payer WEB Site	1300		1	S	
PER01	Contact Function Code		ID	2--2	R	
PER02	Name		AN	1--60	N/U	
PER03	Communication # Qualifier		ID	2--2	R	
PER04	Payer Contact Communication #		AN	1-256	R	
PER05	Not Used					

- There are new RDM (Remittance Delivery Method) elements being added to Loop 1000B. These will be ignored in posting but need to be defined in the IG. These are the following:

		POS#	ID	Min/Max	Usage Req	Loop Repeat	Values
RDM	Remittance Delivery Method	1400		1	S		
RDM01	Report Transmission Code		ID	1--2			BM, EM, FT, OL
RDM02	Name		AN	1--60			
RDM03	Communication Number		AN	1--256			
RDM04	Not Used				N/U		

- There is a new DTM (Coverage Expiration Date) element for ANSI 5010. This segment explains that coverage was denied because the patient's coverage has expired. The new values are below:

		POS#	ID	Min/Max	Usage Req	Loop Repeat	Values
DTM	Coverage Expiration Date	0500		1	S		
DTM01	Date/Time Qualifier		ID	3--3	R		050
DTM02	Date*		DT	8--8	R		CCYYMMDD
DTM03					N/U		

*This is the date on which the patient's coverage expired.

- There are new Claim Received Date Elements (DTM) in Loop 2100. These have been added to the IG so that they are recognized if they are received. They are not used in posting a remit, however. Here are the new values:

		POS#	ID	Min/Max	Usage Req	Loop Repeat	Values
DTM	Claim Received Date	0500		1	S		
DTM01	Date/Time Qualifiier		ID	3--3	R		050
DTM02	Date*		DT	8--8	R		CCYYMMDD
DTM03					N/U		

*This is the date that the claim was received by the payer.

- The number of repeats for the REF Service Identification Element in Loop 2110 has been increased to 8 for 5010. The 4010 required only 7.

- There is a new element for 5010 added to the IG in Loop 2110 (Service Payment Information): REF Healthcare Policy Identification. Here is a table of the values:

		POS #	ID	Min/Max	Usage Req	Loop Repeat	Values
REF	HealthCare Policy Identification	1000		5	S		
REF01	Reference Identification Qualifier		ED	2--3	R		0K
REF02	Healthcare Policy Identification		AN	1--50	R		

- Updates to reports:
  - Claim Preview Report now includes:
    - any suffix after the patient's name (Segment NM107 in Loop 2100)
    - the Coverage Expiration Date for an expired policy (DTM Coverage Expiration Date in Loop 2100)
    - the Claim Received Date, which shows the date the claim was received by the payer (DTM Claim Received Date in Loop 2100)
  - Claim Details Report now includes:
    - any suffix after the patient's name (Segment NM107 in Loop 2100)
    - the Claim Received Date, which shows the date the claim was received by the payer (DTM Claim Received Date in Loop 2100)
    - the specific amounts of a claim (REF Healthcare Policy Identification in Loop 2110).

- Remittance posting includes Coverage Expiration Date in Loop 2100.
- 25 Changes to the 5010 Eligibility IG.

Element	Location	Modification
ISA11 (Interchange Control Standards ID)	Interchange Control Header	Was previously hardcoded to U, but is now blank.
ISA12 (Interchange Control Version Number)	Interchange Control Header	Replaced 00401 with 00501 for use with 5010.
GS08 (Version/Release/Industry Identifier Code)	Function Group Header	Updated from 004010X092 to 005010X279
ST03 (Implementation Convention Reference)	Transaction Set Header	This is a new segment added after ST02 and hardcoded to 00510X279.
NM112 (Name Last or Organization Name)	Loop 2100A	This is a new element for 5010.
NM112 (Name Last or Organization Name)	Loop 2100B	This is a new element for 5010.
REF04 (Reference Identifier)	Loop 2100B	This is a new element for 5010
NM107 (Name Suffix)	Loop 2100C	The insured person's name Suffix has been made available as a data element.
NM112 (Name Last or Organization Name)	Loop 2100C	This is a new element for 5010.
REF04 (Reference Identifier)	Loop 2100C	This is a new element for 5010.
N407 (Country Subdivision Code)	Loop 2100C	This is a new element for 5010.
DMG10 (Code List Qualifer Code)	Loop 2100C	This is a new element for 5010.
DMG11 (Industry Code)	Loop 2100C	This is a new element for 5010.
DTP01 (Date/Time Qualifier)	Loop 2100C	This has changed from 472 to 291.
EQ01 (Service Type Code)	Loop 2110C	New codes have been added. In addition, there is a new data element that takes the value from the appointment. If that value is null, it takes the value from practice preferences. If that value is null, 30 (Health Benefit Plan Coverage) is hardcoded. The latter is current functionality.

NM107 (Name Suffix)	Loop 2100D	The patient name suffix is added.
NM112 (Name Last or Organization Name)	Loop 2100D	This is a new element for 5010.
REF04 (Reference Identifier)	Loop 2100D	This is a new element for 5010.
N407 (Country Subdivision Code)	Loop 2100D	This is a new element for 5010.
DMG10 (Code List Qualifier Code)	Loop 2100D	This is a new element for 5010.
DMG11 (Industry Code)	Loop 2100D	This is a new element for 5010.
EQ01 (Service Type Code)	Loop 2110D	New codes have been added. In addition, there is a new data element that takes the value from the appointment. If that value is null, it takes the value from practice preferences. If that value is null, 30 (Health Benefit Plan Coverage) is hardcoded. The latter is current functionality.
REF04 (Reference Identifier)	Loop 2110D	This is a new element in 5010.

The following PER segments have been deleted from Loop 2100B:

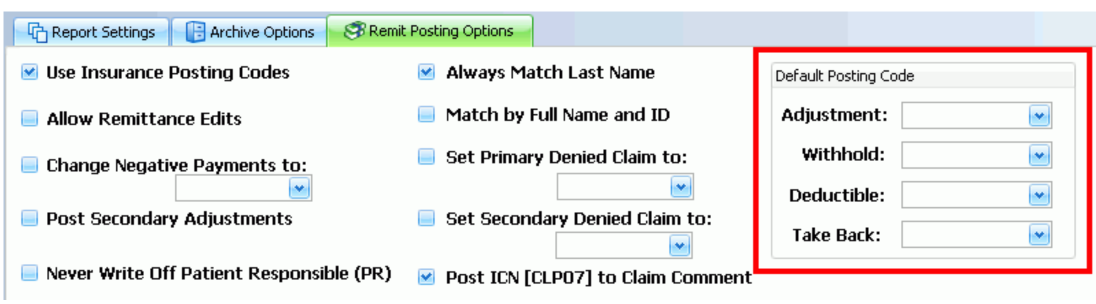
		ID	Min/Max	Usage Req	Values
PER	Information Receiver Contact Information		3	S	
PER01	Contact Function Code	ID	2--2	R	IC
PER02	Name	AN	1--60	S	
PER03	Communication Number Qualifier	ID	2--2	S	ED, EM, FX, TE
PER04	Communication Number	AN	1--80	S	
PER05	Communication Number Qualifier	ID	2--2	S	ED, EM, EX, FX, TE
PER06	Communication Number	AN	1--80	S	AAABBBCCCC
PER07	Communication	ID	2--2	S	ED, EM, EX, FX,

	Number Qualifier				TE
PER08	Communication Number	AN	1--80	S	AAABBBCCCC
PER09	Contact Inquiry Reference	AN	1--20	N/U	

Revenue Management Configuration and Setup Changes

Several changes have been made to Revenue Management to simplify the setup and configuration process. Among them are the following:

- Eliminated the Alias table for ERA processing. The user will not need to choose the practice or payor information for ERA processing. Instead, information from the ERA file itself is used to process the ERA file. The Pay To field from Loop 1000B (practice or provider) and the Payer Name field from Loop 1000A Segment N102 (payor information) directly match the information sent out on the claim and will be used, eliminating these steps.
- Allow the user to edit the Receiver table directly, bypassing the wizard. Certain sections of the table remain locked, however.
- Allow the user to log in to Revenue Management automatically from Medisoft.
- Simplify the setup of ERA. Assign Posting codes will be populated by default with the appropriate payment codes that reference carrier-specific codes in Medisoft. In addition, there is a set of default ERA posting defaults in the Remit Posting Code window in Revenue Management. If Use Insurance Posting Codes is checked and there are no carrier-specific codes, these new Default Posting Codes will be sent.



Office Hours Professional Registration

Office Hours Professional is registered at the same time as Medisoft. Although there is still a place where you can register Office Hours Professional, you do not have to perform a separate registration once you register your Medisoft product. Any messages you might receive to register Office Hours Professional can be ignored once Medisoft is registered.