Please note this is a text only version and doesn’t contain many of the live features of the eLearning interactive program.

If you wish to access the eLearning interactive program, click here.

Doing Business with Medicare Electronically

This program is an overview of how to do business with Medicare electronically by providing information on Electronic Medicare Claiming, including the various electronic claiming channels available. It also outlines the functionalities of the Health Professional Online Services (HPOS).
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Module 1 – Introduction to Electronic Medicare Claiming and Health Professional Online Services (HPOS)

This module provides an introduction to Electronic Medicare Claiming including an overview of security systems and benefits of online services. It also provides an overview of HPOS.

Topic 1: Overview

The Medicare Program

The Medicare program provides access to:

- free or subsidised treatment by health professionals such as doctors, specialists, optometrists, dentists and other allied health practitioners (in special circumstances only)
- free treatment and accommodation as a public (Medicare) patient in a public hospital, and
- 75 per cent of the Medicare Schedule fee for services and procedures if you are a private patient in a public or private hospital (does not include hospital accommodation and items such as theatre fees and medicines).

The Department of Human Services (Human Services) makes payments for services provided by eligible health professionals under Medicare, the Pharmaceutical Benefits Scheme (PBS) and other government programs, such as the Australian Childhood Immunisation Register (ACIR).

What is Electronic Medicare Claiming?

Human Services is committed to delivering easy and convenient services by offering health professionals a variety of electronic options for their Medicare claiming.

Electronic Medicare Claiming is a convenient way for health professionals to claim Medicare benefits online. It offers you, as a health professional, an alternative to paper based claiming and allows you to lodge Medicare claims on behalf of claimants at your practice allowing for faster and more efficient payments.
The electronic claiming channels available include:

- Medicare Online
- Medicare Easyclaim
- ECLIPSE

All systems use highly secured encrypted networks to transmit information.

View the Electronic Medicare Claiming Fact Sheet.

Reference
Claimants
A claimant is the person who incurred the expense for services provided. The claimant is not always the patient (for example the claimant could be the patient's parent).

Types of claims
The number of health professionals claiming electronically is increasing. There are three types of Medicare claim categories processed electronically by Human Services:

Bulk billing
Bulk billing is where a health professional accepts the amount of the Medicare benefit that is payable to the patient as full payment for the service.

If a patient is ‘bulk billed’:

- an additional fee cannot be charged
- it is the responsibility of the health professional to lodge the claim with Human Services, and
- the claim must be lodged with Human Services within 2 years from the date of service.

Patient claims
Health professionals are free to set their own fees for their professional services. Electronic Patient Claiming (i.e. patient claims) is the process by which a surgery transmits a private account on behalf of a patient to Human Services. If a payment is made in full, the Medicare benefit will be paid into the claimant’s registered bank account.

Simplified billing
Simplified billing aims to reduce the number of accounts a private patient receives after being in hospital by lodging a claim with Human Services and the private health insurer at the same time.
**Benefits of Electronic claiming**

Electronic claiming offers a number of benefits, including:

- faster payments for health professionals and patients,
- more convenient claiming options and channels,
- less paperwork, and
- more certainty around unpaid accounts – **90 Day Pay Doctor Cheque Scheme**.

**The 90 Day Pay Doctor Cheque Scheme**

**90 day pay doctor cheque** - A 'Pay Doctor via Claimant' cheque refers to a Medicare benefit cheque sent to a patient but made payable to the provider.

**The Scheme** - Under the scheme, when an unpaid or partially paid electronic claim is submitted and the 'Pay Doctor via Claimant' cheque is not banked after 90 days, Human Services will automatically cancel the cheque and pay the benefit to the provider via EFT to their nominated bank account.

Where a health professional presents a cheque 90 days or more after the issue date, Human Services is not liable for any dishonour bank charges.

**Eligibility** - General practitioners (GPs), specialists and consultant physicians, including pathologists, are eligible for the scheme if they electronically transmit claims (there is no need to register separately for the scheme).

Allied health professionals, optometrists and dentists are not eligible for this scheme.

**Collection of bank account details**

Electronic Medicare Claiming is a cashless system that requires either a health professional's or claimant's bank account details to process and issue benefits (depending on the type of claim). To assist medical practices, Human Services collects and stores bank account details for both health professionals and the public for the purposes of electronic claiming.

**Bulk bill claims**

Medicare and the Department of Veteran's Affairs (DVA) bulk bill benefits are no longer issued by cheque. All health professionals are now required to register bank account details to receive Medicare benefits.

Health professionals are required to register bank account details for each of their practice locations.
Patient claims
Human Services collects and stores the public's bank account details so benefits from Medicare Online claims can be issued to a patient's bank account via EFT. This allows medical practices to submit claims via Medicare Online without having to collect or store a claimant's bank account details. Payment will be made via a cheque to the claimant where no bank account details are lodged.

Simplified billing
Human Services will make payments to a private health insurer or billing agent via EFT into the bank account registered with Human Services.
Topic 2: Public Key Infrastructure

Public Key Infrastructure (PKI) Certificates for doing business with Medicare electronically

Safeguarding privacy when sending and receiving personal information is critical. A Public Key Infrastructure (PKI) certificate is supplied to you by Human Services to provide you with a secure way to authenticate with us and have confidence that the information you send is secure and private.

A PKI certificate allows you to:

- lodge Medicare claims electronically
- access provider services in HPOS
- verify patient details with Medicare, and
- securely send and receive health information with other healthcare individuals and organisations that also have a PKI certificate.

Types of Certificates

A PKI site certificate is used for Medicare Online claiming and access to basic services in HPOS.

A PKI site certificate allows a number of people at the same location to do electronic business on behalf of their organisation. A PKI site certificate is issued on a CD, together with instructions for installation.

A PKI individual certificate is used to access HPOS.

An individual certificate allows only you, as the certificate holder, to do your business electronically. The PKI individual certificate is issued on a USB token or a smart card (including a card reader).

Applying for a PKI certificate

To apply for a PKI certificate, just download and complete the forms available on the Human Services website.

If your application is successful, we will send your certificate and installation instructions to your preferred mailing address.
Installation and Validity

To install your PKI certificate you will need:

- a PC or MAC
- a CD reader
- a spare USB port (for individual certificates)
- practice software that is compliant with Medicare's electronic claiming channels (for site certificates), and
- an internet connection

For security reasons, your Personal Identification Code (PIC) is mailed separately. You need your PIC to install and start using your certificate. Please keep your PIC in a safe place so that you can easily refer to it in the future.

For individual certificates

When you get your certificate, you must install the software on the accompanying CD. You have to install the software onto each computer you want to use. Please keep your PIC in a safe place so that you can easily refer to it in the future.

For site certificates

Please contact your software vendor for help with installing your certificate into your practice software. Your PIC only needs to be entered when you install (or re-install) your site certificate. If you need additional help, contact the eBusiness Service Centre on 1800 700 199 (call charges apply from mobile and pay phones only).

Validity of certificates

The site and individual certificates are valid for 5 years from the time they are issued. You may need to request for the renewal of your certificate after this time if your certificate cannot be automatically renewed. You will be sent a letter by Human Services prior to your certificate expiring if your certificate cannot be automatically renewed. You will need to complete and fax back the request form that accompanies your letter before we will send you a replacement certificate.

If you need to replace a lost, stolen, faulty or broken certificate, complete the Request to Revoke/Reissue Department of Human Services PKI site or individual Certificate form available here.

humanservices.gov.au
Topic 3: HPOS

What is HPOS?
HPOS is a secure and convenient online service for health professionals and administrators. It helps to streamline your interactions with us by reducing the need to call, and helps to avoid rejected claims, making your practice more efficient.

HPOS offers numerous benefits for health professionals, including:

- access to services that will help to reduce rejected claims for your practice
- access to the Healthcare Identifiers (HI) Service
- ability to register to use the eHealth Record System and authorise healthcare providers to access the eHealth Record System Provider Portal
- ability to subscribe to receive Patient Treatment Reports for veterans in your care who are enrolled in the Coordinated Veterans’ Care (CVC) program
- ability to subscribe to receive online statements, letters and notifications for a range of services, and
- ability to complete and submit Medical Report Disability Support Pension and Medicare Certificate forms securely to Centrelink.

View the HPOS fact sheet for more information on HPOS services.

Accessing HPOS
HPOS can be accessed through the Human Services website. To access HPOS you need a Human Services PKI certificate.

**PKI individual certificate**
For providers, your PKI individual certificate provides access to the full range of services based on your provider type.

For administrators, your PKI individual certificate allows access to basic HPOS services. Health professionals can delegate access to administrators to undertake some tasks on their behalf.

**PKI site certificate**
A PKI site certificate allows practice staff access to patient verification and basic mail centre functions.
Services

HPOS provides health professionals and administrators access to a range of online services.

The HPOS main menu screen is activated after logging on to HPOS. Menu options will vary depending on your access. Services can be selected from the main menu on the left hand side.

Below is information on some of the HPOS services:

Medicare Services

Services available:

- request Medicare Easyclaim processing and payment reports
- update provider personal details
- view provider number details
- add a new Medicare practice location
- reopen a closed Medicare practice location

Updates or changes made through HPOS will automatically update the user's DVA and ACIR records.

Below is an example of a Medicare Easyclaim Processing Report retrieval page.
Resources and Forms
Access to:

- Human Services' Forum magazine
- MBS Online and PBS Online
- Online eligibility tool
- Human Services' health professional forms

Centrelink Forms
Health professionals can download, complete and submit the Medical Report – Disability Support Pension and Medical Certificate forms online. The information is sent to Centrelink through a secure channel and automatically links to the patient’s Centrelink record. Draft forms can be saved in HPOS until complete and previously submitted forms are available to view and print for the patient.

Mail Centre
Send secure emails to pre-defined mail centres in Medicare and subscribe to receive statements, letters and notifications online for:

- Medicare bulk bill
- National Bowel Cancer Screening
- ACIR
- 90 day pay doctor cheque scheme EFT payments
- Rural Incentive programs'
- Telehealth incentive payment advice
- Track and Scale
For More Information
Call the eBusiness Service Centre on 1800 700 199 for more information about other services available in HPOS and to arrange a Business Development Officer to visit your practice.

MBS Items Online Checker
The MBS Items Online Checker allows you to check a patient's eligibility to claim a Medicare benefit based on their claiming history. HPOS will advise if the patient meets eligibility before you submit the claim, avoiding the possibility of a rejected claim. Verbal consent by the patient must be obtained before completing the check.

Details of the MBS Item numbers available can be found on the HPOS logon page under Frequently Asked Questions (FAQs).

Using the MBS Items Online Checker.
1. To perform a search:
   - Enter the Patient’s Medicare details
   - Read and agree to the declaration
2. In this section:
   - Your provider number will automatically appear.
   - Select the number range from the drop down arrows. The drop down arrows next to item number groups will expand the list. *The screen may vary from this view due to system enhancements.*

3. In this section:
   - Select the item numbers you would like to check and then select ‘Search’.
4. Example MBS Items Online Checkers results screen is below.

Patient Verification

Patient Verification allows you to confirm and search for a patient's Medicare card details. Patient Verification can be accessed from the main menu.

Patient verification is accessed with a PKI individual or site certificate and provides the following services.

- **Confirm Patient Details** - allows you to confirm a patient's Medicare card number when the card has been presented or previously recorded against the patient record, a response is provided immediately.

- **Search Patient Details** - allows you to search for a Medicare card number based on basic patient information, a response is provided immediately.

- **Multiple Details Request** - allows a bulk request of up to 500 Medicare card numbers with a response within 24 hours.
Delegation model

Health professionals can delegate access to administrators to undertake some tasks on their behalf. These tasks include:

- adding new or re-opening existing practice locations
- checking MBS items using the MBS Items Online Checker, and
- generating Medicare Easyclaim Bulk Bill processing and payment reports.

Administrators require a PKI individual certificate to undertake these tasks.

If you have previously provided evidence of identity (EOI) in your role as a Duly Authorised Officer (DAO) when applying for your organisations' site certificate, you will not need to provide EOI again when applying for your PKI individual certificate.
Compliance overview

Human Services is committed to building a culture of voluntary compliance by actively encouraging the public and health professionals to meet their obligations.

Criminal Behaviour and Fraud
A small number of people seek to deliberately exploit our programs. Human Services’ response is to enforce the law.

Opportunistic Noncompliance
Inappropriate behaviour. A few people seek to take advantage. Human Services’ response is to correct behaviour.

Accidental Noncompliance
Sometimes people make mistakes, Human Services’ response is to counsel and provide feedback.

Voluntary Compliance
The majority of people do the right thing, Human Services’ response is to help and support.
Health Professional responsibilities

When electronically submitting Medicare claims, health professionals must ensure that they continue to use correct claiming practices. Health professionals are responsible for all claims submitted under their provider number or in their name.

Some important things to remember when using HPOS or electronic claiming:

- Online bulk bill assignment of benefit forms must still be signed by patients.
- Claims submitted electronically must be accurate and still meet the MBS item number and provider eligibility requirements.
- Individual PKI certificates must only be used by the person it is issued to.
- Verbal consent must be obtained from the patient before submitting a patient claim or when doing any online eligibility check (including patient verification, item number check, private health fund checks).
- Under Simplified Billing Arrangements, billing agents must obtain a signature from the patient under the Simplified Billing Assignment of Benefit.

Audits

Where we identify a risk that payments may have been made incorrectly, Human Services conducts audits with health professionals or medical practices to verify the details of services.

A compliance audit is designed to check that benefits are claimed correctly. We will check that both the health professional and patient were eligible for Medicare benefits, that the service was provided, and that it meets the item requirements.

Where an incorrect payment is identified we seek to recover the incorrectly paid amounts.

Refer to the Compliance Audit flowchart for more information.
Topic: Summary and References

Summary

This module has covered:

- an overview of what Electronic Medicare Claiming is
- the benefits of Electronic Medicare Claiming
- the different PKI certificates and what you can use them for
- the systems and function of HPOS
- the importance of compliance.

References

Online Education material  Online Education Services

Electronic Medicare Claiming  Fact Sheet

HPOS  Fact Sheet
Module 2 – Electronic Medicare Claiming Channels

This module provides an overview of the different Electronic Medicare claiming channels available to health professionals, including their functionalities and claiming processes.

Topic 1: Medicare Online

Medicare Online

Medicare Online allows medical practices to transmit bulk bill and patient claim transmissions using practice management software (software). It helps to streamline your claiming process, allowing for faster payments via electronic funds transfer (EFT).

Human Services has worked with software vendors and other health industry bodies to continually build this claiming channel to improve Medicare claiming efficiencies for health professionals.

Key features

- Less paperwork
- Faster payments
- System is integrated with your practice management software
- Payments are made via EFT within 2-3 working days
- Bulk bill and patient claims can be submitted online
- Available to all eligible providers
- No manual batching required for bulk bill claims
- Offers a secure electronic channel using Public Key Infrastructure (PKI)

Public Key Infrastructure (PKI)

For Medicare Online claiming, you will be issued with a PKI certificate that will need to be integrated with your software to securely claim with Medicare Online.

The PKI site certificate allows a number of people at the same location to do electronic business on behalf of their organisation. The PKI site certificate is issued on a CD, together with instructions for installation.

For PKI site certificate registration forms, refer to the Human Services [website](#).
Systems
For Medicare Online claiming, you can use a PKI site certificate. For bulk bill claims this option requires that the provider signs a post-claim declaration from time-to-time for substantiation purposes.

Getting started with Medicare Online
- contact your software vendor or IT support to check the compatibility of your software for Medicare Online claiming
- connect to the Internet, and
- register to use Medicare Online.

Each software package is different and may not offer all the Medicare Online functionalities. You should contact your software vendor directly regarding function availability. For a full list of software vendors offering Medicare Online claiming functions, click here.

Registration Process
Each individual provider in a practice must be registered individually to do business online and register their bank account details for EFT payments. The registration forms, which will also register the practice location for online claiming, are available on the Human Services website.

Once you have registered for Medicare Online you can submit any type of online claiming transmission for any practice site that has Medicare Online activated.

Maintaining online claiming registration
You will need to contact the eBusiness Service Centre on 1800 700 199* to update your online claiming registration details if:
- you discover that your individual certificate registration authority number has been incorrectly entered or your contact details (eg. telephone number and/or mailing address) change
- your bank account details change, and/or
- there is a change in business ownership.

* call charges apply from mobile and pay phones only.
Functionalities

Medicare Online claiming offers a variety of functionalities to make claiming easier for both you and your patients. Some software products do not offer all the online claiming functionalities, so please refer to your software for further details.

Overview of the main Medicare Online functionalities

Online Patient Verification (OPV)

There are two types of patient verification functionalities through your software:

- OPV PVM (Patient Verification Medicare)
  This check confirms if a patient's Medicare number and expiry date are correct. It can be completed prior to submitting the claim to avoid rejections. Batch checking for multiple patients at once is also available.

- Concessional Entitlement Verification (CEV)
  This check confirms the concessional status of a patient before processing a bulk bill claim and determines whether the GP practice is entitled to claim a bulk bill incentive item.

Online bulk billing

Key features of submitting bulk bill claims online:

- Payments are received within 3 working days by EFT. Pathology has a 14 day payment period.
- Payment and processing reports are available electronically through your software.
- Batching of claims is completed in your software (no manual batching or paperwork is required).
- 80 bulk bill vouchers can be included per batch claim. There is a limit of 14 items per voucher.

Patient Claiming (PC)

Lodge private accounts (paid, unpaid or partially paid accounts) for your patients through your software. Key features include:

- For fully paid claims, payment is received into the claimant's nominated bank account within 2-3 working days.
- GPs and specialists are automatically eligible for the 90 day pay doctor cheque scheme for unpaid or partially paid claims.
- Same day delete option is available - delete a transmitted patient claim from the Medicare system using your software on the same day you transmitted the claim.
- PCI (Patient Claiming Interactive) - claim is processed in real-time and a confirmation is received within minutes.
- PCS (Store and Forward) - store claims to submit later.
Department of Veterans' Affairs (DVA) claiming
Claiming for medical and pathology with limited or no paperwork to be mailed to Human Services. This will be dependent on your software’s capabilities.

OVV (Online Veteran Verification) allows you to check your patient’s eligibility for DVA services.

Australian Childhood Immunisation Register (ACIR)
Receive notification of immunisations and record immunisations provided online.

Reports
Electronic bulk bill processing and payments reports are available by submitting a request to Human Services via your software.

In most cases, the payment reports, will automatically reconcile your bulk bill claims in your software. There is no requirement for practices to reconcile patient claims.

Processing reports will specify claims that have been successfully processed and provide detail of any exceptions within the claim. A Medicare reason code is displayed next to rejected service lines and can be used to determine what information in a claim caused the rejection and if appropriate change the claim details and resubmit.

A full list of reason codes can be found here.

Medicare Online bulk bill claiming process
1. After the consultation (using your software) create a bulk bill voucher with all applicable claim information.

2. Print off the bulk bill assignment of benefit form for the claimant to sign.

   Bulk bill assignment of benefit forms must still be signed by the patient/claimant. A copy must be offered to the patient/claimant.

3. Using your software, electronically create a bulk bill claim by batching all bulk bill vouchers together. Up to 80 bulk bill vouchers can be batched together.

4. Submit the claim to Human Services for assessment and processing.

   Claims cannot be submitted more than two years after the initial date of service as per normal procedures.
5. Human Services will check the:
   - provider’s registration details
   - patient’s Medicare entitlement
   - patient’s concession entitlement.

6. If a voucher is accepted for a Medicare benefit, Human Services makes payments directly into the payee provider’s nominated bank account.

   Payment is made within 2 to 3 working days. *(Pathology has a 14 day payment period)*.

7. Your processing and payment reports will be available within 2 to 3 working days. Payment reports will show all claims that were deposited in a single payment run. Processing reports will show all vouchers sent within a single batch where an exception or rejection has occurred.

   If any vouchers contain exceptions or rejections, it will be stated on your processing report with an associated reason code. If applicable, the claim can be amended and resubmitted online.

**Medicare Online patient claiming process**

1. After the consultation, the patient/claimant pays the account in full as per normal channels (eg. cash, cheque, credit card or EFTPOS).

2. Enter the claim details into your system as normal.

   Obtain verbal consent from the claimant to lodge the claim online on their behalf.

3. Select the patient’s benefit payment option – Cheque or EFT. If the patient has given Human Services their bank account details, choosing the cheque option will automatically pay via EFT.

   You will need to enter your patient's bank account details for the EFT option.

4. Submit the claim to Human Services for verification and processing.

5. Human Services will check the:
   - provider’s registration details
   - patient’s Medicare entitlement
   - claim details
6. Human Services will respond with an approved, decline, or pended message within seconds.

A pended message means the claim is being assessed by a Human Services customer service officer for either payment or rejection.

For claims assessed successfully at the time of transmission a statement of benefit will be printed for the patient’s records. For pended claims or PCS claims a 'Lodgement Advice' will be printed.

7. For approved claims, Human Services pays the benefit directly into the patient’s cheque or savings account within 2 to 3 working days. A cheque may be sent to the patient if their bank account details are not available.

8. For REJECTED claims a reason code will be sent in order for you to determine if there is a claim error that can be fixed immediately. Alternatively, you will need to issue an itemised account and/or receipt to the claimant for claiming directly with Human Services.

For PENDED claims a lodgement advice will be printed for the patient and after assessment the benefit will be paid or a rejection letter will be sent to the claimant.
**Topic 2: ECLIPSE**

**ECLIPSE**

ECLIPSE stands for: Electronic Claim Lodgement and Information Processing Service Environment.

ECLIPSE allows billing agents and health professionals to electronically lodge In-patient Medical Claims (IMCs) and In Hospital Claims (IHCs) directly to Human Services and the private health insurer in a single transaction. ECLIPSE is an extension to the Medicare Online claiming system and continues to offer a secure connection between practices, public and private hospitals, billing agents, Medicare and DVA and private health insurers.

**Key features**

- One claiming process for all private health insurers
- Paperless transactions between you, the private health insurer and Human Services
- Easier way to obtain informed financial consent from patients
- Quicker processing times – reduction from weeks to days
- Private hospital patients can pay the gap only
- Better data quality leading to fewer errors and quicker response times

**PKI**

A PKI site certificate is used for ECLIPSE claiming.

Since ECLIPSE is an extension of Medicare Online, there is no requirement to install a different PKI site certificate to the one installed in your practice for Medicare Online claiming.

For PKI site certificate registration forms, refer to the Human Services website.

**Functionalities**

To access ECLIPSE functionalities, your software vendor and the private health insurer must have implemented the system's functions. For information on health insurers and their ECLIPSE functionalities, click here.
Overview of the main ECLIPSE functionalities

**Online Patient Verification (OPV)**
Verify whether a patient is known to both Human Services, Medicare (OPV PVM) and the health insurer (OPV PVF).

Enterprise Patient Verification (EPV) allows you to submit up to 1000 patient verifications in one transmission. The batch can contain multiple private health insurers (as long as the private health insurer supports EPV).

**Online Eligibility Check (OEC)**
Lodge electronic eligibility checks with Human Services and/or private health insurers on behalf of a patient with their consent. It helps facilitate the process of the patient receiving informed financial consent (*discussed later in this topic*).
- OEC ECF (Hospital Eligibility Check Only) - obtain an estimate of a patient’s likely out-of-pocket expenses (excess) from a private health insurer.
- OEC ECM (Medicare Check Only) - determine whether Medicare covers the patients and what benefits are available.

**In-patient Medical Claims (IMCs)**
Lodge claims for admitted patients with Human Services and/or private health insurers.
- IMC PC (Patient Claiming) - claims can be submitted to Human Services and the private health insurer (for services not provided under a Gap cover arrangement).
- IMC AG (Agreements) - claims for services under an agreement.
- IMC SC (Scheme) - claims for services under a gap cover scheme.
- IMC (Medicare Only) - Medicare benefits only are paid to the billing agent.
- IMC (Medicare Benefits) - Medicare benefits and health insurer benefits are paid to the specified billing agent.

**In Hospital Claims (IHCs)**
Public and private hospitals and day facilities can lodge claims for a patient’s hospital stay direct to the private health insurers. This includes claims for accommodation, transfers and miscellaneous items such as prosthetics.

This function also includes interim and final processing reports and electronic remittance advices.

**Overseas Claiming**
Overseas medical claims (OVS) from overseas students or overseas visitors holding overseas cover with a private health insurer can be lodged directly with a participating private health insurer. Claims can be made for both in-hospital and out-of-hospital services.
**ECLIPSE Remittance Advice (ERA)**
The private health insurer will initiate an ERA when they deposit the EFT funds into your bank account. If you have more than one payee submitting per location, you will receive a remittance advice for each payee.

The ERA details the payments made in relation to In-patient Medical Claims (IMCs), In Hospital Claims (IHCs) and Overseas Claims (OVS).

**In-patient Medicare claims**
In-patient Medical Claims (IMCs) ECLIPSE functionality:

**Claims under Schemes (IMC SC) or Agreements (IMC AG)**
Electronically submit a claim to Human Services and the private health insurer for in-patient medical services under a Scheme (IMC SC) or Agreement (IMC AG). Human Services pays the Medicare benefit via EFT to the private health insurer under these arrangements. The payment of Medicare benefits is subject to the government's minimum payment times, which is currently 10 days after the claim has been lodged.

Only unpaid in-patient medical claims can be submitted under these claim types.

**Timeframes**
For the majority of claims an assessed result will be known within 24 hours. Some claims may take longer to process because of their complexity, resulting in a delay of up to six days.

Payments are made via EFT from the private health insurer to the health professional.

Things to check with your private health insurers before submitting your claim:
- the type of Simplified billing arrangements you have with the private health insurer e.g. schemes or agreements
- whether you need to quote a Fund Payee ID to direct payment and if so, confirm the ID
- that your EFT banking details are registered with the private health insurer. This is a mandatory requirement for submitting claims through ECLIPSE.
Patient Claims (IMC PC)
Electronically submit a claim for in-patient medical services with both Medicare and the private health insurer. Patient claims can be either:

- fully paid; or
- fully unpaid.

For the majority of claims, you will know within 24 hours when an assessment has been completed. Some claims may take longer to process because of their complexity.

An ECLIPSE remittance advice is not available for this claim type. Providers continue to have access to the 90 day pay doctor cheque scheme for unpaid accounts.

IMC Medicare Benefits (MB) and IMC Medicare Only (MO) - Billing Agents
Billing agents can electronically submit a claim for in-patient medical services to:

- Human Services (Medicare) only (IMC MO); or
- Human Services (Medicare) and the private health insurer (IMC MB)

Only unpaid in-patient claims can be submitted by a billing agent.

Claiming and information checks
There are mandatory details required to successfully submit an ECLIPSE claim, and key information required to successfully transmit an Online Eligibility Check (OEC).

Below are some claim tips and claim information that is required.

Claiming Rules
A claim can only contain:

- one patient
- one billing agent (if applicable)
- one fund payee id (agreement and scheme claims only, if applicable)
- one principal provider
- single or multiple assisting providers

Claims with a lodgement date more than two years after the date of service, and Medicare Claims Review Panel (MCRP) items can not be accepted via ECLIPSE.
**Patient Information Required**
Patient information required for claims and OEC:

- Fund Brand ID
- Membership Number
- Patient
- Date of Birth
- Gender
- Medicare and IRN (Individual Reference Number)
- Account Reference ID (patient reference with provider)

**Hospital Information**
Key hospital information required for an OEC:

- Admission Date
- Same Day Indicator
- Estimated Length of Stay
- Presenting Illness
- Accident Indicator (if treatment is a result of an accident)
- Emergency Indicator (Emergency admission)
- PEA Indicator (pre-existing ailment)

**Medical Information**
Key medical information required for an OEC:

- Claim Type (Agreement, Scheme, Patient Claim)
- Fund Payee ID
- Principal Provider
- Servicing Provider
- Service Date
- Item Number
- Fee Charged
Informed financial consent

Regardless of the claiming channel, where there is an out-of-pocket expense, you must receive informed financial consent (IFC) from the patient.

Written IFC must be obtained under a Gap Cover Scheme before a claim can be submitted to Human Services. When using ECLIPSE, you must indicate that IFC has been given before submitting the claim to Human Services for assessment.

For claims covered under an Agreement (AG), written or verbal IFC must be obtained.

Where IFC is not required because the patient would not incur any out-of-pocket expenses under a Gap Cover Scheme, the practice uses the ‘Not Obtained’ option.

Reference
Informed financial consent (IFC)
Informed financial consent is informing the patient of any amounts they will be expected to pay for treatment, and noting their acknowledgement of this advice.

Financial interest disclosure

Under an approved Gap Cover Scheme, a servicing provider must disclose to an insured patient any financial interest that they have in any product or service recommended or given to the patient. Where an indication of financial disclosure is not evident in an ECLIPSE claim, the claim will not be accepted.

Reports

A number of reports are available to download when using ECLIPSE.

ERA Report

ECLIPSE Remittance Advice (ERA) reports contain information relating to the payment for medical services provided in a claim. The presentation and structure of this report will depend on the type of software used. ERAs' can be received at any time and may be requested more than once in a 6 month period after the original request.

Eligibility Processing Report

The eligibility processing report contains information on the estimated out-of-pocket hospital expenses, prosthesis and medical services requested in a check. If the OEC is accepted, Human Services and private health insurer assessing is conducted as required.
Claim Processing Report
A claim processing report provides information on the medical services provided in a claim. It can be requested more than once within the 6 month period after the claim is complete.

Status Request (STS)
A status request provides the current status of a transaction and confirms whether the claim/request has been fully assessed and whether or not a report is available. The state of the transmission can include:

- Processing – applies to patient verifications in claiming, claiming and eligibility checks.
- Ready – applies to claiming, eligibility checks and remittances.
- Reported – applies to claiming, eligibility checks and remittances.

Get Participant Report
The Get Participant Report returns the details of all ECLIPSE enabled private health insurers.
Topic 3: Medicare Easyclaim

Medicare Easyclaim

Medicare Easyclaim is an electronic claiming option that allows practices to lodge Medicare claims using an Electronic Funds Transfer Point of Sale (EFTPOS) terminal.

Medicare Easyclaim enables payments of the Medicare benefit to be paid electronically into a claimant’s nominated bank account. A claimant’s bank account details do not need to be registered with Human Services or collected by the practice.

Key features

- Can be used for bulk bill and patient claims
- Bulk bill payments made via EFT within 24-72 hours
- No manual batching or storage required for bulk bill claims
- Paid patient claims are paid almost immediately into a claimant’s bank account via EFTPOS
- No additional bank transaction fees, only standard EFTPOS charges
- Available to all eligible providers

PKI

If you submit claims using Medicare Easyclaim, you will not need a PKI certificate.

You will need to apply for a PKI individual certificate to access HPOS in order to obtain your processing and payment reports for bulk bill claims. A PKI individual certificate is required for each health professional (or delegate) working at the practice. A PKI individual certificate allows only you, as the certificate holder, to do your business electronically.

The PKI individual certificate is issued on a USB token or a smart card (including a card reader).

For PKI individual certificate registration forms, refer to the Human Services website.
Systems

Medicare Easyclaim can be used as a stand-alone system which does not require you to have or change your computer system or software. The following institutions are currently signed on to deliver this service:

- Commonwealth Bank of Australia
- National Australia Bank/HICAPS
- Tyro Payments
- ANZ
- Suncorp Bank

All information sent via the EFTPOS terminal is encrypted and sent through a highly secured network.

Registration

To use Medicare Easyclaim for patient claiming you are not required to complete any registration forms with Human Services.

To lodge bulk bill claims via Medicare Easyclaim, you will need to complete the Medicare Easyclaim – banking details for bulk bill form. This form needs to be completed for every provider in the practice.

Functionalities

Medicare Easyclaim offers a variety of functionalities.

Overview of the main Medicare Easyclaim functionalities

Online Concession Entitlement Verification (CEV)

When a bulk bill claim is lodged, Human Services will validate the patient's concession entitlement only if the patient's Medicare card is valid.

Bulk Billing

Key features of bulk billing using Medicare Easyclaim:

- Use an EFTPOS terminal to submit claims.
- Payments are deposited within 2 to 3 working days.
- Claims are submitted individually - no batching is required.
- Payment and processing reports available via HPOS.

Note: It is a legal requirement for the patient to assign their bulk bill benefit to you. Using Medicare Easyclaim, the patient is required to press OK on the EFTPOS terminal.
Patient Claiming (PC)
Fully paid, partially paid, or unpaid claims can be submitted using Medicare Easyclaim. Payments are made to the patient almost immediately (or within 24 hours) for fully paid claims. No bank account details need to be stored, benefits are deposited into the claimant’s debit account used at the time of processing.

GPs and Specialists have access to the 90 day pay doctor cheque scheme.

Claims data coding
Some claim data can be hard coded into the EFTPOS terminal, such as provider numbers and common MBS item numbers to speed up transactions and reduce the chance of errors.

Claims not accepted
Some claims can not be submitted using Medicare Easyclaim, for example:

- In-hospital items
- ACIR information
- Bulk bill claims more than two years from date of service
- Patient claims more than two years from date of service
- Time duration dependant items
- Notional charges (e.g. provider has raised a total charge to cover a group of services
- Patient claims for pathology items excepting Group 9 items
- Bulk bill pathology items which are self deemed or Rule 3 exemptions
- Patient claims and bulk bill claims with non-standard referrals
- Items where the charge exceeds $9999.99
- GP multiple attendance items (e.g. MBS item 24,35 etc)
- Separate sites override – unless the item is listed under Restrictive override codes in the ‘General terms explained’ list found on the Human Services website.

Note: Transmission of some complex Medicare Benefits Schedule (MBS) items may also require additional specialised support.
Reports

Bulk Bill processing and payment reports for Medicare Easyclaim can be retrieved through the HPOS Mail Centre. Reports are available 2 to 3 days from the date of lodgement.

The **Bulk Bill Processing Report** details information for all accepted, paid and rejected claims including exception/error codes. In some instances, these claims can be resubmitted where information has been omitted or is incorrect. A processing report will not be available where there have been no claims rejected.

The **Bulk Bill Payment Report** details information for all accepted and paid bulk bill claims submitted, including the rebate deposited, the bank details and a list of claims/transactions covered by the payment.

Retrieving your reports

**Step 1:** After logging on to HPOS, select **Medicare Services** from the main menu.

**Step 2:** Select either Easyclaim Processing Reports or Easyclaim Payment Reports.
**Medicare Easyclaim bulk bill claiming process**

1. After the consultation, the patient’s Medicare card is swiped through the practice’s EFTPOS terminal.
   
   The claimant’s Medicare card is also swiped if the patient and claimant are not on the same card.

2. Claim details are entered via the EFTPOS terminal (short cut keys can be used for provider and common item numbers.).

3. Submit the claim to Human Services for assessment and processing.
   
   Claims cannot be submitted more than two years after the initial date of service as per normal procedures.

4. Human Services will check the:
   
   - provider’s registration details
   - patient’s Medicare entitlement
   - patient's concessional entitlement.

   Human Services responds either accepting the claim for processing or rejecting the claim.
5. The practice accepts or declines the claim. Where the claim is accepted a partially printed advice is displayed on the EFTPOS terminal for the patient to read.

6. The patient presses a button on the EFTPOS terminal to assign their Medicare benefit to the payee provider. The terminal prints the full assignment of benefits advice, which should be offered to the patient. A second copy can be printed for practice records.

7. Payment is made within 2 to 3 working days. *(Pathology has a 14 day payment period).*

8. Your processing and payment reports will be available within 2 to 3 working days. These reports provide you with information relating to a claim and the services provided within that claim, including details of a payment deposited and a list of claims/transactions covered by the payment.

   If any claims are rejected, it will be stated on your processing report with an associated reason code. If applicable, the claim can be amended and resubmitted.

   No processing report is returned if there are no rejections.

**Medicare Easyclaim patient claiming process**

1. After the consultation, the patient/claimant pays the account in full as per normal channels (eg. cash, cheque, credit card or EFTPOS).

2. The patient’s Medicare card is swiped through the terminal. The claimant’s Medicare card is also swiped if the patient and claimant are not the same person.

3. Claim details are entered via the EFTPOS terminal (short cut keys can be used for provider and common item numbers).

4. Submit the claim to Human Services for assessment and processing.

5. For successfully paid claims, the claimant’s bank debit card is swiped through the terminal and the claimant is required to select either the cheque or savings account option and enter their PIN.

6. Only a cheque and savings account can be used to receive the benefit.
A message is sent to the claimant’s bank via the EFTPOS terminal advising the amount to be deposited. The Medicare benefit amount is deposited into the claimant’s bank account.

7. A Medicare claim receipt is printed through the EFTPOS terminal and is provided to the patient by the practice.

### Integrated Medicare Easyclaim

Integrated Medicare Easyclaim connects your EFTPOS terminal with your software allowing practices to combine Medicare Easyclaim and Medicare Online functionalities for a fully integrated solution. Integrated Medicare Easyclaim is available to GPs, Specialists and allied health professionals and can be used for both bulk bill and patient claims.

**Integrated Medicare Easyclaim allows you to input your claims data directly into your software. Then use your EFTPOS terminal to claim the benefit.**

For example, for patient claims, the EFTPOS terminal is used to deposit the benefit into the claimant’s debit account.

If you are registered for online claiming you can use each system as separate claiming channels. For example, you can choose to lodge some types of claims using Medicare Easyclaim and Medicare Online for other types. You should contact your software vendor and EFTPOS provider to find out if you have access to Integrated Medicare Easyclaim.
Topic 4: Common Rejections and Reason Codes

Common rejections and reason codes
Claims submitted electronically can be rejected by Human Services due to many reasons, including:

- incorrect item number used;
- patient or provider eligibility; and
- system issues.

When claims are rejected a reason code is provided that describes what has happened during the assessment of a claim for Medicare benefits and an explanation for the rejection. In many cases, this information can be used to identify the claim error and re-submit with the correct information. Reason codes vary depending on the electronic claiming channel used. Below are the reason code types and some examples.

**Medicare Reason Codes**
Medicare reason codes are 3 digit codes for claims submitted to Human Services. These codes are found on the processing reports. Where an @ symbol appears on a statement of benefits it means the card number quoted on the claim has been changed to reflect the current card issue number. Medicare reason codes can be found on the Human Services website.

**Examples:**

<table>
<thead>
<tr>
<th>Reason Code Number</th>
<th>Short Descriptive Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>131</td>
<td>Date of service is not supplied/invalid</td>
</tr>
<tr>
<td>208</td>
<td>Card number used has expired</td>
</tr>
<tr>
<td>341</td>
<td>No referral details – details required for future claims</td>
</tr>
</tbody>
</table>

**Medicare Easyclaim Reason Codes**
Medicare Easyclaim return codes are 4 digits returned on the Easyclaim (EFTPOS) device for claims submitted using Medicare Easyclaim. Medicare Easyclaim return codes can be found on the Human Services website.

**Examples:**

<table>
<thead>
<tr>
<th>Reason Code Number</th>
<th>Short Descriptive Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015, 2025</td>
<td>A system error has occurred. Please resubmit or call the eBusiness Service Centre and quote the error number displayed on the EFTPOS terminal</td>
</tr>
<tr>
<td>9301, 9364</td>
<td>The patient’s Medicare card number has not been entered. Please resubmit with this information</td>
</tr>
<tr>
<td>9638</td>
<td>Claimant’s details are required. Patient or quoted claimant is a minor</td>
</tr>
</tbody>
</table>
4-Digit Response Codes

4-Digit return codes are for claims submitted electronically. Return codes fall into the following categories:

- Function related return codes (starting with 1 or 2) - relating to environmental factors or coding errors within the software
- Transmission return codes (starting with a 3)
- Information messages (starting with 52 or 8)
- Data return codes (starting with 70 or 90)

The 4-Digit response codes can be found on the Human Services [website](https://www.humanservices.gov.au).

Examples:

<table>
<thead>
<tr>
<th>Return Code Number</th>
<th>Short Descriptive Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>1006</td>
<td>PKI login failure.</td>
</tr>
<tr>
<td>3010</td>
<td>The data has been corrupted in transmission.</td>
</tr>
<tr>
<td>8006</td>
<td>Claim accepted however Medicare patient validation outstanding - this return code will be deleted.</td>
</tr>
<tr>
<td>9122</td>
<td>Location ID missing from transmission.</td>
</tr>
</tbody>
</table>

Common rejections

There are reason codes that are commonly received by practices when submitting electronically. In some cases, rejections can be avoided using the electronic claiming systems to check details prior to claim submission.

Below is a list of some of the most common rejections, their associated reason codes and information on how to minimise rejections based on these codes.

**Example 1**

- Reason Code 162 – Benefit has been previously paid for this service
- Reason Code 160 – Maximum number of services for this item already paid
- Reason Code 179 – Benefit not payable – associated service already paid
- Reason Code 550 – Associated service not claimed – no benefit payable

If the service is eligible for a Medicare benefit, these rejections could be minimised by using the MBS Item Online Checker available on HPOS.
Example 2

- Reason Code 374 – Old Card issue used – benefit not payable

This rejection could be minimised by using the OPV functionality (this can be done before a claim is submitted). Alternatively, you can search for a patient's medicare card using HPOS.

Example 3

- Reason Code 157 – Service Possibly aftercare – refer to provider
- Reason Code 252 – Service possibly aftercare

If the service is eligible for a Medicare benefit, this rejection could be minimised by including a system override indicator into your software or Easyclaim device.

Common system overrides

Human Services electronic claiming systems automatically approve or reject claims based on the data being transmitted.

Using override codes when submitting a claim forces the electronic claiming system to override automatic processing and refer the claim to a Human Services Customer Service Officer to be assessed.

Medicare Online and Medicare Easyclaim systems have specific override indicators available to use as standard service text fields when submitting electronic claims. (Please refer to your software's or EFTPOS terminal's user guide).

The most common override indicators for a claim include:

- Not normal aftercare – services unrelated to a previous procedure
- Not duplicate service – two separate consultations on a single day
- Not for comparison – for diagnostic imaging services
- Unrelated – e.g. care plan and a separate consultation at the same attendance
- Separate sites – multiple excisions done on different areas of the body
- Self determined or Self deemed – for diagnostic imaging services.

When using Medicare Online, additional information can be entered into the free text field. However, this should only be used where the available override indicators do not meet your requirements. There is no free text field available for Medicare Easyclaim.
Where can you get support?

eBusiness Service Centre
The eBusiness Service Centre is your primary point of contact for general enquiries about Electronic Medicare Claiming by assisting with:

- enquiries about software and software functionality
- information about Medicare electronic claiming and what it involves
- information about the status of your electronic claims
- updating your bank account or site details
- Any transmission failure that you may experience
- referring your enquiry to Business Development Officers.

Contact the eBusiness Service Centre at 1800 700 199 (call charges apply).

Business Development Officers
Human Services’ Business Development Officers have extensive knowledge of Electronic Medicare Claiming and can provide information about Medicare electronic claiming channels.

For provider or item number enquiries:

- contact the Provider enquiry line on 132 150 (call charges apply)
- refer to the MBS online; or
- email: askMBS@humanservices.gov.au.
Topic: Summary and References

Summary
This module has covered:
- the functionalities and benefits of Medicare Online
- the process for Medicare Online claiming
- ECLIPSE and how it works
- the functionalities and benefits of Medicare Easyclaim
- the process for Medicare Easyclaim
- common electronic claiming rejections and reasons codes.

References
Online Education material  Online Education Services

ECLIPSE  Medical and Eligibility User Guide