Australian Government
Department of Human Services

ECLIPSE Online Hospital Claiming User Guide V0.6

Note: billing agents or medical claim providers should refer to the Medical and Eligibility User Guide.

Contents

Abbreviations and definitions

Term	Description
ACD	Accommodation Detail Segment
AIR	Australian Immunisation Register
ACS	Accommodation Summary Segment
AN-SNAP	Acute, Non acute, Sub Non Acute Patient classification
ANB	Add Newborn Baby Segment
AR-DRG	Australian Refined Diagnosis Related Groups
ARIF	Acceptable Referee Identification Form
AROC	Australian Rehabilitation Outreach Centre
Atomic transaction	For an IHC the transaction will either pass or fail on the basis of the data contained within the IHC. Its condition cannot be altered by adding or deleting any of its content. The transaction will be processed to completion and will either pass or fail in its own right
CCG	Critical Care Segment
CCU	Coronary Care Unit
CER	Certificate Segment
CID	Claim Identification Segment
CMBS	Commonwealth Medicare Benefits Schedule
CS	Client System – the computing system used by a Provider's Practice
DMG	DRG Morbidity Group Segment
DOB	Date of Birth
DRG	Diagnosis Related Group
DVA	Department of Veterans' Affairs
ECF	Eligibility Check Fund
ECLIPSE	Electronic Claim Lodgement and Information Processing Service Environment
ECM	Eligibility Check Medicare
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EPM	Equitable Payment Model

Term	Description
EPD	Episode Data Segment
ERA	Electronic Remittance Advice
HCL	Health Care Location
HCP	Hospital Casemix Protocol – The Hospital Casemix Protocol (HCP) Data Collection was established in 1995 to monitor the deregulation of the private health industry. It is supported by the *Health Insurance Act 1973*
HDU	High Dependency Unit
HPPA	Health Provider Purchasers Agreement
HSE	Health Sector Entity
ICD10	International Codification of Diseases version 10 – AM (Australian Modification)
IFC	Informed Financial Consent
IHC	In Hospital Claiming
ISO	International Organization for Standardization
LPD	Leave Period Segment
MBS	Medicare Benefits Schedule
MIG	Miscellaneous Services Group Segment
MOR	Non-DRG Morbidity Segment
MSG	Multiple Services Group (secondary and subsequent theatre) Segment
NOI	Notice of Integration
OEC	Hospital and medical check at both Medicare and the private health insurer
Outreach	Any service specified in a determination under section 5D of the Act, that is provided to a patient by, or on behalf of, a hospital or day hospital facility, but does not include service provided by a medical practitioner that would attract a Medicare benefit of 85% of the scheduled fee
OVV	Online Veterans' Verification
PAS	Patient Administration System
PAT	Patient Details Segment
PEA	Pre-Existing Ailment
PHA	Private Health Australia
PHI	Private Health Insurer

Term	Description
PKI	Public Key Infrastructure
PMS	Patient Management System
PR	Private Hospital
PSG	Principle Services Group (Primary Theatre) Segment
PU	Public Hospital
PVH	Patient Verification Hospital
PWG	The Pilot Working Group of ECLIPSE
RHBO	Registered Health Benefits Organisation – the terms RHBO and Health Fund are interchangeable within the context of this document. References to RHBO in this document also include DVA unless otherwise stated
SVB	Single Value Benefits (Case Payment) Segment
TFR	Transfer Segment
UPI	Unique Patient Identifier

Introduction

The Australian Government Department of Human Services (Human Services) in collaboration with the healthcare industry, the medical software industry and public and private hospitals, developed Medicare online claiming, including the Electronic Claim Lodgement and Information Processing Service Environment (ECLIPSE).

Health Sector Entities (HSEs) can use ECLIPSE for the communication of health information, eligibility checks, and hospital and medical claims between connected entities.

ECLIPSE claiming processes follow current privacy and legislative requirements, as determined under the *Health Insurance Act 1973*, and relevant Human Services and industry guidelines and policies.

About ECLIPSE

ECLIPSE is an extension of Medicare online claiming. It offers a secure connection between practices, public and private hospitals, billing agents, Human Services, health care providers, private health insurers (PHI) and the Department of Veterans' Affairs (DVA). It offers providers direct communication with Human Services and private health insurers in the one transaction.

Benefits of using ECLIPSE

ECLIPSE allows public and private hospitals, including day facilities, to submit claims securely over the internet to private health insurers, saving time and money. The range of benefits include:

- reduction in the use of paper
- quicker processing times
- reduction in administration time, which results in reduced management costs
- faster resolution of complex claims
- better data quality with fewer errors and quicker resolutions
- ECLIPSE Remittance Advice from PHI and DVA allowing efficient reconciliation of your accounts.

ECLIPSE is a single system for all private health insurers together with other Human Services online claiming services. It provides a one-stop shop for electronic business – access to Human Services, DVA, Australian Immunisation Register (AIR) and PHI in one product.

Getting started

Before using ECLIPSE, you need to:

- make sure you have an internet connection
- make sure your patient administration system is ECLIPSE-enabled, and
- complete the application process for a Medicare Public Key Infrastructure (PKI) Site Certificate.

PKI Site Certificate

A Medicare PKI Site Certificate lets a number of authorised people at the same location sign and encrypt messages on behalf of the site. This certificate provides confidentiality, authentication and integrity of the transmitted information.

To register for a Medicare PKI Site certificate, you must:

- review and meet the certificate pre-application checklist
- complete and submit the relevant application form with certified copies of confirmation of identity documents, and
- complete an Acceptable Referee Identification Form (ARIF).

You can find these forms at **humanservices.gov.au/pki**

More information about PKI Site Certificates is available at humanservices.gov.au/pki or you can call us on **1800 700 199**.

Private health insurer and Human Services requirements

All ECLIPSE payments direct to hospitals will be through Electronic Funds Transfer (EFT). You should contact private health insurers to tell them you are planning to use ECLIPSE. To start using ECLIPSE you will need:

- ongoing testing capabilities after you have received your Notice of Integration (NOI) with Human Services to enable private health insurers testing to occur
- knowledge of any special contract requirements between your hospital and your private health insurer and how to process under ECLIPSE
- to make sure your banking details are registered with the private health insurer.

The Get Participants report shows you which private health insurer you can connect with. A contact list can be found at **privatehealthcareaustralia.org.au** then go to Industry Portal > ECLIPSE Portal.

More information about ECLIPSE claiming is available at **humanservices.gov.au/healthprofessionals** then go to Services > Simplified Billing and ECLIPSE.

Get Participants report

The Get Participants report returns the details of all private health insurers participating in ECLIPSE as well as the ECLIPSE transactions they support. When you send the request, the report response is provided in real time.

The Get Participants report will return the following details of participating private health insurers:

- fund brand ID
- trading name of the private health insurer
- contact number for the private health insurer
- date the record was last updated
- ECLIPSE functions supported by the private health insurer.

Eligibility checking

There are three types of eligibility checks available in ECLIPSE:

- *Hospital-only checks (ECF)* – used by hospitals and day surgeries to find out whether the patient is eligible for a selected presenting illness/condition on the admission date. This check provides the out-of-pocket expenses for excess, exclusions and co-payments associated with the patient's hospital product
- *Medicare-only checks (ECM)* – used by hospitals, day surgeries and medical providers to determine whether Medicare covers the patient, and which Medicare benefits are payable for inpatient medical services
- *Hospital and medical checks at both Medicare and the private health insurers (OEC)* – used by hospitals, day surgeries and medical providers to determine whether the patient is eligible for a selected presenting illness/condition on the admission date. It provides the out-of-pocket expenses for excess, exclusions and co-payments associated with the patient's hospital product, and the Medicare and the private health insurer benefits payable for the medical services.

> **Important:** DVA use a different eligibility check (OVV) than private health insurers. More information is available on Department of Veterans' Affairs website.

The eligibility check can help the hospital determine the patient's out-of-pocket expenses for in-hospital care. It also provides an overview of the required information to make sure the most accurate assessment can be provided and the assessment data is clearly interpreted.

To conduct an eligibility check, you will need the patient's:

- pre-admission forms
- private health insurer membership details.

Eligibility checks are grouped into three areas:

- general information that applies to all eligibility checks
- request information
- response information.

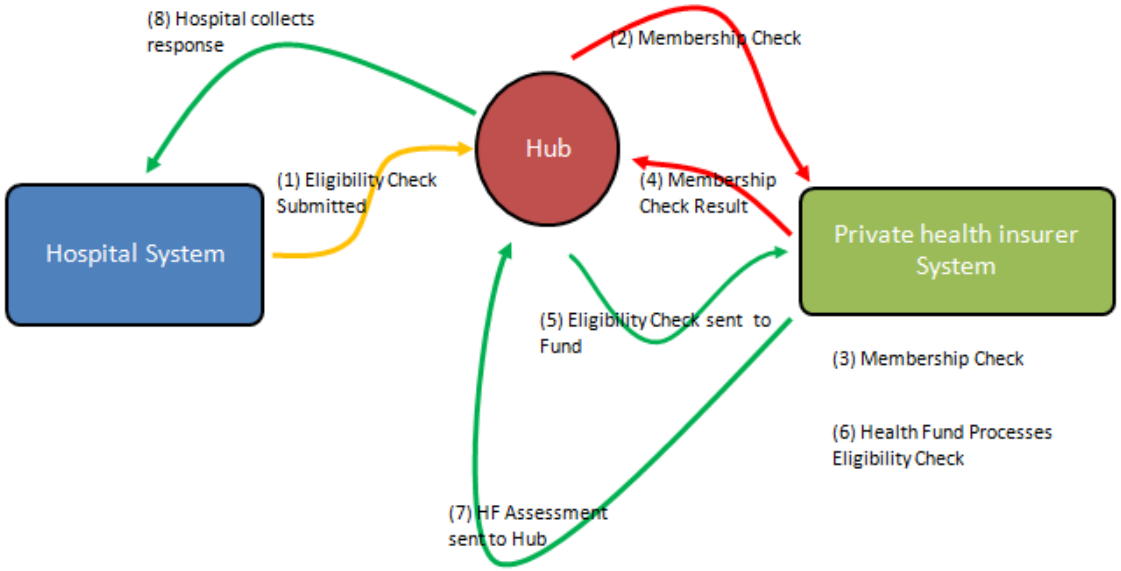

Figure 1: Eligibility Check flow example for a hospital-only check (ECF)

1. The provider submits the eligibility check using ECLIPSE to the Hub.
2. The Hub sends the patient details to the private health insurer or DVA only. This includes the patient's name, DOB, sex, membership number and unique patient identifier. The rest of the eligibility check information is not sent to the private health insurer or DVA at this stage.
3. The private health insurer or DVA checks the patient details against their membership database.
4. The result of the private health insurer's or DVA's membership check is sent back to the Hub.

> **Important**: If the private health insurer or DVA is unable to match the patient details against their membership database, they will return an error code: 9663, 9665, 9667, 9668, 9669 etc. The hospital then needs to find the cause and correct the data where necessary.

5. Once the private health insurer or DVA has confirmed that the membership details are correct, the Hub sends the entire eligibility check to the private health insurer or DVA.
6. The private health insurer or DVA process the eligibility check.
7. The private health insurer or DVA sends the assessment back to the Hub.
8. The provider's system collects the assessment from the Hub.

General information

Patient authorisation

Before submitting an eligibility check, the patient or other lawfully authorised person—for example, a guardian or power of attorney appointee—must consent to the hospital performing the check. The way the patient gives consent will depend on legislative requirements and your software product.

- Only enter the first name in the first name field. Where there is no field for the second name or initial, do not enter it in the first name field. Only use hyphens where they are part of the person's name displayed on the fund membership card
- The patient's private health insurer unique patient identifier (UPI) is optional. If it has been supplied, you should use it to help the matching process at the private health insurer
- The addition of any optional data requirements will assist with patient matching.
- Where a patient is only known by one name, that name should appear in the patient's last name field. Enter 'Onlyname' in the patient's first name field
- The private health insurer component will indicate that a patient holds a level of hospital cover with the private health insurer on the anticipated date of admission. It does not guarantee that benefits are payable for the service/s, or that the patient is still covered on the proposed hospital date/s.

Patient information validation

The first step in the eligibility check is a validation check against the PHI to make sure the patient can be identified. If the patient details are correct, the ECLIPSE system will accept the eligibility check for processing.

If the patient cannot be identified, the eligibility check will not be accepted for processing and a response will be returned advising the reason the patient cannot be matched.

Possible reasons the patient cannot be identified include:

- the patient is unable to be uniquely identified
- the patient is known to the PHI, but personal or membership details in the transmission differ from the PHI records
- the patient does not have hospital cover with the PHI.

If the patient details are incorrect, check the details with the patient and update your hospital records, and then re-submit the eligibility check.

Refer to Appendix A—Patient Verification Error Message lists patient verification error messages.

Multiple eligibility checks for the same patient

Multiple eligibility checks can be submitted for the same patient. This allows for variances that could occur, for example different item number/s.

Each eligibility check is assessed in its own right and does not take any previous eligibility checks for the patient into consideration. For example, if two checks are submitted for the same admission date, the hospital excess and/or co-payment will be shown on both responses as payable, however it is only payable per admission.

Submission

An eligibility check can be submitted for an anticipated admission date up to 12 months in the future or up to seven days in the past for an emergency admission.

The eligibility check will return the product and benefit information that will apply as at the admission date, as it is known on the day the check is submitted.

The benefit amounts are the amounts that apply on the day you submit the eligibility check based on the patient's history and level of cover.

> **Important:** It is recommended that you submit one eligibility check to assist receiving informed financial consent. For an admission date well into the future, perform another eligibility check before the patient's admission to make sure you are submitting in accordance with your contract or private health insurer honouring rules. This highlights any changes in benefits that may affect the patient's out-of-pocket expenses.

A patient may have an annual maximum out-of-pocket expense. For example, an excess or co-payment benefit that they can receive in a financial, calendar or membership year from their private health insurance. You should also check financial and membership status close to the admission date.

> **Important:** The results of the eligibility check will be available within 20 minutes of the transmission. If Human Services or the PHI systems are unavailable, or cannot complete processing within 20 minutes, you will receive a message telling you that the eligibility check was not completed successfully.

You will need to re-try or check with the PHI.

Disclaimer

The information received from the eligibility check is not confirmation the PHI will pay the claim. However, if the information received from the private health insurer is found to be incorrect, and if the check has been requested within the private health insurer agreed timeframes, the eligibility check will be honoured.

The private health insurer may decline a claim based on eligibility or other conditions that are applicable at the time the claim is made including:

- pre-existing ailments
- waiting periods not being served
- product exclusions
- accident or compensable claim where damages can be claimed from another source
- cancelled, suspended or non-financial memberships
- the patient's history.

A claim can have a different outcome to the eligibility check, for example:

- extra services or change of the presenting illness/condition being performed that were not detailed in the original eligibility check
- a change of private health insurer membership cover and/or entitlements.

Request information

Input elements are in two main areas:

- patient information
- hospital information.

Each is used for a different purpose.

The information below is an example only and does not include all data elements. The key information requirements that determine the eligibility response are shown.

Example 1: hospital eligibility request – patient information

Data element	Patient information
Fund brand ID	ABC
Membership number	52647891
Unique patient identifier	01
Patient	John Citizen
Date of birth	01/01/1900
Gender	M
Account reference ID	290876543

Example 2: hospital eligibility request – hospital information

Data element	Hospital information
Facility ID	1354275W
Admission date	02/09/2006
Same day indicator	N
Estimated length of stay	05
Presenting illness or MBS	342 or 49518
Accident indicator	N
Emergency indicator	N
PEA indicator	N

Patient information

Fields within this section are self-explanatory. If there is an error with the patient information you will need to correct it and resubmit.

The following patient information it used to identify private health fund and patient details:

- fund

- membership number
- unique patient identifier
- patient first name
- patient surname
- date of birth
- gender.

> Refer to Appendix A—Patient Verification Error Message for a complete list of error messages and actions to be taken.

Account reference ID

This is a reference number given by the hospital to identify the patient in the eligibility request. Account reference ID is the patient identifier known by the hospital.

Hospital information

The following elements are used to determine whether an inpatient hospital claim is payable by the private health insurer.

Example 3: hospital input elements

Data element	Hospital information
Facility ID	1354275W
Admission date	02/09/2006
Same day indicator	N
Estimated length of stay	05
Presenting illness or MBS	342 or 49518
Accident indicator	N
Emergency indicator	N
PEA indicator	N

Facility ID

This is the hospital provider number where the anticipated admission is to take place.

Admission date

This is the date the patient is expected to be admitted to hospital. The admission date can be 12 months in advance of the date when you enquire or less than seven days in the past for emergency admissions.

> **Important:** this date is used to determine the member's eligibility to have the presenting illness/condition treated.

Same day indicator

The same day indicator tells the PHI whether the patient will be admitted overnight in the facility. This information is used to determine excess or co-payment arrangements payable under the patients cover.

Estimated length of stay

This information is used as a guide only. The information supplied is not used to make any calculations for excess or co-payment information.

Presenting illness

The presenting illness will be used to determine the waiting periods, exclusions and any reduced benefits payable.

Many presenting illnesses are for specific treatments or conditions and will result in very specific responses from private health insurer. However, if a general presenting illness is provided—for example, medical admission (320 or 420) or unknown or other surgery (399 or 499)—the private health insurer will provide a general response that will detail all exclusions or reduced benefits applicable under the patient's cover.

> **Important:** you will need to review all information within a general response of this nature to make your own assessment of whether there are any restrictions or exclusions applicable before supplying details to the patient. It is recommended that if a presenting illness/MBS is documented in the response and it does apply, then the eligibility check should be repeated with the specific illness/MBS to make sure accurate patient entitlement is received.

The current list of presenting illness/condition codes are available on **privatehealthcareaustralia.org.au** then go to Industry Portal > ECLIPSE Portal

MBS item

This is a MBS item number that indicates the presenting illness. Using the MBS item number for an eligibility check will provide more accurate results than using the presenting illness.

> **Important:** an eligibility check must be submitted with either a presenting illness or MBS item number. It cannot be submitted with both.

Accident indicator

You must take care when setting the accident indicator to 'Y' as this will override normal waiting periods applicable for the presenting illness/MBS.

It is recommended this indicator is always set to 'N' in the first instance and only set to 'Y' if waiting periods apply and the treatment is a result of an accident. You can then see if the assessed result changes.

> **Important:** if an accident indicator of Y is selected, private health insurer approval of the accident must be obtained before benefits are paid to make sure the claim is not delayed.

Emergency admission

The emergency indicator should be set to 'Y' if the admission was a result of an emergency. Therefore the eligibility check may note an admission date in the past. Eligibility checks for emergency admissions can be done up to seven days in the past.

Pre-existing conditions

Benefits paid by the private health insurer may be determined based on whether or not the episode of care relates to a Pre-Existing Ailment (PEA). The PEA indicator lets you tell the private health insurer whether they should treat the admission as a pre-existing condition or not.

A two-step process has been developed to help resolve a possible PEA claim. We suggest you always set the PEA indicator to 'N' (not pre-existing). This lets the private health insurer determine whether the presenting illness/MBS could be possibly pre-existing. This information will be returned to you in the response with a warning on the assessment.

If you receive a warning on an eligibility response with the PEA result of 'Y' (possible pre-existing) you should repeat the eligibility check with the PEA indicator set to 'Y'. The private health insurer will then use this indicator to respond as if the presenting illness/MBS was considered pre-existing.

> **Important:** this will allow a 'best case/worst case' scenario for you to tell the patient. Determining whether the hospitalisation will be treated as a pre-existing condition is complex and often done after the hospitalisation has been undertaken.

Prosthesis items

Prosthesis items can be included in the eligibility check. This information will help align the eligibility check information with information which may be used by providers to provide Informed Financial Consent (IFC) to their patients.

Eligibility response information

It is important you understand how to interpret the eligibility response information.

The response is in the following three main areas:

- overall response
- level of cover
- details applicable to admission.

The information below is an example only and does not include all data elements. The key information requirements that determine the eligibility response are shown.

Example 4: overall response

Data element	Response
Response code	A
Assessment code	1101
Assessment text	Eligible for service selected

Example 5: level of cover

Data element	Response
Table name	Bronze Hospital Saver with General Extras
Table description	Full cover for hospital accommodation and theatre fees at participating private hospitals and public hospitals in a shared room If there are any basic benefits that are payable there are benefit limitations. No excess or co-payment applies if basic benefits are payable No benefits are payable on exclusions
Table scale	Family

Example 6: details applicable to admission

Data element	Response
Co-pay amount	$50
Co-pay description	$50 per day to a maximum of $250 per admission
Co-pay days	4
Excess amount	$200.00

Data element	Response
Excess description	$200.00 excess payable per hospital admission, including same day and up to $1000.00 per family

The overall response

The response code will tell you whether the eligibility check has been successful or not.

Example 7: overall response

Data element	Response
Response code	A
Assessment code	1101
Assessment text	Eligibility confirmed for the selected service

Response code indicates the overall eligibility result. Assessment code and assessment text details the result received.

Example 8: the response codes and the appropriate actions to take

Eligibility response code	What it means	What you need to do
A – Accepted	The patient is eligible to claim for the presenting illness specified as at the admission date. **Note:** you will need to read the result to determine if any minimum benefits are payable or there is a restriction on bed level.	Check the product description for what is payable. This can help you to determine the level of benefit payable, for example minimum benefits or shared room only.
W – Warning 	This indicates that the patient may be eligible to claim for the presenting illness specified, however there are certain conditions detailed within the response that must be satisfied before the patient is admitted.	Check the response as conditions apply. For example the member may not be financial, benefit limitations may apply (lower benefits) or the presenting illness could possibly be pre-existing.
R – Rejected	The patient is not eligible to claim for the presenting illness specified at the admission date.	Inform the patient that nothing is payable by the private health insurer towards the cost of treatment for the presenting illness/condition.

A response of ‘R’ is reasonably straight forward.

An assessment response of ‘A’ means the patient is financial and no waiting periods apply. You need to read the assessment including product description to decide whether there are conditions that must be noted as they will affect the payment of benefits.

The message detail section must be checked carefully for a response of ‘W’ as it means that the person could be un-financial, have waiting periods, pre-existing conditions, benefit limitations or exclusions that may affect the payment.

Level of cover

You will need to check the table description carefully. Read it thoroughly to determine minimum benefits. Each private health insurer will describe their level of cover differently. Below is an example of how they may appear.

Some private health insurers will include room restrictions in the product information while others may put it in the benefit limitations if a limit applies. An example of this is if the patient is only entitled to a shared room.

Example 9: level of cover

Data element	Response
Table name	Bronze Hospital Saver with General Extras
Table description	Full cover for hospital accommodation and theatre fees at participating private hospitals and public hospitals in a shared room Basic benefits are payable for any services listed in the benefit limitations section below. No excess or co-payment applies if basic benefits are payable No benefits are payable on exclusions
Table scale	Family

Table name

This will detail the table name that has been used to make the assessment. Generally this will always be the patient’s level of cover, at the date of admission. The only time this may differ is if the PEA indicator is set to ‘Y’ in the incoming request or if the patient has recently upgraded their cover and waiting periods apply on their new level of cover.

> **Important:** both of these situations will be clearly visible in the assessment text displayed in the overall response.

Table description

The table description provides details of the patient’s cover at the date of admission. Read this carefully to determine minimum benefits or conditions that may affect full payment.

Table scale

The table scale relates to the membership type, such as Family, Single, Couple and Sole Parent.

Details applicable to admission

The following data elements and responses provide details for patients’ admission.

Example 10: details applicable to admission

Data element	Response
Co-payment amount	$100.00
Co-payment description	$50 per day to a maximum of $250 per admission
Co-payment days remaining	5
Excess amount	$200.00
Excess description	$200.00 excess payable per hospital admission**,** including same day and up to $1000.00 per family
Excess bonus used	$0.00
Exclusion description	Exclusions that apply to the hospital cover
Benefit limitations	342 Hip replacement

Co-payment amount, description and days remaining

To determine the co-payment payable for the admission you must use the information supplied in any or all of the co-payment fields. This will let you calculate the co-payment amount.

The estimated length of stay submitted in the request is not used to perform any co-payment calculations.

There may be circumstances where the dollar amount cannot be calculated from the eligibility check information, in which case the dollar amount may be left blank and the circumstances are covered in the co-payment description. If this value is blank refer to the co-payment description for information.

Excess amount, description and excess bonus

The excess amount, if displayed, should be the total excess payable for the admission.

If the excess amount is blank and there is an excess description, you can use this information to determine if an excess is payable. If the excess amount is $0.00 it means that no excess is payable.

When a dollar amount appears in the excess bonus used field, this will indicate that excess bonus has been applied and the excess amount has been reduced by the bonus.

There may be circumstances where the dollar amount cannot be calculated from the eligibility check information, in which case the dollar amount may be left blank and the circumstances are covered in the excess description. If this value is blank refer to excess description for information.

Exclusions

No benefits will be payable for any presenting illness/MBS shown in the exclusions field. Care must be taken to make sure the patient is not being treated for one of these illnesses/conditions, otherwise the patient is liable for payment.

Benefit limitations/restrictions

 This section must be read carefully. It details any restricted benefits that apply, at the admission date, which may affect the benefit payable.

> **Important:** if the eligibility check submitted was for presenting illnesses 320 or 420 (medical admission) or 399 or 499 (unknown or other surgery) and information is displayed in the benefit limitations field, it is recommended that the eligibility check should be repeated with the specific illness/MBS item number to make sure accurate patient entitlement is obtained.

Financial

The response shown in the financial field indicates whether the patient is financial as at the admission date.

-  'N' un-financial: the patient is un-financial for the admission date based on payment history, at the date the eligibility check is performed. The membership must be financial at the date of admission for the claim to be paid.
- 'Y' financial: the membership is financial at the admission date based on the payment data, at the date the eligibility check is performed.

> **Important:** we recommend you tell the patient in all circumstances that the payment of the claim will be subject to financial status.

Potential PEA indicator

 If the private health insurer has responded that the presenting illness/condition could be found as possibly pre-existing, a PEA indicator of 'Y' will be returned with a warning on the assessment.

When a warning response is received with the PEA indicator of 'Y' (possible pre-existing) the eligibility check should be repeated with the PEA indicator set to 'Y'. The private health insurer will then use this indicator to respond as if the presenting illness/condition was found to be pre-existing. This will allow a 'best case/worst case' scenario.

Presenting illness

The most current list of presenting illnesses is available on **privatehealthcareaustralia.org.au** then go to Industry Portal > ECLIPSE Portal.

Eligibility response codes

Refer to

Appendix B – Eligibility check response codes for a list of response codes that can be returned for an eligibility check.

In-patient hospital claiming

This section covers submission of the hospital claim types:

- Public Hospital (PU)
- Private Hospital (PR)

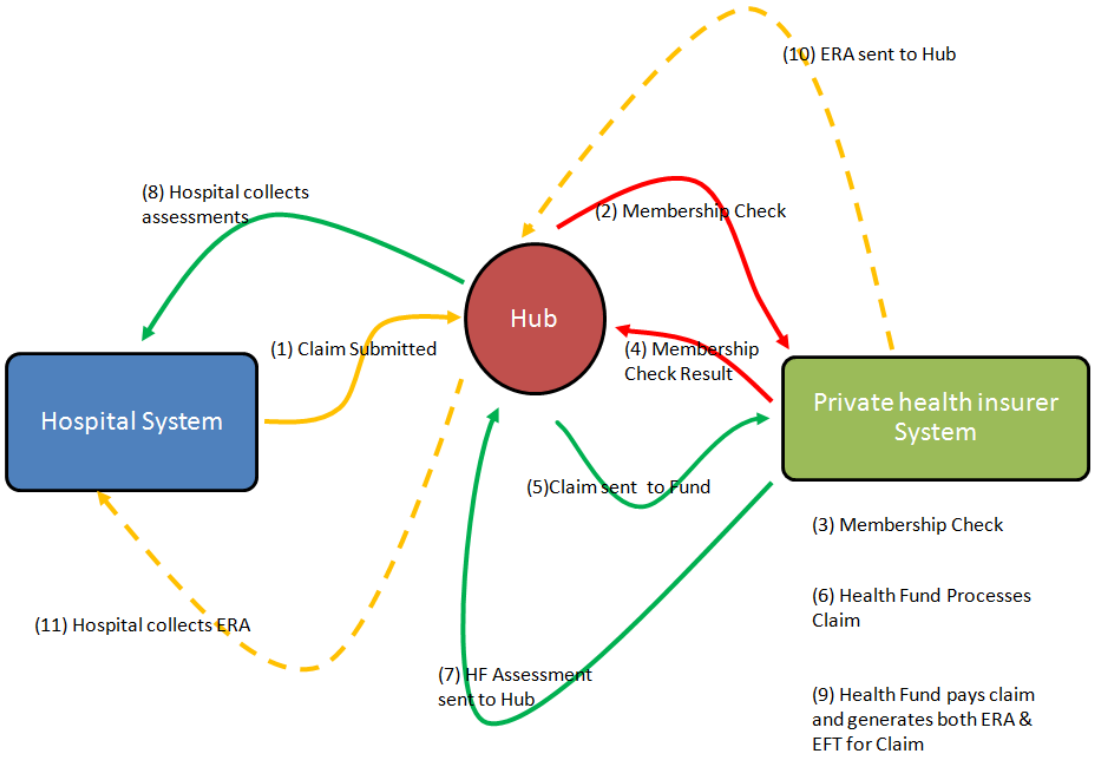

Figure 2: ECLIPSE Hospital claim flow example

1. The provider submits the claim using ECLIPSE to the Hub.
2. The Hub sends the patient details to the private health insurer only. This includes the patient's name, DOB, sex, postcode and membership number. The rest of the claim information is not sent to the private health insurer at this stage.
3. The private health insurer checks the patient details against their membership database.
4. The result of the private health insurer's membership check is sent back to the Hub.

Important: if the private health insurer or DVA is unable to match the patient details against their membership database they will return an error code: 9663, 9665, 9667, 9668, 9669 etc. The hospital then needs to find out the cause and correct the data where necessary.

5. Once the private health insurer confirms the membership details are correct, the Hub sends the entire claim to the private health insurer.
6. The private health insurer assesses and processes the claim.

7. The private health insurer sends the assessment back to the Hub. This may be a rejection message if the claim didn't meet the private health insurer's requirements. If the claim was successful, the assessment will detail how the private health insurer intends to pay the claim.
8. The provider's system collects the assessment from the Hub.
9. Within the payment terms of the HPPA, the private health insurer generates an Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT).
10. The ERA is sent to the Hub.
11. The provider's system collects the ERA from the Hub.

Check patient information

The first step in any hospital claim process is a validation check to make sure the patient can be identified by DVA or the private health insurer. If the patient details are correct, the ECLIPSE system will accept the claim for processing.

If the patient cannot be identified, the claim will not be accepted for processing and a response will be returned advising the reason the patient cannot be matched. The patient might not be able to be identified because:

- the patient is unable to be uniquely identified
- the patient is known to DVA or the private health insurer, but personal or membership details in the transmission are different from the private health insurer's records
- the patient does not have hospital cover with DVA or a private health insurer.

Where the details are incorrect, check the details with the patient and update your hospital records, then re-submit the claim.

Refer to Appendix A—Patient Verification Error Message for a complete list of error messages and actions to be taken.

Account reference ID

You will need to issue each claim with an account reference ID. We suggest you use either the hospital episode number or the patient reference your software has allocated. This number will let you:

- enquire on the claim, and
- reconcile the payment to the claim.

Claims not accepted through ECLIPSE

Claims with a lodgement date more than two years after the admission date cannot be accepted through ECLIPSE. You must lodge them manually with the private health insurer.

Claim adjustments

An adjustment claim can be made when an original claim processed through ECLIPSE needs to be changed.

An adjustment can only be processed after the original claim has been accepted by the private health insurer. Adjustment claims can be lodged before or after the original claim has been paid.

Where an adjustment claim has been rejected by the private health insurer, the original claim will stand.

An adjustment claim will be treated as a claim in its own right. It will replace the original claim in its entirety.

Automated adjustment facility

There is an automated adjustment facility for any hospital claims submitted through ECLIPSE, however not all private health insurers currently provide this facility. Check with individual private health insurer if they have this function.

Any claim adjustments must be sent manually to the private health insurer concerned where an automated facility is not available.

Claim rejections

When a claim has been rejected by the private health insurer, the claim can be re-submitted once a correction has been made, for example adding additional information.

Supplementary claims

Supplementary claims are only supported for Public Hospital claim types and not for Private Hospitals.

When a non-billed item is found after the claim has been submitted, the original claim will need to be adjusted.

If a non-accommodation item – for example prosthesis, drugs etc. – was omitted from the accommodation hospital claim, it can be submitted through ECLIPSE as a supplementary claim.

Supplementary claims will only be accepted after the private health insurer has accepted the corresponding accommodation claim.

When there has been an omission of any other charge to be raised for the Episode of Care by the hospital, it cannot be submitted as a supplementary claim. It must be submitted as an adjustment claim.

Interim claims

Interim claims refer to a bill raised and sent to a payer at regular intervals during the episode of care for a patient who has an extended length of stay in a hospital. The bill can be an invoice, account or claim.

An interim claim is not the first or the last claim made in a continuous claiming episode.

Public hospital interim claims will be accepted by all private health insurers.

Private hospital interim claims will be accepted based on contractual arrangements or where default benefit arrangements are being paid for all non-contracted hospitals.

Contractual agreements determine how often and if interim bills can be submitted.

Claim structure

There are 20 individual segments within the hospital claim message. Use of the segments is determined by the claim type and private health insurer contractual requirements, in the case of Private Hospital Claims, or specific field validations within the segments. Refer to the Vendor Guidance section for further information about each segment.

Claim types

There are 2 ECLIPSE claim types:

- PR – Private hospital claims, including overnight, same day and non-admitted
- PU – Public hospital claims, including overnight and same day.

> **Important**: day procedures fall under either of the above claim types.

The following claim options are available within these claim types:

- overnight
- same day
- admitted
- non-admitted.

Contract and benefit types

Claim payments are driven by three payment methods:

- a per diem – day rate
- Casemix – total episode rate, or
- EPM (Equitable Payment Model).

Private health insurer contracts for contracted private hospitals will determine how claims will be submitted, in order for the claims to be paid.

Examples of all claim and benefit types are available at **privatehealthcareaustralia.org.au**

Miscellaneous codes

DVA or the private health insurer use miscellaneous service codes to report and charge miscellaneous items, such as prosthesis or specific items, payable as per a private health insurer contract. DVA also use their own miscellaneous code set.

If a service code such as an MBS item number, ICD10, or DRG is already available then these codes should be used. If none of the above are available then a miscellaneous code should be used.

Private health insurer contracts for contracted private hospitals will determine which miscellaneous codes must be submitted in order for the claims to be paid.

Admitted vs non-admitted patients

Both admitted and non-admitted claims can be submitted through ECLIPSE. Non-admitted patients are not submitted by public hospitals.

Private room add-on indicators

The method for advising of private room add-ons varies depending on the claim contract or benefit type.

Case payment add-ons should be set in the ACD segment. There should be two lines with corresponding dates. Per-Diem add-ons should be billed as a private room rate in the ACD segment. Refer to the Vendor guidance section for examples.

Critical care add-on indicators

The submission of critical care add-ons is subject to individual private health insurer contracts.

The critical care add-on indicator is set to Y if dates in the ACD and CCG segments are the same.

Refer to the Vendor guidance section for an example.

HCP collection

ECLIPSE is aligned with HCP data collection requirements. The industry, Human Services and Department of Health (DoH) are working towards automating the collection of the ECLIPSE HCP data to reduce the effort of reporting this information.

AN-SNAP

The AN-SNAP collection is a separate data collection to the episode record for rehabilitation. It provides specific information regarding the functional gains of patients undergoing rehabilitation, as well as the AN-SNAP class for overnight admitted patients.

It is expected that one AN-SNAP record be reported for each overnight admitted rehabilitation program, and one AN-SNAP record be reported for an entire episode of care consisting of multiple same day visits. The AN-SNAP record should be linked to the episode with the same separation date.

AN-SNAP data can be submitted through ECLIPSE when available. Refer to the Vendor Guidance section for more information.

Information messages

An interim response or information message with response code of 2501, 2502, 2512 or 2530 will be sent if an assessment cannot be processed. It will be sent within five working days to advise the reason the claim could not be processed immediately.

Multiple information messages may be received prior to the final assessment, informing the progress of the claim.

A claim must be either rejected or accepted by the private health insurer within 60 days of lodgement.

Certificates

Provision within the ECLIPSE message allows the hospital to notify the private health insurers of relevant certificate information needed to support the claim. Private health insurers have different certificate requirements. Some private health insurers can receive the data in the CER segment, however others will also want to see the hard copy certificate. Certificate requirements could also vary by hospital contracts.

Individual private health insurer requirements can be found at **privatehealthcareaustralia.org.au**

Auditing

Private health insurers reserve the right to audit any claims or certificates that relate to a claim.

Data that supports the claim submission must be kept by the submitting site as per statutory or contractual requirements.

Newborn babies

The hospital can notify the private health insurer of a newborn baby that may be on a membership through ECLIPSE. Although submission of the data is required for HCP purposes, private health insurers do not use this information to update a patient's membership. There is still a requirement for the patient to inform the private health insurer before future claims can be made against the newborn.

Transfer information

Information to report the transfer of a patient between hospitals can be submitted through ECLIPSE.

A maximum of one admission and one separation transfer segment is preferred by private health insurers in order to comply with HCP.

Leave periods

Any leave periods that occur during the total period of hospitalisation must be reported.

Leave days can be at any stage of the episode, including at the end of the stay, and must not overlap with accommodation or critical care periods of stay.

Remarks

Free format text can be submitted in a claim in the remarks section, however this will not be used by all private health insurers. You will need to contact individual private health insurers to find out if you are required to enter any remarks before submitting the claim.

ECLIPSE remittance advice

Private health insurers and DVA will initiate an ECLIPSE remittance advice to the submitting location when they deposit the EFT funds into your bank account. If you have more than one payee submitting per location you will receive multiple remittance advices, for example one per payee per location.

The remittance advice will contain a reference that will correspond to the payment reference on the bank statement.

One remittance can contain details of up to 500 individual claim payments. Where the settlement for a provider exceeds 500, the remittance will be split into parts. For example if a provider has 1500 individual claim payments they will receive three remittances with the following part numbers noted: 1 of 3, 2 of 3, 3 of 3.

All remittances will be retrievable up to six months from the date of lodgement by the private health insurer.

The payment amount for a claim within the remittance advice will equal the response dollar amount previously sent back through ECLIPSE for that claim.

The adjustment can be submitted through the automatic adjustment facility if it is required. This must be done after the claim has been submitted and before the claim has been paid. However, you and the private health insurer must have an adjustment facility.

Claim adjustments must be sent manually to the private health insurer concerned where the automated adjustment facility is not available.

Refer to the Reports section for more information about ECLIPSE remittance advice.

Reports

There are a number of reports currently available to ECLIPSE users. The format and data of the reports depend on the type of software used by the practice.

You can receive reports using the retrieve report function. The availability of each report will depend on the function and the release you use.

Get Participants report

A Get Participants report returns the details of all private health insurers that are ECLIPSE enabled.

The report is requested from a practitioner's site and a response is provided in real time. The method used to retrieve the report depends on the software you use. This report should be requested regularly to make sure you have the latest information. New private health insurers come on board regularly and existing private health insurers upgrade to new releases giving you access to more transactions and functionality.

The Get Participants report does not show the type of Inpatient Hospital Claim a fund can submit i.e. PU (Public claims) or PR (Private claims).

Example 11: the Get Participants report will return the following details for participating private health insurers for release 4 or lower

Data element	Description
Fund brand ID	The three character acronym that applies to the trading name
Trading name of fund	The health fund trading name
Contact number	Help desk contact number for the fund
Last update date	The date this information was last updated

Example 12: the Get Participants report will return the following details for participating private health insurers for release 5 and above

Data element	Description
Fund brand ID	The three character acronym that applies to the fund trading name
Trading name of fund	The health fund trading name
Contact number	Help desk contact number for the fund
Last update date	The date this information was last updated
Transactions available	Which ECLIPSE transactions are available for use at that fund

Status report

The status report helps you track the progress of the transaction.

Depending on the software you use, the report may be requested or provided automatically in response to submitting a transaction.

A response will be returned according to one of the following states:

- *interim report* – information reports for IHC
- *processing* – applies to patient verifications in claiming and, claiming and eligibility checks
- *ready* – applies to claiming, eligibility checks and remittances
- *reported* – applies to claiming, eligibility checks and remittances.

The responses available will depend on the originating transaction.

Claim processing report

A claim processing report provides information on the hospital services provided in a claim.

Claim processing reports can be retrieved at any time, and may be requested more than once within the six-month period after the claim is complete. The presentation and structure of the report will depend on the type of software your practice uses, however it should provide the details included in example 13.

Example 13: claim processing report

Data element	Description
Account reference ID	This is set by the location when the claim is transmitted
Facility ID	Commonwealth hospital facility provider number. It is the unique identifier of a registered hospital or day care facility
Claim fund assessment code	A = you will be paid for a service line with a benefit more than zero R = rejected. No payment made I = information only These codes, along with your service assessment, will determine what you will or won't be paid
Fund status code	2-digit identifier that shows the version of the statement format. The version number will increase for subsequent releases
Process status code	The code that indicates the processing status of the claim or request
Claim fund explanation code	The fund's explanation or reason code for the claim assessment status
Claim fund explanation text	The fund's explanation text for the specified Claim Fund Explanation Code
Total charge amount	The total amount charge for the hospital claim

Data element	Description
Total benefit amount	The total benefit paid for the hospital claim
Excess amount	The amount of excess the patient will pay for this admission
Co-payment amount	The amount of product co-payment dollars to be paid for this admission
Charge amount	The amount charged for the service in cents
Number of services	The number of services for a non-accommodation item
Date of service	The date the service was provided to the patient or the patient was assessed
From date	The date from for the accommodation period
To date	The date to for the accommodation period
Fund benefit amount	The fund benefit paid or payable for this individual service in cents
Item number	A number that identifies the services provided to enable assessment of the claim for benefit
Service fund assessment code	The assessment status of a service determined by the fund
Service Id	A unique identifier for the service within the claim. This is the Object ID assigned to the service when created
Service description	Fund description of the service provided
Service fund explanation code	The fund's explanation or reason code for the service assessment status. Provides additional information on the assessment of a service
Service fund explanation text	The fund's explanation text for the service explanation code

Eligibility processing report

An eligibility processing report provides information relating to the hospital out-of-pocket expenses, prosthesis and medical services requested within the eligibility check.

The eligibility check processing report can be retrieved within 20 minutes of processing the original transaction, and may be requested more than once within the six-month period after the original request.

The presentation and structure of this report will vary according to the type of software your practice uses, however it should provide the details included in example 14.

Example 14: eligibility processing report

Data element	Description
Account reference ID	This is set by the location when the claim was transmitted
Benefit limitations	Description of waiting period and benefit limitations applicable at anticipated admission date
Claim fund assessment code	The assessment status of a claim on its return to the Hub from the fund
Co-payment amount	The amount of product co-payment dollars to be paid for a predefined period in the co-payment amount description. There may be circumstances where the dollar amount can't be calculated from the OEC information. In this case the dollar amount may be left blank and the circumstances are covered in the co-payment amount description
Co-payment days remaining	The number of days remaining that the patient has a co-payment amount applied to their cover
Co-payment description	This is a free text field that holds the description of the co-payment and how it is applied
Excess amount	The amount of excess the patient will pay for this admission based on the policy information at the date of lodgement. It can be blank. If blank, refer to excess amount description for information
Excess amount description	This is a free text field that has information on the excess amount and how it should be applied
Excess bonus amount	Amount in dollars that can be used to reduce the excess amount
Exclusion description	The exclusions that apply to the hospital cover
Financial status	The financial status of a membership at anticipated date of admission
Fund reference ID	This is a reference allocated by the health fund identify an OEC outcome
Fund status code	Funds patient verification fund assessment result code
PEA potential indicator	This is used to indicate whether a potential previously existing ailment scenario was identified by the health fund
Table name	The table name, used for the assessment of the OEC, that the patient has hospital cover for
Table scale	This is a free text field that has information on the table scale; for example single, family, etc.
Table description	This is a free text field that has the description of the table that the patient has hospital cover for

ECLIPSE remittance advice report

ECLIPSE remittance advice (ERA) reports can be retrieved at any time, and may be requested more than once within a six-month period after the original request.

An ERA report provides information relating to the payment for hospital services provided within a claim. The presentation and structure of this report will vary according to the type of software your practice uses, however it should provide the details included in example 15.

Example 15: ECLIPSE remittance advice report

Data element	Description provided once per remittance
Payment run date	This is the date the payments were processed
Payer name	This contains the name of the paying organisation
Remittance advice ID	The health fund's reference
Payee location ID	The payee's location ID
Part no.	When the remittance advice is large, it will be split into parts. This number will help make sure all parts of the report have been collected
Part total	When the remittance advice has been split, this is the total number of parts
Bank account number	The last four digits of the bank account number the monies are being paid into
Bank account name	The bank account name the monies are paid to
BSB code	The BSB of the bank the monies are paid to
Payment reference	The payment reference on the bank statement
Deposit amount	The total amount of the EFT deposit

Example 16: ECLIPSE remittance advice report

Data element	Description returned for each claim within the remittance
Transaction ID	The identity of the transaction of the claim being paid
Account reference ID	The account reference identity of the claim being paid
Benefit	The amount of benefit being paid for the claim
Date of lodgement	The date of lodgement of the claim

Data element	Description returned for each claim within the remittance
Claim channel code	The channel of the claim

Processing messages and response codes

Codes documented in the manual apply to private health insurer processing only. Processing codes can be added and deleted as new private health insurer processing requirements develop. The descriptions used in the messages are standardised and apply to all private health insurers.

Processing messages can be displayed in transactions for one of the following reasons:

- advising a rejection and possible cause
- providing information only, or
- giving a warning that you will need to note.

The latest list of private health insurer processing codes, messages and actions required can be found at **privatehealthcareaustralia.org.au** then go to Industry Portal > ECLIPSE Portal.

Human services contacts

Human Services contact details can be found at **humanservices.gov.au/healthprofessionals** then go to Contact us

Participating private health insurer contacts

A list of participating private health insurer contacts can be found at **privatehealthcareaustralia.org.au** then go to Industry Portal > ECLIPSE Portal

Vendor guidance

You must make sure you have the following before you can submit your first ECLIPSE transaction:

- a Medicare PKI Site Certificate
- a copy of the ECLIPSE claim examples to determine the structures required
- a copy of the miscellaneous codes that will be used in the claim process
- a copy of the presenting illness list for online eligibility checking.

If you need help, go to **humanservices.gov.au/pki** or call us on **1800 700 199**.
Claim examples, miscellaneous codes and presenting illness lists can be found at **privatehealthcareaustralia.org.au** then go to Industry Portal > ECLIPSE Portal

Medicare PKI site certificate

Before submitting transactions online, all health professionals must be registered with the Health eSignatory Authority (HeSA). You can access the online registration form at humanservices.gov.au/pki

Claims

Claim structure

There are 20 individual segments within the hospital claim message. The way the segments are used is determined by the claim type and private health insurer contractual requirements in the case of private hospital claims, or specific field validations within the

segments. The following diagram shows the claim structure and the conditions of each segment.

A full list of data segments and field validation requirements can be found in the IHC Data Dictionary available at **privatehealthcareaustralia.org.au** then go to Industry Portal > ECLIPSE Portal.

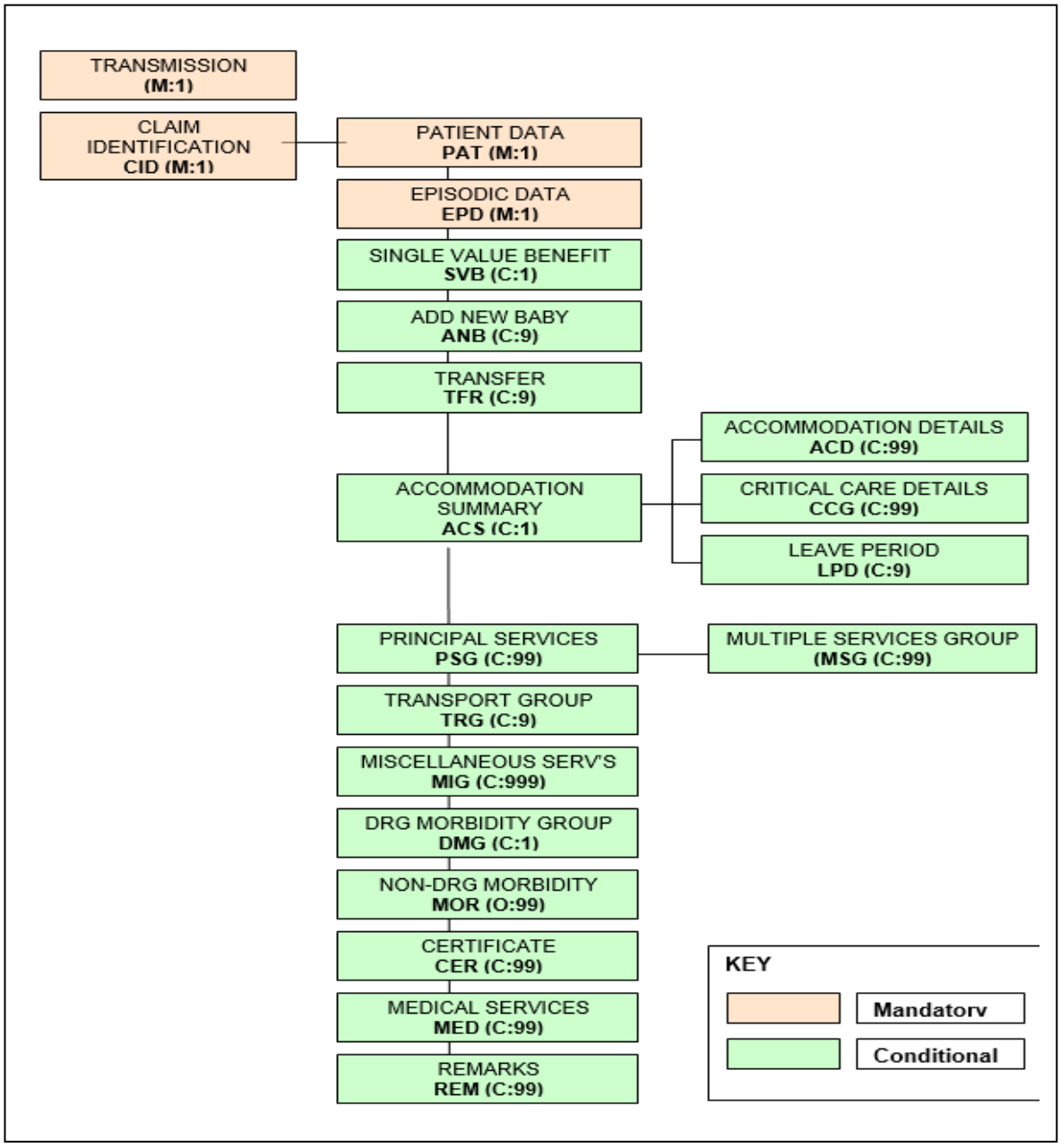

Figure 3: Hospital claim message example

Claim segments

Example 17: claim segments abbreviations

Segment	Obligation	Description	Repetition
CID	Mandatory	Claim identification (CID)	1

Segment	Obligation	Description	Repetition
		The CID holds details of the claim. The claim can be for a completed episode of care, a contiguous claim or an interim claim. All other segment groups are nested within the CID segment. It also contains the total charge for the claim (sum of the SVB, ACS, PSG and MIG but only where those segment have a charge code = C)	
PAT	Mandatory	Patient data (PAT) The PAT segment is used to define the patient information.	1
EPD	Mandatory	Episode data (EPD) The EPD segment is used for giving summary information regarding the patient's hospitalisation.	1
SVB	Conditional	Single value benefit (SVB) The SVB segment is used for bundled inpatient accommodation only. It is used for single value benefit (casemix) arrangements and fully or partially bundled episodic billing.	1
ANB	Conditional	Add new baby (ANB) The ANB segment is used to notify the private health insurer of a newborn baby that may or may not be on a membership. Note: Private health insurers cannot load newborn information directly onto a membership without contact with the policy owner.	9
TFR	Conditional	Transfer (TFR) The TFR segment is used to report the transfer of a patient between hospitals. Separate segments are required for each transfer in and out.	9
ACS	Conditional	Accommodation summary (ACS) The ACS segment provides a summary of accommodation and critical care details. If accommodation is included in the SVB, then total accommodation charges under ACS should be set to zero dollars. ACD and CCG, LPD segments are nested within the ACS segment.	1
ACD	Conditional	Accommodation details (ACD) The ACD segment is used for the detailed reporting of differing periods of accommodation.	99
CCG	Conditional	Critical care details (CCG) The CCG segment is used for the detailed reporting of critical care where used by private hospitals and charged for by public hospitals.	99
LPD	Conditional	Leave period (LPD)	99

Segment	Obligation	Description	Repetition
		The LPD segment is used for the reporting of up to nine leave periods that may have occurred within the total period of hospitalisation.	
PSG	Conditional	Principal services (PSG) The PSG segment is used for the reporting and charging of all instances where a principal service or procedure is carried out during a single theatre visit. The repetitions allow for the inclusion of more than one visit during a claim period. Secondary services can be reported using the MSG segment nested within this group.	99
MSG	Conditional	Multiple services group (MSG) The MSG segment is used for the reporting of multiple or secondary services for each of the principal services reported in the PSG segment.	99
TRG	Conditional	Transport group (TRG) Not currently used	9
MIG	Conditional	Miscellaneous services (MIG) The MIG segment is used for the reporting and changing of miscellaneous items not covered elsewhere in the claim, i.e. prosthesis.	999
DMG	Conditional	DRG morbidity group (DMG) The DMG segment is required for the collection of diagnosis and ICD codes. It is essential for episodic billing.	1
MOR	Conditional	Non-DRG morbidity (MOR) The MOR segment is for the collection of non-DRG classifications. AN-SNAP	99
CER	Conditional	Certificate (CER) The CER segment is used to notify the collection of relevant certificate information needed to support the claim.	99
MED	Conditional	Medical services (MED) Not currently used	99
REM	Conditional	Remarks (REM) The REM segment allows for the collection of free format text that may be needed for the processing of a claim	99

Claim types

The ‘Claim Type Code’ is found in the CID segment. There are two ECLIPSE claim types:

- PR – Private hospital claims, including overnight, same day and non-admitted
- PU – Public hospital claims, including overnight and same day.

Important: day procedures will fall under either of the above claim types.

The following claim options are available within these claim types:

- overnight
- same day
- admitted
- non-admitted.

Contract/benefit types

Claim payments are driven by three payment methods:

- a per diem – day rate
- Casemix – total episode rate, or
- EPM – Equitable Payment Model.

Private health insurer contracts for contracted private hospitals will determine how claims must be submitted in order for the claims to be paid.

Examples of all claim and benefit types can be found at **pha.org.au**

Miscellaneous codes

Private health insurers use miscellaneous service codes to report and charge miscellaneous items. For example, prostheses or specific items payable as per a private health insurer contract. DVA also use their own miscellaneous code set.

If a service code such as an MBS item number, ICD10, or DRG is already available then these codes should be used. If none of the above are available then a miscellaneous code should be used.

Private health insurer contracts for contracted private hospitals will determine what miscellaneous codes must be submitted in order for the claims to be paid.

With the exception of prosthesis, the miscellaneous code comprises of 11 characters. It is made up from four different code lists that are interchangeable to produce a unique code:

- type of service: 2
- health care provider code: 2
- service code: maximum 6
- session type: 1

code format: _ _ / _ _ / _ _ _ _ _ _ / _

Miscellaneous codes can be used in many claim segments. A full list of miscellaneous codes can be found at **privatehealthcareaustralia.org.au** then go to Industry Portal > ECLIPSE Portal.

The miscellaneous code list will continue to grow as new codes are requested to support new contract requirements. You can request new miscellaneous codes on the Private Healthcare Australia website at **privatehealthcareaustralia.org.au**

Allow up to two weeks for a new code approval.

Prosthesis miscellaneous codes are nine characters in length, PX00 and a five-character prosthesis code.

Admitted vs non-admitted patients

Both admitted and non-admitted claims can be submitted through ECLIPSE. The Accommodation Status Code in the EPD segment is used to determine admitted status.

Private room add-on indicators

The method for advising of private room add-ons varies depending on the claim contract or benefit type.

Case payment add-ons should be set in the ACD segment. There should be two lines with corresponding dates. For example, the per-diem add-on should be billed as a private room rate in the ACD segment.

Case payment claims

Private health insurers have a preferred model for sending private room charges for case payment claims as shown in example 18.

Example 18: preferred model for case payment claims

Segment#	First day	Last day	Type	Rate	Add-on indicator	Charge indicator
ACD00001	1	3	Shared	0	N	I
ACD00002	3	5	Shared	0	N	I
ACD00003	3	5	Private	250	Y	C
ACD00004	5	7	Shared	0	N	I
ACD00005	5	7	Private	250	Y	C

Per diem claims

For per diem claims, the preferred model for sending private room charges is shown in example 19.

Example 19: preferred model for per diem claims

Segment#	First day	Last day	Type	Rate	Add-on indicator	Charge indicator
ACD00001	1	3	Shared	400	N	C
ACD00002	3	5	Private	650	N	C
ACD00003	5	7	Shared	400	N	C

Critical care add-on indicators

The submission of critical care add-ons is subject to individual private health insurer contracts.

The critical care add-on indicator is Y if dates in the ACD and CCG segments are the same.

Case payment claims

Private health insurers have a preferred model for sending critical care charges for case payment claims as shown in example 20.

Example 20: preferred model for sending critical care charges for case payment claims

Segment#	First day	Last day	Type	Rate	Add-on indicator	Charge indicator
ACD00001	1	3	Shared	0	N	I
ACD00002	3	5	Shared	0	N	I
ACD00003	3	5	Private	250	Y	C
CCG00001	1	3	ICU	1000	Y	C

Per diem claims

For per diem claims, the preferred model for sending critical care charges is shown in example 21.

Example 21: preferred model for sending critical care charges for per diem claims

Segment#	First day	Last day	Type	Rate	Add-on indicator	Charge indicator
ACD00001	1	3	Shared	400	N	C
CCG00001	3	7	ICU	1000	N	C

Theatre claiming

The PSG segment is used to report and charge all instances where a principal service or procedure is carried out during a single theatre visit. The repetitions allow for the inclusion of more than one visit during a claim period. Secondary services can be reported using the MSG segment nested within this group.

The initial PSG segment may not be claimable if it is covered by the charge in the SVB i.e. a case payment claim. If there is no charge payable for the theatre then the segment should be set with a charge indicator of I. However, if there is a charge to be raised because of a subsequent procedure or MBS as noted in the MSG segment, then the PSG segment should have a charge code of C that equals the sum of the chargeable MSG segments.

There are instances where a PSG segment must be submitted even though the service was not performed in a theatre. Examples of a charge for the MBS in the PSG and the other where the PSG charge amount is zero and MSG is non zero are shown in example 22.

Example 22: a theatre claim where a charge is raised for the principal procedure

Data element	Value
Message part ID	PSG00001
Anaesthetic type code	G
Charge amount	100000
Charge raised code	C
Service code	32508
Service code type code	C
Service date	13022015
Service time	1325
Theatre band code	5
Theatre band type code	N
Theatre category code	S
Theatre mins	95
Total charge amount	150000
Message part ID	MSG00001
Charge amount	50000
Charge raised code	C
Service code	34103
Service code type code	C
Theatre band code	3
Theatre band type code	N
Theatre category code	S

Example 23: a theatre claim where a charge is not raised for the principal procedure and a charge is raised for the secondary procedure

Data element	Value
Message part ID	PSG00001
Anaesthetic type code	G
Charge amount	0

Data element	Value
Charge raised code	C
Service code	32093
Service code type code	C
Service date	24022015
Service time	1600
Theatre band code	3
Theatre band type code	N
Theatre category code	S
Theatre mins	30
Total charge amount	10000
Message part ID	MSG00001
Charge amount	10000
Charge raised code	C
Service code	30473
Service code type code	C
Theatre band code	1
Theatre band type code	N
Theatre category code	S

Important: this example is only accepted from ECLIPSE release 6, November 2012 and onwards.

Charge indicators

There are two charge indicators that will be used to determine the rates being charged or billed by the hospital. A charge indicator of:

- C indicates the value is a charge raised
- I indicates the segment is for information purposes only.

HCP collection

ECLIPSE is aligned with HCP data collection requirements. The industry, Human Services and DoH are working towards automating the collection of the ECLIPSE HCP data to reduce the effort of reporting this information.

AN-SNAP

AN-SNAP is the Australian National Sub-Acute and Non-Acute Patient Classification System.

The AN-SNAP collection is a separate data collection to the episode record for rehabilitation, which provides specific information regarding the functional gains of patients undergoing rehabilitation, as well as the AN-SNAP class for overnight admitted patients. It is expected that one AN-SNAP record be reported for each overnight admitted rehabilitation program, and one AN-SNAP record be reported for an entire episode of care consisting of multiple same day visits. The AN-SNAP record should be linked to the episode with the same separation date.

ECLIPSE allows for the collection of AN-SNAP data in the MOR segment which is currently optional however this will become conditional in the future.

Hospital in the home

Hospital in the home is an admitted service. Claim information will be submitted in the ACD or the MIG.

Contractual arrangements with the private health insurer will determine which segment HITH will be submitted in.

There are multiple ways to create HITH depending on the contract with the private health insurer. Please check with the individual private health insurer.

Information messages

An interim response or information message will be sent if an assessment cannot be processed within five working days. It will advise the reason the claim could not be processed immediately.

Multiple information messages may be received before the final assessment, informing the progress of the claim.

Only one information message will be stored where multiple information message are sent from a private health insurer. You will **only** be able to retrieve the last message.

A claim must be either rejected or accepted by the private health insurer within 60 days of lodgement.

Certificates

The CER segment is used to notify the collection of relevant certificate information needed to support the claim. Private health insurers have different certificate requirements. Some private health insurers can receive the data in the CER segment while others will also want to see the hard copy certificate. Certificate requirements could also vary by hospital contracts.

Individual private health insurer requirements can be found at **privatehealthcareaustralia.org.au** then go to Industry Portal > ECLIPSE Portal.

Newborn babies

The ANB segment is used to notify the private health insurer of a newborn baby that may or may not be on a membership. Whilst submission of the data is required for HCP purposes, private health insurers do not use this information to update a patient's membership. There is still a requirement for the patient to inform the private health insurer before future claims can be made against the newborn.

Transfer segment

The TFR segment is used to report the transfer of a patient between hospitals. Separate segments are required for each transfer in and out.

A maximum of one admission and one separation transfer segment is preferred by the private health insurers in order to comply with HCP.

Leave periods

Any leave periods that occur during the total period of hospitalisation must be reported.

Leave days can be at any stage of the episode, including at the end of the stay and must not overlap accommodation or critical care periods of stay.

TRG

This segment is currently not in use.

MED

This segment is currently not in use.

Remarks

Free format text can be submitted in a claim within the remarks section. However, this will not be used by all private health insurers. Please contact individual private health insurers to understand use before you submit.

Auditing

Private health insurers reserve the right to audit any claims or certificates that relate to a claim.

Data that supports the claim submission must be kept by the submitting site as per statutory or contractual requirement.

DVA claiming information

DVA does not follow all of the same standards that private health insurers do. Items to be set differently for DVA are:

- *Service code* – DVA does not use the ECLIPSE Miscellaneous Codes list. Instead DVA requires that the Service code be populated using their contract codes
    - Prosthesis: these are not to be mapped but instead populate the Service code with the rebate code itself, i.e. JJ003 instead of PX00JJ003
    - Prosthesis handling fees: DVA has their own mapping for this. All handling fees need to be mapped to QA00
- *Service code type code* – as DVA uses their own contract codes in the Service code field, the Service code type code must be set to V
- *Program num* – DVA does not require the Program num field in the ACD segment to be sent. Instead they use their own internal contract codes in the Service code to determine the program
- Dates in ACD/CCG: unlike the private health insurers, the way the ACD segment dates are populated for DVA is continuous and not overlapping:

Example 24: ACD00001

Data element	Input
From date	28112013
To date	29112013

Example 25: ACD00002

Data element	Input
From date	30112013
To date	05122013

DVA claims must be for 99 days or less. If you have a long term episode you will need to interim bill it so that each claim contains no more than 99 days

DVA claims have a dollar limit of $99,999.99. If you have a more expensive episode you will need to interim bill it so that each claim is for no more than $99,999.99

You can use the Online Claiming Provider Agreement form to give EFT details to DVA. It can be found at **humanservices.gov.au/hpforms** then go to Forms by title > Online Claiming Provider Agreement form.

Appendix A – Patient verification error messages

Response code	Message	Reason	Action required
7026	DVA file number does not have a Gold or White card and may not be eligible for services	DVA specific	Verify file number and resubmit claim
7028	Name does not match registered name for File Number	DVA specific	
7035	Patient gender must be male or DVA specific IHC claims	DVA specific	
9650	The patient data supplied failed validation checks against Medicare data	DVA specific	
9662	Provider not recognised by fund	Provider not recorded on health fund system	Location or provider to contact fund
9663	Member number not recognised by fund	Member number not known by the fund the claim was submitted to. No other patient data checked at this time	Check member number and fund, correct whichever is wrong and try again
9665	Patient not recognised on the membership	Member number is valid Cover for membership number is permitted – no patient is identified or multiple patients are identified	Check patient details and re-submit. Make change to the alias name if Medicare has sent back a successful response Provide sufficient patient details to ensure unique match within membership
9666	Member to contact fund	Possible fraud, accident claim or membership issues	Member to contact fund
9667	Cover is suspended or cancelled	Member Number is valid	Can't lodge a hospital claim as member is not covered for that service. Check with member
9668	Inappropriate cover	Cover is either ancillary or ambulance only	Can't lodge a hospital claim as member isn't covered for that service. Check with member

Response code	Message	Reason	Action required
9669	Patient is ceased or pending cessation	Member number is valid Appropriate cover for membership number Patient details matched	Member to contact fund Patient may not have current student registration
9686	Baby not known at fund	No patient match is found and the DOB of the patient is less than 29 days from the earliest date of service in the Online Patient Verification Request	Member needs to register the baby at the fund

Appendix B – Eligibility check response codes

Response code	Message	Reason	Action required
1005	Facility ID not known to fund	The facility ID supplied is: not registered at the fund not current	Check the facility ID; if correct contact the fund, if incorrect re-submits with corrected data
1100	Not eligible for selected service	The patient is not eligible for treatment for the presenting illness or item according to the information supplied in the eligibility check	Tell the patient that they are not eligible for the service
1101	Eligible for service selected	Patient is eligible for the presenting illness or item according to information supplied in the eligibility check	
1102	Eligible subject to conditions	Patient may be eligible for the presenting illness or item according to the information supplied in the eligibility check. However, there may be conditions you will need to note before you proceed such as: • financial status • reduced benefit is payable • possible pre-existing condition	Refer to OEC guide for assistance on areas to check
1103	Resubmit for new assessment if presenting illness is shown	A general presenting illness or item was requested and a general answer displaying all benefit limitation or restriction that apply to the patients cover was returned in the response	Check the eligibility response carefully and re-submit if the actual presenting illness or item is displayed to obtain an accurate assessment

Response code	Message	Reason	Action required
1104	Eligible for selected service at previous cover	The patient is eligible for the presenting illness or item on the incoming eligibility request but not at their current cover. This message generally results where the patient is still serving the required waiting period applicable on the upgrade in cover	The patient is eligible for the service on their previous level of cover
1105	Not eligible for selected service – wait period applied	The patient is not eligible for the presenting illness or item as they have not completed serving their required waiting periods	
1106	Eligible for selected service at previous cover – wait period applied	The patient is eligible for the presenting illness or item as input on the incoming eligibility request but not at their current cover. This message generally results where the patient is still serving the required waiting period applicable on the upgrade in cover	
1107	Not eligible for selected service – pre-existing ailment	The patient is not eligible for the presenting illness or item if it is deemed to be a pre-existing condition	
1108	Eligible at previous cover subject to conditions	The patient is eligible for the presenting illness or item as input on the incoming eligibility request but not at their current cover. This message generally results where the patient is still serving the required waiting period applicable on the upgrade in cover	
1109	Eligible subject to approval of accident certificate	Fund won't guarantee payment of the service until an accident certificate is supplied and approved	Ask member to contact the fund

Response code	Message	Reason	Action required
1110	Eligible subject to conditions and approval of accident certificate	Fund won't guarantee payment of the service until an accident certificate is supplied and approved and there is another condition that will affect assessment. This could be: • financial status • pre-existing ailment or waiting period • reduced benefit is payable	Ask member to contact the fund regarding the accident certificate and to check the other conditions of the eligibility response
1111	Unknown presenting item	The presenting illness or MBS item could be: • incorrectly input • ceased • not on item database at the fund	Check the item number. If correct contact the fund, if incorrect amend and re-submit
1112	Use Presenting Illness in the range 400 - 499	Presenting Illness submitted in range 300 – 399 for a product that has been categorised using clinical categories	Resubmit the eligibility check with a Presenting Illness in the range 400 - 499
1113	Use Presenting Illness in the range 300 - 399	Presenting Illness submitted in range 400 – 499 for a product that has NOT been categorised using clinical categories	Resubmit the eligibility check with a Presenting Illness in the range 300 - 399
1114	Item is common or support. Use Presenting Illness or Primary MBS code	No benefits are payable for a common or support item.	Resubmit the eligibility check with either a presenting illness or the Primary MBS code
1999	Processing error		Contact fund
2001	Waiting period applies for pre-existing ailments	No benefit payable	
2002	Service is within the required waiting period	No benefit payable	
2006	Benefit not payable for services claimed or requested	No benefit payable	

Response code	Message	Reason	Action required
2007	Incorrect charge – charge exceeds allowable amount for claim type	Charge input is greater than the agreed rate for an agreement or scheme claim	Check the charge amount and claim type, correct the error and re-submit
2008	Public hospital table – Nil benefit	No benefit payable	
2009	A benefit is not payable for this service under this level of cover	No benefit payable	
2010	Membership was not paid to the date when the service was provided		
2017	Default benefit only paid for this procedure	Lesser benefit paid for this service	
2026	Member issue as at date of service		Ask the member to contact the fund
2888	Refer to OEC response & assessment text	There is an issue with the overall eligibility response that will affect the service line assessment result	Check and correct the eligibility issue, then re-submit
2999	Processing error contact fund	The fund has a processing error that maybe unique to the membership or claim supplied	Contact the fund to find out the reason for the error