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For Better Health

ahm
by Medibank

MPPA BILLING CHANNEL

GUIDE FOR PRIVATE PATHOLOGY AND DIAGNOSTIC IMAGING PROVIDERS

The Medical Purchaser Provider Agreement (MPPA) Billing Channel is a claiming option offered by Medibank and ahm Health Insurance to private providers of in-hospital pathology and diagnostic imaging services.

This guide explains everything you need to know about claiming under the MPPA Billing Channel.

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Contact Us

Medibank

Call our Provider Information Line on **1300 130 460**.

medibank.com.au >For Providers > MPPA Billing Channel

ahm Health Insurance

Call our Claims Enquiry Line on **1300 309 438**.

ahm.com.au > For Providers > MPPA Billing Channel

This Guide is available at:

medibank.com.au > For Providers > MPPA Billing Channel.

ahm.com.au > For Providers > MPPA Billing Channel.

This Guide may be changed by Medibank from time to time.

This version is current as at 1 September 2014.

Advantages of the MPPA Billing Channel

- You can choose to participate on a patient by patient basis
- Claiming is easy as you send one account directly to either Medibank or ahm Health Insurance
- You can claim electronically via Eclipse which is fast and efficient and helps streamline your billing process
- You receive one full payment that includes both Medicare and health fund benefits
- Benefits are paid directly into your bank account v ia Electronic Funds Transfer (EFT)
- You are free to charge out-of-pocket costs to members so long as you obtain their informed financial consent before treatment or as soon as practicable after treatment

Informed Financial Consent (IFC)

Medibank and ahm acknowledge that, in accordance with your billing policies, you may elect to charge our members an out-of-pocket expense for pathology or diagnostic imaging services you provide, when they are admitted into hospital.

We expect that:

- Members will be adequately informed of any out-of-pocket expenses as part of your standard informed financial consent (IFC) procedures for in-patients.
- You will comply with your obligations regarding patient informed financial consent.

MPPA Billing Channel - Terms and conditions of use

The following terms and conditions apply to participation in the Medical Purchaser Provider Agreement (MPPA) Billing Channel:

1. You must be registered with Medibank and ahm to obtain a Billing Entity Number and to register your EFT and contact details.
2. You can claim under the MPPA Billing Channel on a patient by patient basis.
3. Medibank and ahm will pay benefits for eligible services to an eligible member at 100% of the applicable Medicare Benefits Schedule fee.
4. You must comply with your obligations regarding patient informed financial consent. To avoid doubt, you must provide our members with a written estimate of fees indicating any out-of-pocket costs they will have to pay. Where possible, you must ensure the member has given their informed financial consent to these charges prior to treatment, or as soon as practicable after treatment.
5. You must include the total cost of treatment on the account including the full amount the member will have to pay.
6. All unpaid claims must be submitted by you directly to either Medibank for Medibank policy holders or ahm for ahm policy holders.
7. You must keep proper records of each professional service provided to an eligible member.
8. Where requested by Medibank or ahm, you must provide evidence of transactions the subject of a claim by an eligible member, request forms, patient records and other supporting documents, such as written evidence of the member's informed financial consent.

How to register

To start claiming under the MPPA Billing Channel, simply fill out the MPPA Billing Registration form to obtain a Billing Entity Number and register your EFT and contact details. Registration forms are available at:

medibank.com.au > For Providers > MPPA Billing Channel

ahm.com.au > For Providers > MPPA Billing Channel.

Simply complete the form, and email to mppa@medibank.com.au
or post to MPPA Billing registration, Medibank, GPO Box 9999, Melbourne VIC 3000.

Providers to be linked to your Billing Entity number

You will also need to provide us with a list of providers who need to be linked to your MPPA Billing Entity number. Please include details of the provider's name and provider number for each service location. If you have a large number of providers, please detail the provider names and provider numbers in an Excel spreadsheet and email to mppa@medibank.com.au.

Payment of benefits

Medibank and ahm will pay benefits for eligible diagnostic services to an eligible member at 100% of the applicable Medicare Benefits Schedule (MBS) fee. To avoid doubt, 'diagnostic services' are services within the scope of the diagnostic imaging items set out in category 5 of the MBS and the pathology items set out in category 6 of the MBS (and, in each case, any associated items).

We will make every effort to process accounts within 21 days, provided they satisfy the requirements outlined in this guide. Benefits will be paid in accordance with Medicare Australia's assessing rules, which are subject to change.

Eligible hospital covers

Most Medibank and ahm hospital covers provide benefits for pathology and diagnostic imaging medical services which are eligible for benefits under the MPPA Billing Channel.

However the following hospital covers cannot be processed under the MPPA Billing Channel:

Medibank:

- Medibank Overseas Student Health Cover (OSHC)
- Medibank OSHC Essentials
- Young Visitors
- Intermediate 70 Visitors
- Top 85 Visitors
- Working Visa Hospital
- Working Visa Hospital & Medibank
- Top 85 Working Visa

ahm:

- ahm Overseas Student Health Cover

Likewise, members with Extras only cover and/or Ambulance Cover are not eligible. If the member is not eligible, please bill them directly.

Eligible membership

Benefits are paid for members only where:

- The membership is financial at the date of service.
- The member has served all relevant waiting periods.
- The member is eligible to receive a Medicare benefit.
- The service is eligible for a Medicare benefit.
- The service for which the benefit is being claimed is covered under the member's product.

No other circumstances exist pursuant to which the benefit may not be payable under the Fund Rules of Medibank or ahm.

Eligibility checking

To ensure a member is entitled to Medicare or health fund benefits it is recommended you perform an eligibility check prior to providing a service. Patient eligibility must be checked to ensure that the member has the right level of cover and that their membership is financial at the date you plan to provide the service. This will also assist you in obtaining Informed Financial Consent (IFC).

How to check patient eligibility for Medibank policy holders

Call Medibank Private on 1300 130 460. You will be connected to a Customer Service Officer. Ensure you have the member's Medibank member number and their date of birth to complete the eligibility check.

How to check patient eligibility for ahm Health Insurance policy holders

- Use Eclipse Online Patient Verification (OPV) to check that the patient is a valid Medicare card holder or health fund member; and/or
- Call ahm on 1300 309 438. You will be connected to a Customer Service Officer. Ensure you have the member's ahm member number and their date of birth to complete the eligibility check.

How to bill

Use the information in the following sections to ensure your accounts can be processed as efficiently as possible.

Billing options

There are two ways you can submit MPPA accounts:

1. You can use Eclipse which allows you to process your claims electronically in a streamlined way.

   To claim through Eclipse simply send your claims to either Medibank using Fund ID 'MPL' or to ahm Health Insurance using Fund ID 'ahm' and Claim Type 'AG' for both. For Medibank use your 'Billing Entity number' in the Fund Payee ID field, whereas for ahm use the 'Payee Provider number' in the Fund Payee ID field.

2. If you don't have Eclipse you can lodge manually by using the batch headers available.

   To claim with either Medibank or ahm Health Insurance manually you will need to follow the three simple steps below:

1. Provide necessary account information
2. Use a MPPA batch header with correct Billing Entity number (you must use the correct fund MPPA batch header for either Medibank or ahm or your claims may be rejected)
3. Send your accounts to either Medibank or ahm

Faster claiming through Eclipse – Electronic claiming

Eclipse is the in-patient claiming system developed by Medicare Australia that enables providers, health insurers and Medicare to exchange and pay claims electronically.

The benefits of Eclipse

- Fast and efficient claiming
- No limit to the number of claims or batches you can submit at one time
- Online verification of Medicare eligibility and health fund membership in a matter of seconds
- Online viewing of claims submitted and payments received
- Improved financial management through faster resolution of claims
- One system for the complete claims picture

Become an Eclipse user

To register for Eclipse or if you want more information about how it works, contact the Medicare Australia eBusiness Service Centre on 1800 700 199.

Account information

For claims to be assessed for payment, they must contain all relevant and accurate information, which includes the following:

- Your correct Billing Entity number and entity name
- Patient's Medibank or ahm Member number
- Patient's name, address and date of birth
- Medicare Number – ensure it is correct and current
- Medicare Reference Number applicable to the patient
- Provider Name
- Provider Number for location of service
- Name of the hospital in which the service/s was provided.
- For each service provided, the date of service and Medicare Benefits Schedule (MBS) item number.
- A fee for each MBS item number (this must be the exact fee charged for the service including any amounts payable by the member but excluding any discounts or other conditions)
- Whether the claim was compensable or accident related.
- Referral details including referral date, referring provider name, number and address
- Any other information relevant to assessment of the service as outlined in the MBS.

Batch headers for manual accounts

It is important that claims are submitted with the appropriate MPPA Batch Header and complete details. The batch headers can be used for all claims, including resubmissions, and can be found at:

medibank.com.au > For Providers > MPPA Billing Channel > Forms & Batch headers

ahm.com.au > For Providers > MPPA Billing Channel > Forms & Batch headers

Send your accounts

Medibank and ahm operate as two separate brands and claims need to be forwarded to different addresses with the correct batch header attached.

Send your accounts for Medibank Private policyholders to:

Medical Billing
Medibank
GPO Box 1608
MELBOURNE VIC 3001

For ahm policyholders, send to:

ahm Health Insurance MPPA
Locked Bag 1006
Matraville NSW 2036

Where details are incomplete or inaccurate, Medibank or ahm (as applicable) will return the claim to you to add the correct information. You can then resubmit the claim, however, this will delay processing and payment time.

By ensuring that all claims submitted contain the correct information, you can reduce the need for resubmissions and improve claim turnaround time for assessment and payment.

Account payment

Payments will be made by electronic funds transfer (EFT) directly into your nominated bank account.

Medibank will forward payment for each account as soon as assessment is complete regardless of the processing status of the other accounts submitted within the same batch.

Please provide Medibank with the banking details by completing the MPPA Billing Registration form or MPPA Billing Change of Details form which can be found on our websites.

Remittance advice

If you submit your accounts via Eclipse you will receive your Remittance Advice electronically at the time of your payment.

If you submit accounts manually, your Remittance Advice will be automatically sent to the address of the provider number listed on the batch header. To nominate a different postal address for your Remittance Advice you will need to specify this on the MPPA Billing Registration form or MPPA Billing Change of Details form, which can be found on our websites.

Please allow approximately 10 working days after the EFT payment to receive your statement of benefit through the mail.

Account rejections

When an account is rejected it can be for either a Medicare or health fund assessment reason.

Examples of when an account would be rejected are:

- If any necessary account information is missing
- Where ineligible items are included on the account
- If the account has already been paid
- When a batch header has not been provided with the account or the incorrect batch header has been attached
- When more than one patient has been billed on one account.

If your account is rejected you will be notified in one of the following ways:

If you lodged via Eclipse, you will receive a message electronically advising why the claim was rejected.	If you lodged via a batch header, you will receive a letter detailing why the claim has been rejected.
Your Remittance Advice will also outline the reason(s) an account was rejected by either the health fundor Medicare. Refer to pages 10 – 18 for a list of assessment/rejection explanation codes.	

Depending on the reason for rejection, you may need to check the account details in accordance with the rejection reason and:

- Amend the account as necessary, reissue and resubmit the account with your next Eclipse lodgment or next batch. If lodging a resubmitted account/s please indicate on the batch header that it is being resubmitted
- If benefits are not payable, bill the patient directly using your normal patient billing procedures. Please ensure the patient account includes the following message 'The amount on this account is claimable through Medicare Australia only'.

Changes to your MPPA Billing Entity postal address, contact or bank account details

It is important to keep all details relating to your MPPA Billing Entity Number current with Medibank and ahm.

To make any changes to your postal address, business manager and account contact or bank account details, please use the MPPA Billing Registration and Change of Details forms which can be found on our websites.

MPPA provider maintenance and updates

To add, change or delete any linked providers, please send details of the provider's name and provider number by email to mppa@medibank.com.au.

Please remember to use your unique MPPA Billing Entity number when emailing your provider update requests to help identify your organisation. If you have a large number of provider changes, please detail the provider names and provider numbers in an Excel spreadsheet.

There is no requirement for you to use any other form to make these changes to providers who should be paid under your MPPA Billing Entity number.

Claims enquiries - review of payments

overpayments – underpayments - non-payment

Medibank

Call our Provider Information Line on **1300 130 460**.

ahm Health Insurance

Call our Claims Enquiry Line on **1300 309 438**.

When medical benefits are not payable

Medibank will not pay a medical benefit under the MPPA Billing Channel in the following circumstances:

- If the service provided is not a service within the scope of the diagnostic imaging items set out in category 5 of the MBS or the pathology items set out in category 6 of the MBS (or, in each case, any associated item).
- If the service provided is not covered by the member's health insurance product
- If the member's product (or the Fund Rules of Medibank or ahm) excludes the relevant service
- If the service was not performed whilst the member was a private in-patient of a recognised hospital, private hospital or a day hospital facility
- If the membership was unfinancial at the date of service
- If the claim is for services where an entitlement exists, or may exist, to compensation or damages
- Where waiting periods had not been served at the date of service
- Where a Medicare benefit is not payable or where Medicare has rejected the claim, or the member is not eligible for a Medicare benefit
- Where the claim has not been lodged within two years of the date of service
- Where the member is not covered by a health insurance product that provides medical benefits.

Record keeping and access to records

Medibank will keep records of the benefits it pays to you. If you are concerned that benefits have not been paid correctly, please contact us.

We expect you to keep proper records of each professional service provided to an eligible member by a medical practitioner that show:

- The name and date of birth of the eligible member;
- The current Medicare card number and card reference number of the eligible member;
- The name, address and provider number of the medical practitioner who provided the professional service;
- The professional service(s) the medical practitioner provided, including Medicare Benefits Schedule item(s);
- The date on which each professional service was provided; and
- The price that was charged for each Medicare Benefits Schedule item number;
- The referral details for the professional service(s); and
- Written evidence of the eligible member's informed financial consent.

Where requested by Medibank or ahm, you must provide evidence of transactions the subject of a claim by an eligible member, request forms, patient records and other supporting documents within 10 business days of our request.

Assessment/ rejection explanation codes

Medibank Private - Assessment/ Rejection Explanation Codes

Code	Assessment / Rejection Explanation	Code	Assessment / Rejection Explanation
3	Service provider not recognised by Medibank at date of service	622	Referral date missing/ invalid
5	Date of service prior to membership effective date	625	Medicare number missing/invalid
7	Patient does not match membership number	630	Service condition/service text missing
11	Patient not on membership at date of service	632	Not an in hospital service
18	Following review, the benefit is not payable for the item claimed	634	No valid billing entity contract at date of service
117	No benefit payable for this service	636	Date of service over 2 years-late lodgement form required
211	Benefit is not payable for the item claimed under member's cover	637	Claim is a duplicate - original claim being reassessed
401	Charge amount missing or invalid - benefit not payable	639	Not normal aftercare not valid
480	Invalid quantity	645	Anaesthetic detail combination invalid/ missing
509	Unrecognised item service code	620	Lspn details invalid/missing or details not valid for diagnostic imaging claim
901	Service performed in waiting period	621	Scp details invalid/missing or details not valid for pathology claim
300	Lodgement date invalid	623	Pathology requesting details/request override details invalid/missing
304	Lodgement date is prior to date of service	624	Diagnostic imaging requesting details/ request override details missing/invalid
306	Member is not insured at date of service	640	Service condition text must be selected when multiple procedure override is selected
307	Member is inactive at date of service	641	Service condition text must be selected when duplicate override is selected
308	Member not on membership at date of service	646	Anaesthetic referral details/referral override details invalid/missing
309	Member not covered at date of service	647	Service provider and referring provider numbers cannot be the same
315	Service provider not recognised at date of service	648	Details not valid for specialist consults claims
316	Membership unfinancial at date of service	649	Details not valid for specialist surgical claims
428	Date of service is older than 2 years from lodgement date - no benefit payable	626	Number of patients/fields radiated invalid/ missing
617	Billing entity is not valid for date of service	655	Billing agent not valid for date of service

Assessment/ rejection explanation codes

Medibank Private - Assessment/ Rejection Explanation Codes

Code	Assessment / Rejection Explanation	Code	Assessment / Rejection Explanation
005	Cancelled claim	NBM	No Benefit – miscellaneous item
555	No benefit payable – item rejected by Medicare	NIP	No Benefit – not an inpatient service
888	Adjustment to previous claim	TOP	Adjustment to previous claim, top up to Medicare benefit
DUP	Duplicate - benefit previously paid, contact ahm for more information	WWP	No benefit – within a waiting period
LDA	Latter Day Adjustment		

Medicare - Assessment/ Rejection Explanation Codes

The following lists are not exhaustive and are subject to change.

Code	Assessment / Rejection Explanation	Code	Assessment / Rejection Explanation
1101	More details of service required to assess benefit	1138	Benefit only payable when self-determined/ deemed necessary
1102	No amount charged is shown on account/ receipt	1139	Approved pathologist should not use this item number
1103	Letter of explanation is being sent separately	1140	Non-specialist provider
1104	Balance of benefit due to claimant	1141	No benefit payable for services performed by this provider
1105	Benefit paid to provider as requested	1142	Letter of explanation is being sent separately
1106	Servicing provider unable to be identified	1144	Claim benefit not paid - further assessment required
1107	Benefit paid on item number other than that claimed	1150	Member has not supplied details to permit claim payment
1108	Benefit is not payable for the service claimed	1151	Associated service already paid-adjustment being processed
1111	No benefit payable-claim/s over 2 years old	1154	Diagnostic imaging multiple service rule applied to service
1113	Total charge shown on account apportioned over all items	1155	Letter of explanation is being sent separately
1115	Benefit recommended for this item	1156	For a derived fee
1117	Benefit not recommended for this item	1157	Service possibly aftercare - refer to provider
1120	Age restriction applies to this item	1158	Benefit paid on associated abandoned surgery/anae item
1122	Associated referral/request line not required	1159	Item associated with other service on which benefit payable
1123	Benefit paid on radiology item other than service claimed	1160	Maximum number of services for this item already paid
1124	Item is restricted to persons of opposite sex to patient	1161	Adjustment to benefit previously paid
1125	Not payable without associated operation/ anaesthetic item	1162	A claim for this service has been previously processed
1126	Service is not payable without radiology service	1626	Number of patients/fields radiated invalid/ missing
1127	Maximum number of additional fields already paid s	1655	Billing agent not valid for date of service
1128	Benefit paid on associated fracture/ amputation item	1163	Surgical/anaesthetic item/s already paid for this date
1129	Service is not payable without the base item/s	1164	Assistant surgeon benefit not payable
1130	Letter of explanation is being sent separately	1166	Letter of explanation is being sent separately
1131	Date of service not supplied/invalid	1168	Not payable without associated operation/ anaesthetic item
1134	Single course of treatment paid as subsequent attendance	1169	Operation/anaesthetic item not claimed
1135	Provider not a consultant physician - specialist rate paid	1170	Assistant anaesthetic benefit not payable
1136	Referral details not supplied - paid at g.p. rate	1171	Benefit not payable - provider may only act in one capacity
1137	Details of requesting provider not shown on account/receipt	1173	Patient episode coning - maximum number of services paid

Medicare - Assessment/ Rejection Explanation Codes

The following lists are not exhaustive and are subject to change.

Code	Assessment / Rejection Explanation	Code	Assessment / Rejection Explanation
1174	Patient episode coning adjustment	1236	Letter of explanation is being sent separately
1175	Benefit paid on associated foetal intervention item	1237	Letter of explanation is being sent separately
1176	Pay each foetal intervention item as a separate item	1238	Not paid because all associated services rejected
1177	Foetal intervention item paid using derived fee item	1240	Gap adjustment to benefit previously paid
1179	Benefit not payable - associated service already paid	1241	Total charge and benefit for multiple procedure
1184	Benefit paid for additional time item using a derived fee	1242	Service is part of a multiple procedure
1194	Letter of explanation is being sent separately	1243	Apportioned charge and total benefit for multiple procedure
1195	Letter of explanation is being sent separately	1244	Benefit not paid - service line in error
1206	Item number does not attract a benefit at date of service	1245	Benefit paid on service other than that claimed
1208	Card number used has expired	1246	Patient cannot be identified from information supplied
1209	Claimants name stated is different to that on card number	1250	Explanation/voucher will be forwarded separately
1211	Patient not covered by this card number at date of service	1251	Details of requesting provider not supplied
1212	Date of service used is in the future	1252	Service possibly aftercare
1214	Claim form not complete	1253	Radiotherapy assessed with other item number on statement
1215	Service claimed prior 1 February 1984	1254	Assessment incomplete - further advice will follow
1217	Patient cannot be identified from information supplied	1255	Benefit assigned has been increased
1222	Benefit paid on associated anaesthetic item	1256	Benefit not payable on this service for a hospital patient
1223	Service not payable - specified item not claimed or present	1260	Benefit assessed with associated item on statement
1225	Patient contribution substantiated-additional benefit paid	1261	Associated surgical items/anaesthetic time not supplied
1226	Date of service is prior to patients date of birth	1262	Insufficient prolonged anaesthetic time - service not paid
1227	Date of service prior to date eligible for Medicare benefit	1264	Benefit not payable - compensation/ damages service
1228	Date of service after benefit period for overseas visitor	1265	Service not covered by reciprocal health care agreement
1229	Benefit paid at 100% of schedule fee	1267	Service not payable - associated service not present
1230	Combination of 85% and 100% of schedule fee paid	1271	Not payable without associated ophthalmological item
1232	Service claimed not covered by Medicare	1272	Benefit paid on associated ophthalmological item
1233	Provider not entitled to Medicare benefit at date of service	1274	Provisional payment
1234	Letter of explanation is being sent separately	1280	Cannot identify service. Resubmit with correct MBS item

Medicare - Assessment/ Rejection Explanation Codes

The following lists are not exhaustive and are subject to change.

Code	Assessment / Rejection Explanation	Code	Assessment / Rejection Explanation
1282	Date of service outside of referral/request period	1335	Service is not payable without nuclear medicine service
1306	Card# not valid at date of service-future claims may reject	1336	Benefit paid on nuclear medicine item other than one claimed
1307	Claim not paid – card number not valid for date of service	1337	Provider must claim content-based items
1308	IVF service - conditions not met - no benefit payable	1338	Provider not registered to claim benefit at date of service
1316	Benefit not payable - item cannot be self-determined	1339	Benefit paid at the concession rate
1317	Benefit not payable - additional item to those requested	1340	Refund of co-payment amount
1320	Quoted Medicare card number is incorrect	1341	No referral details - details required for future claims
1322	Provider not approved for this Medicare pathology benefit	1342	Referral expired - paid at unreferred (GP) rate
1325	Laboratory not accredited for benefits for this service	1343	Card number quoted on claim form has been cancelled
1326	Laboratory not accredited for benefits at date of service	1344	Concession number invalid - benefit paid at general rate
1328	Benefit paid on associated tomography item	1345	No safety net entitlement - benefit paid at general rate
1329	Not payable without associated tomography item	1346	Co-payment not made - $2.50 credited to threshold
1331	Benefit not payable – H.I. act sect 20(a)(1)	1347	Safety net threshold reached - benefit increased
1332	Category 5 lab - benefit not payable for requested service	1348	Overpayment of claim - invalid concession number
1333	Provider must claim time-based items	1349	Replacement for requested EFT payment rejected by bank
1334	Benefit not payable-associated pathology must be inpatient	1350	Hospital referral - paid at specialist/ consultant rate
1335	Service is not payable without nuclear medicine service	1351	Benefit not payable - LCC number incorrect or not supplied
1336	Benefit paid on nuclear medicine item other than one claimed	1352	Service date outside LCC registration dates
1337	Provider must claim content-based items	1353	Pathology items not present - no benefit payable
1338	Provider not registered to claim benefit at date of service	1356	Documentation required to process service
1339	Benefit paid at the concession rate	1358	Documentation not received - unable to process service
1340	Refund of co-payment amount	1359	Documentation not received - unable to process claim
1341	No referral details - details required for future claims	1360	No benefit payable when requested by this provider
1342	Referral expired - paid at unreferred (GP) rate	1361	DI exemption/items not approved
1343	Card number quoted on claim form has been cancelled	1363	PEI paid in association with R3EX pathology services
1344	Concession number invalid - benefit paid at general rate	1364	Items claimed must be as a combination item

Medicare - Assessment/ Rejection Explanation Codes

The following lists are not exhaustive and are subject to change.

Code	Assessment / Rejection Explanation	Code	Assessment / Rejection Explanation
1366	Rule 3 item	1410	Age restriction applies for this item - verify details
1367	Service associated with MBAC item in a multiple procedure	1411	MBAC determination/precedent number not supplied or invalid
1370	Benefit paid on item number other than that claimed	1412	Benefit not payable - provider unable to claim this service
1371	Future claims quoting old style card no. Will be rejected	1413	Benefit not payable - date of serv prior to date of request
1372	Old style card number quoted - benefit not payable	1414	Provider practice location is closed at date of service
1373	Expired card - benefit not payable	1415	Referral details same as rendering provider - self-deemed
1374	Old card issue used - benefit not payable - also refer	1416	Services form a composite item - composite item required
1375	Service being processed manually	1417	Referral needed - if no referral, nr item to be transmitted
1377	Number of patients seen not indicated	1418	Item cannot be claimed more than once in one attendance
1378	Provider cannot refer/request service at date of request	1419	Benefit already paid on item - verify if multiple pregnancy
1390	Documentation not received	1420	Operation/s schedule fee does not meet item description
1391	Service provider on db1 differs from transmitted data	1421	Wrong assistant item used for the operation/s performed
1392	Benefit amount changed	1422	Benefit paid has been reduced (benefit = charge)
1393	No benefit payable - baby not an admitted inpatient	1423	Optical condition not specified - no benefit payable
1395	TAC medical excess	1424	More information required - which eye was treated
1397	Service not related to current compensation case	1425	Benefit not payable - individual charges required
1400	Equipment number missing or invalid	1426	Indicate whether new treatment or continuing management
1401	Benefit not payable - charge amount missing or invalid	1427	Compensation related services - please forward documents
1402	Benefit not payable- number of patients attended required	1428	Date of service over 2 years - late lodgement form required
1403	Subsequent consultation - referral details required	1429	Patient cannot be identified from the information supplied
1404	Benefit not payable - referral/request details required	1430	Conflicting referral details - please clarify
1405	Equipment number invalid for servicing provider	1431	Initial consultation previously paid - query subsequent con
1406	Unable to assess claim - please forward documents	1432	Not multi-op - more information required to pay benefit
1407	Benefit not payable - overseas student	1433	Associated referral/request line not required
1408	Date of service prior to 29 may 1995	1434	Expired or invalid card. Benefit not payable
1409	Card number for this enrolment needs to be verified	1435	Service for nursing home care recipient - benefit not paid

Medicare - Assessment/ Rejection Explanation Codes

The following lists are not exhaustive and are subject to change.

Code	Assessment / Rejection Explanation	Code	Assessment / Rejection Explanation
1436	Cannot claim out of hospital service through simplified bill	1529	Bulk bill additional item claimed incorrectly
1450	EFT details invalid - cheque issued for benefit	1530	Patient not on concession/under 16 years at date of service
1461	Adjustment to benefit previously paid	1535	Missing data
1475	Patient/service details invalid or missing	1536	Location specific practice number not supplied
1500	Rejected in association with another item in this claim	1537	Location specific practice number invalid
1501	Group attendance or item format invalid	1538	Location specific practice number not recognised
1502	Patient is not eligible to claim benefit for this item	1539	Location specific practice number not valid at date of service
1503	Referral date format is invalid	1540	Enhanced primary care plan item not previously claimed
1504	Charge amount missing/invalid - no benefit payable	1549	Bulk bill incentive item already paid - adjustment required
1505	More information required. Evidence of condition	1550	Associated service not claimed - no benefit payable
1507	Site not accredited for this service	1551	Specimen collection point is incorrect or not supplied
1510	Service paid as item 52-96/or similar item	1552	Specimen collection point not valid at date of service
1512	Multiple musculoskeletal MRI service rule applied	1553	Approved collection centre number not supplied
1513	Multiple musculoskeletal MRI and di services rules applied	1554	Total benefit for anaesthetic service
1514	Required equipment type code not on ISPN register	1555	Benefit paid on main RVG anaesthetic item
1515	Equipment greater than 10 years old	1556	RVG time item not claimed
1516	Ben paid for base and derived radiotherapy items claimed	1557	Associated RVG anaesthetic service not claimed
1517	MPSN threshold reached - 80% out of pocket paid	1558	RVG anaesthetic item not claimed
1518	Benefit paid at 100% schedule fee + EMSN	1559	Patient outside age range - please verify age
1519	MPSN threshold reached - partial 80% out of pocket paid	1560	RVG item restriction
1520	Benefit paid at 100% schedule fee + part 80% out of pocket	1561	Benefit paid on RVG item claimed
1521	Paid part 80% out of pocket + between 85% and 100% increase	1562	Benefit paid on associated RVG anaesthetic item
1522	Benefit paid - EMSN + between 85% and 100% schedule fee	1563	Associated RVG service already paid
1523	Charge entered is greater than 350% of the schedule fee	1564	Multiple vascular ultrasound services site rule applied
1524	Safety net benefit adjusted	1565	Multiple DI and vascular ultrasound service rules applied
1525	Only attracts benefit when claimed via bulk billing	1566	Total benefit for diagnostic imaging service
1528	Provider not in eligible area (incorrect RRMA,SSD or state)	1567	Benefit paid on main diagnostic imaging item

Medicare - Assessment/ Rejection Explanation Codes

The following lists are not exhaustive and are subject to change.

Code	Assessment / Rejection Explanation	Code	Assessment / Rejection Explanation
1568	Item cannot be substituted	1627	PDT statement not provided by the doctor
1600	Requesting/referring provider unable to be identified	1629	Initial PDT therapy item not present on patient history
1601	In hospital services cannot be claimed as out of hospital	1633	Refer back to the specialist (referring provider is closed)
1602	Out of hospital service cannot be claimed as in hospital	1634	Refer back to the specialist (servicing provider is closed)
1603	Newborn not yet enrolled with Medicare - no benefit payable	1635	Late lodgement not approved - letter being sent separately
1604	Service over 6 months old - late lodgement form required	1636	Benefit reduced-dental cap broken
1605	Referral expired - no benefit payable	1637	No benefit payable-dentalcap reached
1606	Referring provider number not open at date of referral	1638	Unknown Medicare reason code received
1607	Referral date has been omitted	1700	Benefit cannot be determined for this service
1608	Referring and servicing provider same - no benefit payable	1701	Benefit cannot be determined due to complex assessing rules
1609	Service cancelled at providers request	1702	Item restrictive with another item
1610	Provider specialty not consistent with item claimed	1703	Duplicate of item already quoted
1611	Referral/request details not supplied - no benefit payable	1704	Provider not permitted to claim this item
1612	Date of referral after date of service - no benefit payable	1705	No associated pathology service
1613	Card number cannot be identified from information supplied	1706	Provider not associated with a pathology laboratory
1614	No benefit payable - please notate time of each visit	1707	Pathology laboratory not registered at date of service
1615	Multiple procedures - notate times and area of treatment	1708	Item cannot be claimed from this pathology laboratory
1616	Item cannot be claimed as in hospital service	1709	Another assistant item should be claimed
1617	Item cannot be claimed as out of hospital service	1710	Associated surgical items not present
1618	No benefit if requested by this provider at date of request	1711	Unable to determine associated surgery
1619	Servicing provider number not open at date of service	1712	Base item not present or in incorrect order
1620	Duplicate transmission - no further payment made	1713	Radiotherapy fields greater than maximum allowable
1621	Item not claimable electronically	1714	Benefit not determined - numberof time units not present
1622	Pet drop-down items not claimable via EDI	1715	Number of time units exceeded maximum allowable
1623	Pet items only claimable via direct bill	1716	Service forms a composite item - composite item required
1624	Pet items - payee provider required	1717	Benefit not payable on this service for a hospital patient
1625	Payee provider not eligible to claim pet items	1718	Provider location not open at date of service

Medicare - Assessment/ Rejection Explanation Codes

The following lists are not exhaustive and are subject to change.

Code	Assessment / Rejection Explanation
1719	Benefit cannot be calculated for hyperbaric oxygen therapy
1732	Referral period not valid for referring provider
8005	The individual has been matched using the submitted data however differences were identified. Please check the information returned and update your records.
8014	Claim accepted for processing. Updated information has been supplied
9201	Invalid format for data item
9309	Referral issue date must be supplied, and must be prior to, or the same as, the date of the medical service, cannot be before the date of birth, nor after the referral start date
9311	Request issue date must be supplied, and must be prior to, or the same as, the date of the medical service and cannot be before the date of birth
9633	A new Medicare card has been issued. Please update your records and ask the patient to use the new card number for any future claims.
9649	Patient eligibility cannot be determined.
9650	Patient data supplied failed validation checks a HIC central site.
9675	Current Medicare card has expired. Patient must contact Medicare as claims using this Medicare card may be rejected.