CareRight Billing and Invoicing Overview

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CareRight Billing and Claiming Overview

1 Type of Claim

2 Broad Billing Categorisation

3 Preconfigured Data Prior Billing

4 Invoice Specific Data

5 Account Matching & Creation

1 Type of Claim

Manual Claiming Paper based	Scenario	Claim Process	Claim Form
Paper based Batch Generation			
IHC – Full HC21 Form Generation			
Electronic Claiming	**Scenario**	**Claim Process**	**Claim Form**
Bulk Billing (Medicare & DVA)		Medicare Online	Medicare/DVA
PCI (Patient Claims Interactive)		Medicare Online	Medicare
IMC (Inpatient Medical Claims)		Eclipse	Healthfunds
IHC (Inhospital Claims)	Day stay	Clintel/eclipse	Healthfund/ DVA
		HC21	Healthfund/ DVA
IHC (Inhospital Claims)	Multi stay	Thelma/eclipse	Healthfund/ DVA
		HC21 (manual)	Healthfund/ DVA

2 Broad Billing Categorisation

General / Practice	Scenario	Claim Process	Claim Form
Professional Attendances (Consultations)			
Diagnostic Imaging			
Diagnostic Procedures			

Therapeutic Procedures (Surgery)			
Pathology Services			
Assistant Billing (Providing assistance during surgery)			
Assistant Billing (Receiving assistance during surgery)			
Anaesthetics Billing			
Out of Hospital (Outpatient)			
Billing Medicare, DVA or Private Patients.			
Out of Hospital billing covers all billing not directly associated with a hospital admission.			
In Hospital (Inpatient)			
Billing Health Funds or Private Patients.			
In Hospital billing covers the following billing scenarios:			
Medical Specialist InPatient Medical Claims.			
Hospital Accommodation, Theatre and Bundled Services claims.			
3rd Party Billing			
Non MBS billing to 3rd parties like legal firms and direct patient billing			
billing other hospitals			

Preconfigured Data Prior Billing

Locations

- A location represents the financial entity you to group billing activities on
- You can use different locations for invoicing and the receipting of payments
- Each location has its own banking process.
- Locations are configured per business requirements and independent of Medicare claiming requirements

Service Locations

- A Location can have one or more Service Locations
- A Service Location represents the different locations that a provider provides services.
- A Service Locations may be external to the business running CareRight, for example local public or private hospitals the doctor uses.
- Service Locations are mostly defined based on Medicare registration details for claiming purposes.

Accounts

- Accounts are the financial record for the relationship between a patient, a guarantor and the financial reporting provider.
- The account structure chosen affects reporting options.
- Accounts can be put on hold, sent to debt collectors and closed.

Provider

- Provider can be used in two ways for Billing.s the Provider on an account, called Financial Provider.
- As the Provider on an invoice, called Service Provider.
- Financial Provider is used for reporting and account management based on business process.
- Service Provider is assigned to an invoice based on who did the work from a claiming perspective.

(Controlled via Medicare/DVA etc.).

Guarantor

- The entity responsible for paying an invoice.
- Can be:
    - Patient
    - Patient guardian/parent etc.
    - Medicare/DVA
    - Health Fund
    - WorkCover/Accident Authority.
    - Legal 3rd Party (e.g. Law Firm)
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- In built smarts to manage claiming to Health Funds, Medicare, DVA following applicable rules.
- Claims to any third party can be managed as batches

4 Invoice Specific Data

This should include:

- Who is paying for the invoice:
    - Health fund (Using the health fund predefined on patient record for IMC);
    - Medicare (Only for bulk billing);
    - Specific third party (e.g. Public Hospital under contract)

    - Patient direct invoicing (used for PCI or non claim billing).

- Who provided the service. This needs to be enough data to unambiguously identify a preconfigured Medical Specialist in CareRight.

- Account Provider. This needs to be enough data to unambiguously identify a preconfigured Medical Specialist in CareRight that is used for the account. This is often a provider associated with Clinic/Hospital and separate to the service provider.

- Where the service was provided, this needs to be enough information to identify the service location. This may be done as:

    - Direct reference to a service location (ie. using the name).

    - Inferred by supplying Location name and service location type. E.g. Location X as inpatient would be inferred as a specific service location if only on inpatient service location existed for location X.

- Referral. If the claim requires a referral then the following referral details are required:

    - Referring Doctor Provider Number

    - Referring Doctor First Name

    - Referring Doctor Last Name

    - Referring Doctor Street

    - Referring Doctor Suburb

    - Referring Doctor State

    - Referring Doctor Postcode

    - Referring Doctor Category (GP, Specialist etc) must match to CR categories

    - Referral "Referred On" date (The date the GP wrote the referral)

    - Referral "Referral Activation" date (The first date of service for the patient using this referral)

    - Referral Length (3 months, 12 months, Indefinite). May be inferred based on Referring Doctor Category.

- If no referral, then reason for no referral (e.g. referral not required, emergency referral, self-referral)

- Items.

    - Item number. These should match the item number configured in Careright

    - Quantity.

    - Online Claim Description. (Required for some items/conditions by Medicare).

- Equipment ID (If item requires Medicare equipment ID).

- Date of Service.

- Time of Service (required for multiple treatments on same day)

Price

Note that price is explicitly excluded in the above list as it is anticipated that the configuration of CareRight will determine the price to use for each item. This means that items like High Cost Drugs that are not preconfigured for price in CareRight are excluded from the automated billing interface.

It was discussed that the "price modifier" (a ratio applied to MBS pricing) is assigned to a patient in Aria as function of the quoting process. This would then be passed via the ARIA interface to use a way of setting patient specific pricing without setting the specific dollar value per item.

5 Account Matching & Creation

The above invoice details also provide enough details to create an account as long as it is acceptable to automatically find or create suitable accounts and patient specific account structures are not required.