Importing Pathology Claims – ECLIPSE

To save time double handling your pathology claim data, import your data into FYDO and have the ECLIPSE claims paid within 4-5 weeks by the health funds.

NOTE: DVA in-hospital claims would go via the Medicare Online channel, not the ECLIPSE channel.

Minimum Data Set

Everything is mandatory unless stated otherwise.

- **Patient Info**
  - External Patient ID
  - First Name
  - Middle Initial (optional)
  - Last Name
  - Date of Birth
  - Gender
  - Medicare Number
  - Medicare Reference Number
  - Health Fund Code
  - Health Fund Membership Number
  - Health Fund Payee ID *"also known as practice ID"* (conditional)

- **Claim Data**
  - Type of Service
  - Service Type Code
  - External Invoice ID (optional)
  - External Servicing Provider ID
  - Referring Dr Details (optional)
  - Referring Dr Provider Number
  - Referral Date
  - Specimen Collection Point (SCP)
  - Facility Provider Number
  - Benefit Assignment Authorised
  - Financial Interest Disclosure Indicator
  - Accident Indicator
  - Account Paid Indicator
  - IFC Issue Code
  - Number of Items
  - Time of Service (conditional)
  - Item
    - Date of Service
    - Rule 3 Exempt Indicator
    - S4B3 Exempt Indicator
    - Accession Date and Time (conditional)

- Collection Date and Time (conditional)
- Charge for Item (optional)
- Service Text (conditional)

Notes

Patient Name – The first and last name are mandatory. The middle initial is not.

Tokens available:

- PatientFirstName
- PatientSecondInitial
- PatientFamilyName

Patient Gender – patient gender.

- F = Female
- M = Male
- I = Indeterminate/Intersex
- N = Not Stated/Inadequately

Token name is: PatientGender

Address – patient address. Since this is *optional* (not required by the ECLIPSE), unless you want to build your patient database in FYDO, leave the address tokens empty.

Tokens available:

- *PatientAddressLine*
- *PatientAddressLocality*
- *PatientPostcode*

Health Fund – this is the health fund the patient is with, specific the ECLIPSE code.

Token name is: FundBrandID

Health Fund Membership Number and Universal Position Indicator (UPI) – The UPI appears on the patient's fund membership card to uniquely identify the patient. It is the number in front of the patient name on the card. The UPI is optional, but the membership number is mandatory.

Token name is: PatientFundMembershipNum & PatientFundUPI

Health Fund Payee ID – (conditional) some funds require this, also known as the Practice ID. For example, BUPA and Medibank Private requires this. If not required, leave blank.

Token name is: FundPayeeID

External Patient ID – this is required so we can uniquely identify the patient. This must be unique to the patient. Everytime a claim is imported, we override the patient details (e.g. first name, last name) for a patient with that same external patient id.

Token name is: ExternalPatientId

External Servicing ID – If you are billing under the one provider number, you can skip this field. If however you are billing under multiple provider numbers then we will need something to identify which provider number to use. You do not have to provider the actual provider number, you can place your own unique code, and we will map that code to your actual provider number.

Token name is: ExtServicingDoctor

External Invoice ID – This is only required if you want to import the data back into your main system. Once claims are paid, we can send you a file back, with your external Invoice ID and Patient ID, so you can match it to the correct invoice/patient. But if you do not intend to import the data back, then you can skip this field.

Token name is: ExternalInvoice

Type of Service – this sets the type of claim for ECLIPSE. Always set to N.

- N – Inpatient/ In-hospital..

Token name is: TypeOfService

Service Type Code – this sets the service type, i.e. General or Specialist or Pathology, for example

- P – Pathology

Token name is: ServiceTypeCde

Referring Dr Title / First name / Last name – these are optional, but we would recommend including it in the file. But not a deal breaker.

Tokens available:

- *RefDrFirstName*
- *RefDrLastName*
- *RefDrTitle*
- *RefDrAddress*
- *RefDrSuburb*
- *RefDrState*
- *RefDrPostcode*
- *RefDrPhone*
- *RefDrfax*
- *RefDrEmail*

Referring Provider Number – provider number of the referring doctor.

Token name is: ReferringProviderNum

Referral Date – Date of the referral.

Format dd/mm/yyyy

Token name is: ReferralIssueDate

Referral Period – This is the Referral Period in months. This should be set to either 3 (Specialist), 12 (GP) or 99 (Indefinite)

Token name is: ReferralPeriod

Specimen Collection Point – code provided to each pathology lab.

Token name = SCPId

Facility Provider Number – the provider number of the facility where the service was rendered.

Token name is: FacilityId

Benefit Assignment Authorised – Indicates that the patient has authorised the assignment of their rights of benefit to a provider. Always indicate authorised.
Required when 'Type of Service' is M or V, not required when Service Type = P. If set to N, the claim will not import.

- Y – Authorised

Token name = BenefitAssignmentAuthorised

Financial Interest Disclosure Indicator – Indicates that the provider providing the hospital treatment under a gap cover scheme has disclosed to the patient any financial interest in any products or services recommended or given to the patient.

*Must be set to Y if the **Claim Type Code** is set to SC*

- Y = Financial Interest Disclosed
- N = No Financial Interest Disclosed

Token name is: FinancialInterestDisclosureInd

Accident Indicator – Indicates whether or not the associated information relates to the patient experiencing an accident.

- Y – Service result of an accident
- N – Service not a result of an accident or unknown

Token name is: AccidentInd

Account Paid Indicator – Indicates whether or not an account has been paid in full.

Token name = AccountPaidInd

IFC Issue Code – indicates if an Informed Financial Consent (IFC) was provided to the patient prior to the episode of care.

*If the **Claim Type Code** is set to SC, then this must be either: W or X.*
*If the **Claim Type Code** is set to AG, then this must be either: V, W or X*

- V = Verbal
- W = In writing, where appropriate
- N = Not issued
- X = Not obtained

Token name is: IFCIssueCde

Charge [for each Item] – you do not need to provide any amounts as FYDO can work out the amount when we import the data. If however, you are not charging the Medicare/DVA rate, then you will need to provide the charge amount for each item.

Token name = ChargeAmount

Number of Items – this is like a checker that confirms how many items we should be expecting within the claim/invoice.

Token name = NumberItems

Rule 3 Exempt Indicator – used to indicate Rule 3 in the Medicare Benefits Schedule applies to the pathology service and indicates the patient had multiple pathology tests with a 24 hr period due to a chronic illness, resulting in a a higher rate.

Token name = Rule3ExemptInd

If set to Yes, the 'Time Of Service' must be set and 'S4B3 Exempt Indicator' cant be set to Y.

S4B3 Exempt Indicator – Flags the associated service as requiring assessing in accordance with S4B3 requirements of the MBS.

- Y – Exempt
- N – Not Exempt

Token name = S4B3ExemptInd

If set to Yes, then must set 'Accession Date and Time' as well as the 'Collection Date and Time'. All services for the same patient for a 24 hr period should contain both 'Accession Date and Time' as well as the 'Collection Date and Time'.

Collection Date and Time – This is the date and time the actual pathology sample was taken/extracted from the patient whether this be blood, tissue or a spontaneous ejection.

Format DDMMYYYYHHMM e.g. 300620161330

Token name = CollectionDateTime

Accession Date and Time – This is the date and time when the pathology test was actually performed.

Format DDMMYYYYHHMM e.g. 300620161330

Token name = AccessionDateTime

Time of Service – The time the service was rendered. Format HHMM, expressed in 24 hours time e.g. 1435 for 2:35 pm. This is only required sometimes. Please read above when required.

Token name is: TimeOfService

Service Text – Free text used to provide additional information to assist with the benefit assessment of the service. Only used when absolutely required, as text will mean the claim will need to be manually assessed, which delays the processing.

Token name = ServiceText

Limited to 100 characters for Veterans claims, otherwise limited to 50 characters.

Other tokens that might be required

Claimant Details – provide this if the claimant is other than the patient. If required, then the following is mandatory: First name, Surname, Medicare Number, Medicare Reference Number, Date of Birth. An example of when this is required is when the patient is a child under 18 years of age.

The address is not required. It is only required if you need to indicate a temporary address. The address cannot be a PO BOX.

Tokens available:

- *ClaimantFamilyName*
- *ClaimantFirstName*
- *ClaimantDateOfBirth*
- *ClaimantMedicareCardNum*
- *ClaimantReferenceNum*
- *ClaimantAddressLine1*
- *ClaimantAddressLine1*
- *ClaimantAddressLocality*
- *ClaimantAddressPostcode*

Returned Files that can be imported back into your system

This is an optional step and is useful provided your main system can import files.
Read more at Claims Import – Returned Files – FYDO Wiki

Sample Files