Managing Medicare Claims

The purpose of this guide is to give details on how to manage the different types of claims in Bp Allied. This is applicable to any customer who is using Medicare Online Claiming within Bp Allied

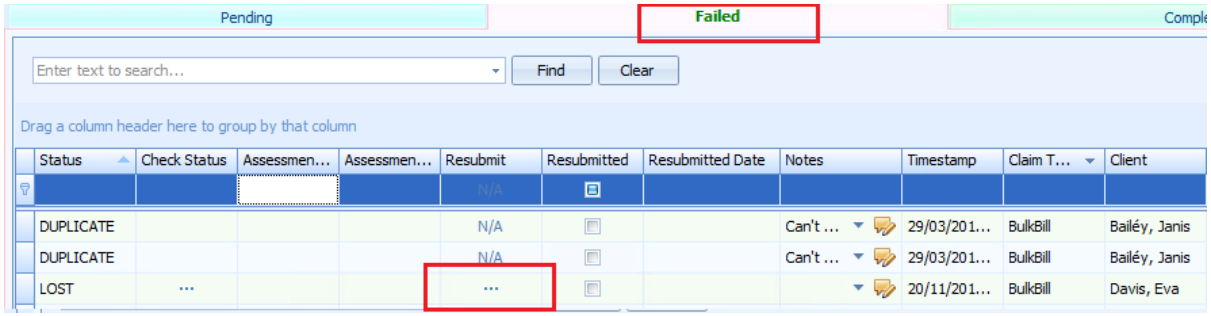
Bulk Bill & DVA

Creating Claims

Bulk Bill and DVA Claims are created when an Invoice payment is made. Information on creating these claims can be found here and here.

Resubmitting Claims

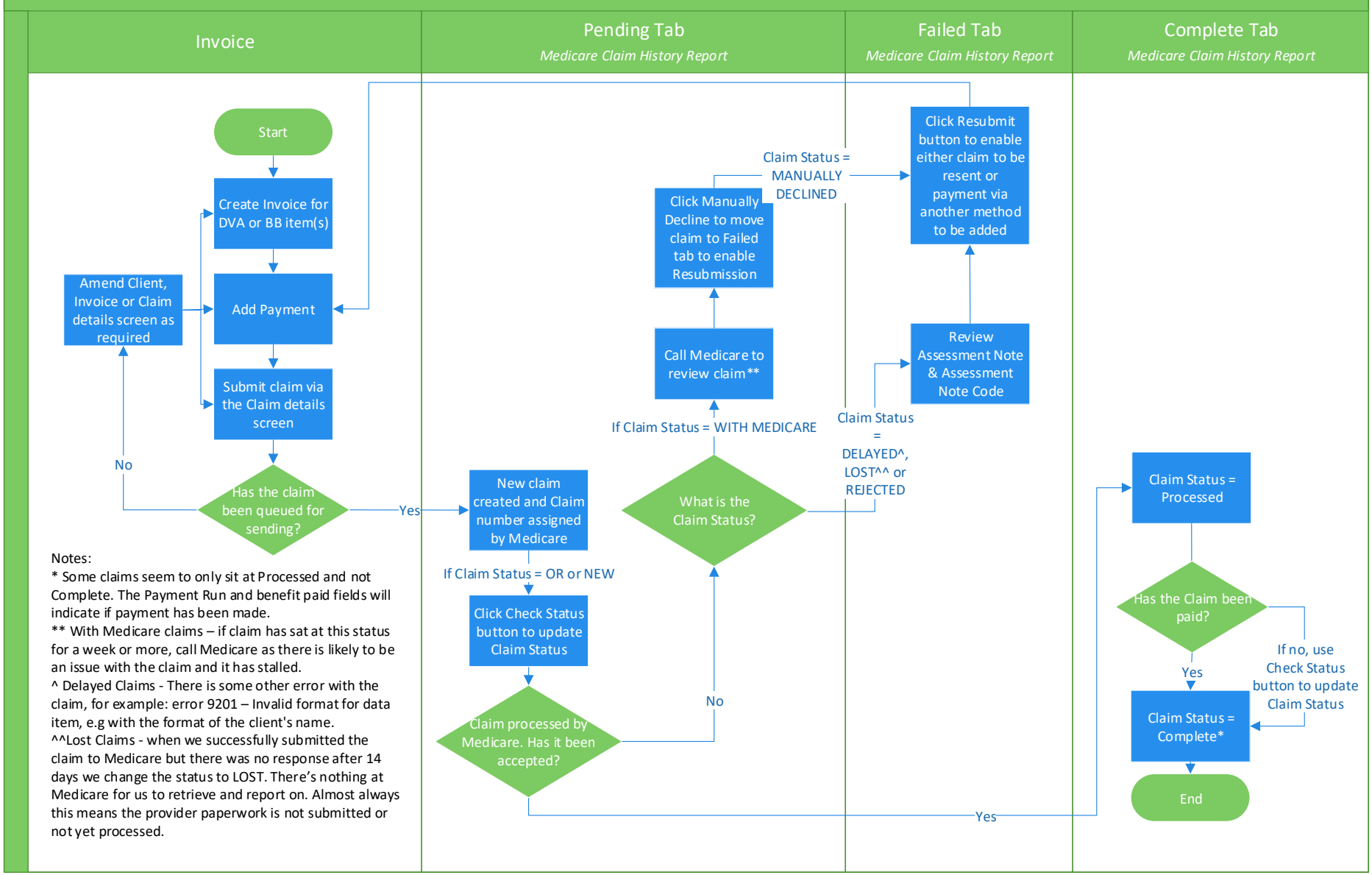
Bulk Bill and DVA Claims are resubmitted by clicking the **Resubmit** button in the **Failed** tab.



Use the **Assessment Code** and **Assessment Code Note** along with the information from Medicare and DVA to ascertain why a claim has been rejected. Details of the rejection codes can be found for Medicare here for common rejection codes and here for details on all reason codes. DVA rejection code information can be found here.

Full details on using the resubmission process can be found here.

Bulk Bill & DVA Claim Workflow



Notes:
* Some claims seem to only sit at Processed and not Complete. The Payment Run and benefit paid fields will indicate if payment has been made.
** With Medicare claims – if claim has sat at this status for a week or more, call Medicare as there is likely to be an issue with the claim and it has stalled.
^ Delayed Claims - There is some other error with the claim, for example: error 9201 – Invalid format for data item, e.g with the format of the client's name.
^^Lost Claims - when we successfully submitted the claim to Medicare but there was no response after 14 days we change the status to LOST. There's nothing at Medicare for us to retrieve and report on. Almost always this means the provider paperwork is not submitted or not yet processed.

Patient Claims

Creating Claims

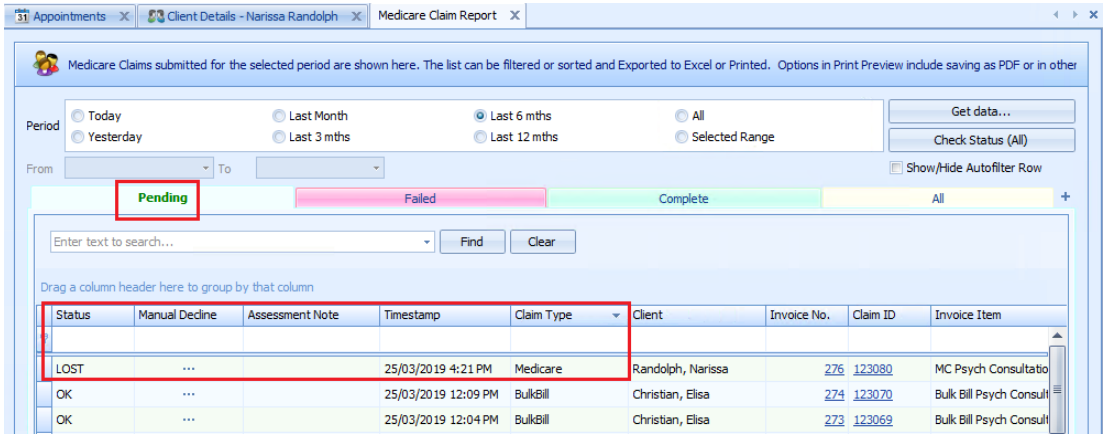
Patient claims are managed differently to Bulk Bill & DVA claims because full payment from the Client is received at the time of the claim and the Medicare rebate from these claims is not received by the practice. Information such as if the claim has been paid by Medicare is not available for us to feed back into Bp Allied, hence a Patient Claim will never get a Claim Status of Processed or Complete. All Patient claims sit in the Pending tab *(this is new in V6 SP3)*.

Information on creating a patient claim can be found here. Note: Patient Claims have a Claim Type = Medicare.

Resubmitting Claims

These claims cannot be resubmitted in the same manner as Bulk Bill or DVA claims. Limited information comes back via the Medicare API on the status of these claims and often if will be a client that will report an issue but the status will not indicate this.

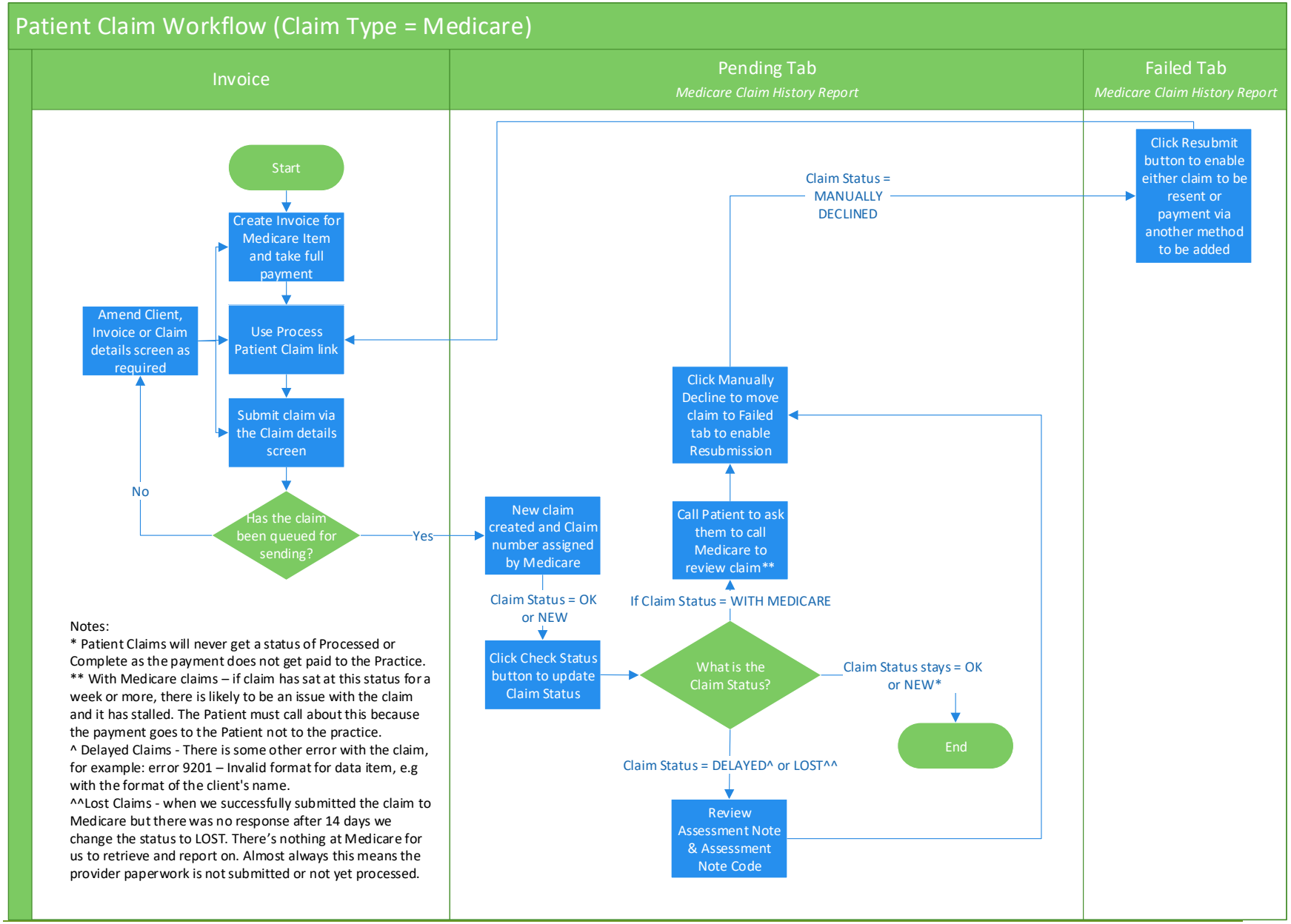
To be able to resubmit a claim that has stalled there is a special function on the **Pending** this tab that allows a patient claim to be **Manually Declined** based on the information received from your client. This over rides the resubmit function not available to a Patient Claim. From here the claim moves to the **Failed** tab and then resubmitted in the usual manner.



Occasionally, a status of **With Medicare**, **Delayed** or **Lost** can be returned if there is a problem with details submitted with the claim. These patient claims can also be viewed on the **Pending** tab to be able to make use of the **Manual decline** function.

Full details on using the manual decline process can be found here.

Patient Claim Workflow (Claim Type = Medicare)



Notes:
* Patient Claims will never get a status of Processed or Complete as the payment does not get paid to the Practice.
** With Medicare claims – if claim has sat at this status for a week or more, there is likely to be an issue with the claim and it has stalled. The Patient must call about this because the payment goes to the Patient not to the practice.
^ Delayed Claims - There is some other error with the claim, for example: error 9201 – Invalid format for data item, e.g with the format of the client's name.
^^Lost Claims - when we successfully submitted the claim to Medicare but there was no response after 14 days we change the status to LOST. There's nothing at Medicare for us to retrieve and report on. Almost always this means the provider paperwork is not submitted or not yet processed.