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Setup

1. Update Genie

You should be on the latest version of Genie in order to take full advantage of all ECLIPSE features.

2. Registration

Your new registration key, that is in your Training Pack, can be entered into Genie via File > Register. If you do not have your new registration key you can update your registration online via Special > Update Genie Registration.

3. Install/Update HIC Online

HIC Online Software must be installed on each computer that you want to use to transmit ECLIPSE claims.

Genie version 7 requires HIC Online version 6.10.28 or higher.

Genie version 8 requires HIC Online version 6.11.4 or higher.

You can install this software either from a recent Genie CD or via Special > Software Updates by ticking the HIC Online checkbox and clicking the Install 1 Item button.

4. Setting Up Health Funds for ECLIPSE

a) Getting ECLIPSE Info

Each health fund uses ECLIPSE to varying degrees. To obtain the ECLIPSE capabilities of each health fund go to Open > Billing Items and click the Health Funds button.

Click the Get ECLIPSE Info button.

Note: If this button is not available, you are either not registered for ECLIPSE (you can check this via File > Register) or you have not installed HIC Online version 6.10.28 or higher on this computer.

Genie will automatically match ECLIPSE funds with funds in your Genie data base if they have exactly the same name. If they do not have exactly the same name, you will need to match them manually.
To do this, click and drag the fund name from the Genie Fund list on the right-hand side into the Link To Genie Fund list in the middle of the window next to the corresponding ECLIPSE fund on the left-hand side. For example, click and drag 'Navy Health' from the Genie Fund list to the Link to Genie Fund list so that it is next to 'Navy Fund Ltd' in the Eclipse Fund list.

Funds in the Link to Genie Fund list can be dragged back to the Genie Fund list, or within the Link to Genie Fund list itself in case you make a mistake. Once all funds have been matched up click OK to obtain the ECLIPSE capabilities. If you do not have a matching Genie Fund for the ECLIPSE Fund, Genie will automatically create a new health fund record for that fund.

For a list of all the health funds involved in ECLIPSE go to: http://www.humanservices.gov.au/health-professionals/services/simplified-billing-and-eclipse/?utm_id=9

b) Linking Health Funds to Account Holders

Once your health funds are linked to the corresponding ECLIPSE fund, you will need to link them to an account holder record in Genie in order to invoice them.

If you have been invoicing health funds prior to using ECLIPSE, most of your health funds will have account holder record already and these will need to be linked to the appropriate health fund. For health funds that you have not invoiced before, you will need to create an account holder record through Open > Account Holders by clicking the Add New Record icon.

You can link a health fund to their account holder record from either the Health Fund window, or the Account Holder window.

To link the account holder from the Health Funds window, go to Open > Billing Items, click the Health Funds button and double-click on the relevant health fund name. If there is no organisation address information listed in the Account Holder field next to the Search icon, click the Search icon, type the name of the health fund in the Organisation field, click OK, select the relevant health fund from the list, click Select and in the Health Insurance Fund window click the OK button to save this information.
This window is also where you would enter the maximum known gap amount that you can charge either per invoice or per item, depending on the health fund.

To link the account holder from the Account Holder window, go to Open > Account Holders, in the Search for AccountHolder... window type the name of the health fund in the Organisation field and click OK. Double-click on the name of the health fund in the list to open their account holder record.

Click the Use this schedule if it's a Private Health Fund drop-down menu and select the relevant health fund. This will link the account holder record to the health fund.

5. Setting Up Providers for ECLIPSE Claiming

To send claims through ECLIPSE each doctor in the practice must specify the hospital or site that they want to claim services for, their payee ID for each fund they will be claiming with, and the default arrangement that they have with each fund.

Facility ID
The facility ID or hospital provider number is usually a seven digit number followed by a letter (i.e. 0012345A) that is used to identify the site this service was performed. To enter this number for a specific doctor, go to File > All User Preferences, double-click on the relevant doctor's name, click on the Practice Sites tab, double-click on the relevant practice site, enter the number into the Facility ID field and click OK.

If you do not have this site listed in this window, click the Add New Record button, enter the relevant details and click OK.
If you do not know the facility ID, you can contact Genie Solutions and we will provide it to you as long as we have the number for the site you require. However, it is best to contact the site directly as they can provide you with the correct, up-to-date number.

**Fund Payee ID and Claim Type**

For doctors who have an Agreement (No Gap) or Scheme (Known Gap) arrangement with health funds you will need to enter their Fund Payee ID into Genie. The Fund Payee ID number should be allocated to a provider at the time that they register with a health fund.

To enter the Fund Payee ID for a doctor, go to **File > All User Preferences**, double-click on the relevant doctor's name, click on the **ECLIPSE** tab, slow-double click (click-pause-click) in the **Fund Payee ID** column next to the relevant health fund, type the ID number, press the **Tab** key on your keyboard and click **Save**.

**Note:** If you are unsure or do not know the Fund Payee ID for a fund, leave this field blank.

In the **ECLIPSE** tab, you can also specify the default claim type for each health fund the doctor will be invoicing. To set this, click in the **Claim Type** column next to the relevant health fund and select either **Agreement**, **Scheme** or **Patient Claim** from the drop-down menu. Only claim types provided by the health fund will be available from this drop-down menu.

**Note:** The **Claim Type** for Medibank Private should be set to Scheme, even if you do No Gap claiming, unless you have a Medical Purchaser Provider Agreement (MPPA). If you have a MPPA then you should set the **Claim Type** to Agreement. However, it is very rare for a private doctor to have a MPPA.
Invoicing

The standard Genie invoicing method is not used when creating ECLIPSE Inpatient Medical Claims (IMC). Instead you must use the IMC Invoice Wizard to generate these invoices. This can be accessed by going to Billing > IMC Invoice Wizard, or by right-clicking on a patient’s name in the Appointment Book or Patient list.

When you select IMC Invoice Wizard, an online patient verification (OPV) will automatically be performed if it has not been done for this patient, or it has not been done for more than one month.

The following section will provide step-by-step instructions and explanations for each of the windows in the IMC Invoice Wizard.
Step 1: Basic Claim Details

The Basic Claim Details window details displays the patient's health fund, the principal provider, the claim type, account holder for the health fund, site of service, facility ID, service type, if the financial interest has been disclosed to the patient and if this treatment is a result of an accident. This will automatically populate the default information for the principal provider if it has been entered into Genie (see the Setting up Health Funds and Setting Up Provider sections). If the default options have not been specified for the doctor or this patient claim is different from the default, you can manually select and change the information in each field.

Once all required information has been entered, click the Next > button to proceed to the next step.

**Note:** If you cannot click the Next > button, refer to the red text at the bottom of the window as this will prompt you as to what information needs to be entered before you can continue.

If you have chosen to do a Patient Claim, when you click Next > the IMC Patient Consent and Declaration form will appear on the screen. The patient is required by law to have sighted this document and given their verbal consent for you to proceed with the claim. It might be a good idea to have a printed version of this document available to show your patients rather than trying to get them to read it on the screen. It is a Medicare requirement that this information be displayed and that the Patient’s Verbal Consent Received checkbox is ticked.
Step 2: Create the Voucher(s)

An IMC Invoice can consist of up to 16 vouchers (similar to invoices). Each voucher can have up to 14 services (items) attached to them.

To add a voucher to the claim, click the Add Item icon. To remove a voucher, highlight it and click the Delete icon.

When you add a voucher, options available will vary according to the claim type, however the details at the top of the window will remain the same.

The provider can be changed by clicking on the Servicing Provider icon. A drop-down menu will appear allowing you to choose from Assistant, Locum or Other. Selecting Assistant will display a list of doctors who have Assists at Operations ticked in their address book record. Selecting Locum will display a list of doctors who have Acts as Locum ticked in their address book record. Selecting Other allows you to search the Address Book for a provider.

The Admission Date field should be left blank unless you also know the date the patient was discharged. If this is the case, when you enter a date in the Admission Date field, the Discharge Date field will appear.

Informed Financial Consent must be specified using one of the four radio buttons. For a Scheme claim, this can be either Written or Not Obtained. For an Agreement claim, this can be either Verbal, Written or Not Obtained.

The Apply Multiple Procedure Rule checkbox will appear when there are two or more items added to the voucher where the Multiple Procedure Rule (MPR) applies. This will be ticked by default. Similarly the Diagnostic Imaging Multiple Service Rule (DIMSR) checkbox will appear when it applies. For more information on diagnostic items, please see the Diagnostic Items section.
We will now go through the vouchers for each of the different claim types.

**Scheme (Known Gap) Claim**

By default, Charge Gap will be ticked with the Maximum radio button selected. The maximum known gap for a health fund is based on what is entered in the Max Known Gap field in the Health Insurance Fund window (Open > Billing Items > Health Funds) for the specific fund (see Setting up Health Funds for ECLIPSE). The Maximum field and the per item tickbox are both greyed out, as these fields can only be modified in the Health Insurance Fund window.

If you tick the Charge Gap checkbox and select the Maximum radio button, when you add items to the voucher you will not need to enter a charge amount as Genie will allocate the Maximum gap as specified. This is either equally among the items or per item.

If you want to charge a gap that is different to the maximum known gap as per your agreement with the fund (eg. if you want to charge less than the maximum gap), you can set a custom gap by selecting the Custom radio button. When the Custom radio button is selected, you will be able to enter an amount in the Custom field and tick per item if applicable.

**Note:** For Medibank Private/AHM No Gap claims, you should leave the Charge Gap checkbox unticked.

**Note:** Prior to Genie 9.0.2, Maximum Gap For Fund is listed in the top right-hand corner of the window. To charge the maximum gap, tick the Auto Charge Maximum Gap checkbox. If Auto Charge Maximum Gap is not ticked, you can charge your own fee and Genie will automatically calculate the gap for you.

To add an item to the voucher, click the Add Item icon. To remove an item, highlight it and click the Delete icon.

In the ECLIPSE IMC Service window, the Charge Amount will default to the Private fee. This can either be changed manually by typing the fee in the Charge Amount field, or by clicking on one of the fee schedule names (i.e. AMA) on the right-hand side of the window.

If you need to adjust the health fund rebate temporarily (eg. to bill for a service done before a fee update), this can be done by simply changing the amount in the Fund Rebate field in the ECLIPSE IMC Service window. This will only change the health fund rebate for this item on this claim; it will not permanently change the fee.
Note: For Medibank Private/AHM No Gap claims, click 'Fund Rebate' so that the Charge Amount is overwritten with the correct fee for No Gap claiming.

The Overrides section allows you to specify if the item is Not Normal Aftercare, Not Multiple Procedure, Not Duplicate Service, Self Deemed or a Substituted Service. These options will only appear in the appropriate circumstance (i.e. Not Duplicate Service will appear if you bill two of the same items with the same service date). If you tick the Not Multiple Procedure checkbox you must enter a note in the Service Text field before you will be able to save the item to the voucher.

The Service Text field allows you to enter a note about this specific item (e.g. area of the body the item was performed). This field has a 50 character limit as specified by Medicare.

Unlike normal invoicing in Genie, fees cannot be adjusted in the columns of the voucher window. Instead, you need to double-click on the item and edit it through the ECLIPSE IMC Service window. You would do this if you wanted to allocate a gap to your assistant fee as Genie does not do this by default.

Once all services have been added, click Save to be taken to the Voucher window.
Agreement (No Gap) Claim

Note: Medibank Private/AHM No Gap Claims need to be processed as a Scheme (Known Gap) claim without a gap added. See the notes in the Scheme (Known Gap) claim section for how to create these claims. If your doctor has a MPPA with Medibank/AHM, you should proceed with the following instructions. It is very rare for a private doctor to have a MPPA.

Services billed on an Agreement claim will always be billed at the health fund rebate amount. The charge amount cannot be edited in any way.

To add an item to the voucher, click the Add Item icon. To remove an item, highlight it and click the Delete icon.

If you need to adjust the health fund rebate temporarily (e.g. to bill for a service done before a fee update), this can be done by simply changing the amount in the Fund Rebate field in the ECLIPSE IMC Service window. This will only change the health fund rebate for this item on this claim; it will not permanently change the fee.

The Overrides section allows you to specify if the item is Not Normal Aftercare, Not Multiple Procedure, Not Duplicate Service, Self Deemed or a Substituted Service. These options will only appear in the appropriate circumstance (i.e. Not Duplicate Service will appear if you bill two of the same items with the same service date). If you tick the Not Multiple Procedure checkbox you must enter a note in the Service Text field before you will be able to save the item to the voucher.

The Service Text field allows you to enter a note about this specific item (e.g. area of the body the item applies to). This field has a 50 character limit as specified by Medicare.

Unlike normal invoicing in Genie, fees cannot be adjusted in the columns of the voucher window. Instead, you need to double-click on the item and edit it through the ECLIPSE IMC Service window. You would do this if you wanted to allocate a gap to your assistant fee as Genie does not do this by default.

Once all services have been added, click Save to be taken to the Voucher window.
**Patient Claim**

Patient Claims are when you do not have an arrangement with the patient’s health fund. This means that the patient is only entitled to the Medicare schedule amount as the rebate.

To add an item to the voucher, click the **Add Item** icon. To remove an item, highlight it and click the **Delete** icon.

In the ECLIPSE IMC Service window, the **Charge Amount** will default to the private fee. This can either be changed manually by typing the fee in the **Charge Amount** field, or by clicking on one of the fee schedule names (i.e. AMA) on the right-hand side of the window. Also in this window you have the option to add a discount if it is applicable.
The Overrides section allows you to specify if the item is Not Normal Aftercare, Not Multiple Procedure, Not Duplicate Service, Self Deemed or a Substituted Service. These options will only appear in the appropriate circumstance (i.e. Not Duplicate Service will appear if you bill two of the same items with the same service date). If you tick the Not Multiple Procedure checkbox you must enter a note in the Service Text field before you will be able to save the item to the voucher.

The Service Text field allows you to enter a note about this specific item (e.g. area of the body the item applies to). This field has a 50 character limit as specified by Medicare.

Once all services have been added, click Save to be taken to the Voucher window.
Assistant Items

Billing for Assistant
For Scheme and Agreement claims you will be prompted upon saving to add an Assistant voucher if any of the items charged are marked as 'Assistant Billable' in Billing Items. A list of your assistants, marked as Assists as Operations in their Address Book record, will appear and the assist fee calculation will be made according to the health fund criteria.

Billing as Assistant
For Scheme and Agreement claims, where your doctor has acted as the assistant, you will need to first calculate the required item and fee outside ECLIPSE (via the quote window or a dummy invoice). Add this item to the voucher just like any other service (ie. through the Add Item icon), ensuring the surgeon's details and the relevant surgical items are entered into the Service Text field.

From Genie version 8.6.9 and higher, you can calculate and bill as the assistant from within the IMC Invoice Wizard. When you save the voucher that contains an assistant billable item, you now have the option to select the Invoice as Assist button.

This works the same as regular invoices in that you select the surgeon who performed the operation from your Address Book. This process will automatically add the surgeon's provider number and the surgical item numbers in the Service Text field.

Note: You cannot claim assist items with Patient Claims. These claims will need to be submitted manually to Medicare.

Diagnostic Items
To transmit diagnostic items through ECLIPSE, the following prerequisites must be met:
- The Service Type in the Basic Claim Details section of the IMC Invoice Wizard must be set to Specialist.
- You must be running version 8.8.8 of Genie or later.
- You must be running version 6.12.1 of HIC Online or later. To update HIC Online, navigate to Special > Software Updates, tick the HIC Online download option, and click Install 1 Item.

Please note: If a diagnostic item is added to a voucher that already has a non-diagnostic item on it, the non-diagnostic item's referral information will cover the entire voucher, and request information will not be required. Therefore, when sending both, simply add the consult/procedure item(s) first, and then add any diagnostic items as normal.

Diagnostic items can be either Requested (R) or Non-Requested (NR). When not sent alongside non-diagnostic items, the correct method of adding these items to an ECLIPSE voucher will depend on whether they are Requested or Non-Requested.

To send a Requested (R) diagnostic item via ECLIPSE:
1. Click the blue plus icon.
2. Search/enter the diagnostic item, ensuring the appropriate details are selected.
3. Click Save. Genie will return you to the voucher, and a Requesting Doctor icon will appear. (See screenshot below.)
4. Click the icon to search for the requesting doctor.
5. Select the requesting doctor and click OK.
6. Continue creating the claim as normal.
To send a Non-Requested (NR) diagnostic item via ECLIPSE:

1. Click the blue plus icon.
2. Search/enter the diagnostic item, ensuring the appropriate details are selected.
3. Ensure the Self Deemed checkbox is ticked.
4. Click Save. Genie will return you to the voucher.
5. Continue creating the claim as normal.

Separate vouchers for diagnostic items

Diagnostic items can still be transmitted via ECLIPSE if you are using earlier versions of Genie (8.8.7 or below) or HIC Online (6.11.8 or below). However, in this case, you will be required to transmit diagnostic items on a separate invoice to non-diagnostic items. If you attempt to add diagnostic and non-diagnostic items to the same voucher in this situation, Genie will prompt you to add these to separate vouchers.

To transmit diagnostic and non-diagnostic items on the same voucher, you must update to version 8.8.8 of Genie or later, and version 6.12.1 of HIC Online or later. For more information about updating Genie, please see the Updates section of the main Genie manual.

Step 3: Make any Payments

This step only applies to Scheme (Known Gap) and Patient Claims.
Scheme Payments

The ECLIPSE IMC Payment window is similar to the standard receipting window in Genie, in that the payment needs to be entered into one of the payment type boxes in the top-left of the window and the payments allocated in order to make the Amount Remaining to be Allocated $0.00.

The Apply Deposit button is used in the same way as the standard invoicing/receipting in Genie.

Payments are best allocated using the Autofill button which will apply the payment against the balance for all items. If you need to allocate the payment to these items in a different way then you will need to slow double-click (click-pause-click) into the Payment field and type in the amount.
Patient Claim Payments

Patient Claims must be either fully paid or not paid at all. This is why the Fully Paid checkbox must be ticked before you can enter an amount into one of the payment type fields.

Enter the full payment amount into one of the payment type fields or use the Apply Deposit button in the same way as regular invoicing and then Genie will automatically allocate the payment against the items in the claim.
Step 4: Create the Claim

Agreement & Scheme Claims

There is the option to either transmit claims Now (Real-Time), which is recommended, or Later (Batch). If you select Later (Batch), you can transmit the claims at a later time by going to File > Maintenance and Reports, clicking on the Daily tab, clicking the ECLIPSE IMC Transmission icon, selecting Stored from the Claim Status drop-down menu, selecting the relevant claim and clicking the Transmit button.

The default setting for transmitting claims can be set through File > Practice Preferences, double-clicking on the relevant clinic name, selecting the Miscellaneous tab, ticking the Run Real Time by Default checkbox and clicking Save.

There is also the option for you to send your contact details with the transmission so that the health fund can contact you directly should they have any queries with the claim.
Unpaid Patient Claims have additional fields in this window to tell Medicare where to send the provider’s cheque.

**Note:** The cheque must be sent to the patient and the patient must then give the cheque to the practice.

If the patient has their details stored with Medicare, select *Address Held by Medicare*. If their details are not stored with Medicare, select *This Address* and enter the relevant information. Once you are happy that the details are correct, click **Transmit**.
Patient Claims - Paid

Fully paid Patient Claims will have additional fields in this window to allow the patient to have their rebate payment made directly into their bank account.

If the patient has registered their bank details with Medicare, then select Cheque from the Payment Method field. This will eliminate the need to enter the details into Genie and the payment will be made into the bank account registered with Medicare.

If the patient has not registered their bank details with Medicare, you can enter this manually in the Bank Account Details section.

You can store the patient's bank details for future transmissions, however if the patient does not want this to occur, tick the Never Store Bank Details checkbox.
QUICK GUIDE: Creating a SCHEME (KNOWN GAP) IMC Invoice

Step 1. Basic Claim Details

1. Select Claim Type as Scheme (Known Gap).
2. Select other information as per the red text at the bottom of the window.
3. Click Next.

Step 2. Create the Voucher(s)

1. Click Add Item icon to add a voucher.
2. Select Provider, Referring Doctor, Informed Financial Consent etc. as appropriate.
3. Select whether to charge Maximum or Custom gap, and tick per item if applicable.
4. Click the Add Item icon.
5. Enter the item number and press Tab on your keyboard.
6. Enter the Charge Amount (if applicable) and any other item information.
7. Click Save.
8. Add any other items using the Add Item icon.
9. Click Save to the voucher window.
10. Add an assistant fee when prompted (if needed).
11. Click Next.

Step 3. Make Any Payments

1. Enter payment amount into the payment type fields and press Tab on your keyboard OR Apply Deposit.
2. Click Autofill OR slow double-click into the payment field and enter the amount.
3. Click Next.

Step 4. Create the Claim

1. Select Now (Real Time) OR Later (Batch).
2. Enter sender contact details if you wish.
3. Click Transmit OR Store.
4. Select to either Print or Don't Print the invoice.
QUICK GUIDE: Creating an AGREEMENT (NO GAP) IMC Invoice

**Step 1. Basic Claim Details**

1. Select Claim Type as *Agreement (No Gap)*.
2. Select other information as per the red text at the bottom of the window.
3. Click **Next**.

**Step 2. Create the Voucher(s)**

1. Click **Add Item** icon to add a voucher.
2. Select *Provider, Referring Doctor, Informed Financial Consent* etc. as appropriate.
3. Click the **Add Item** icon.
4. Enter the item number and press **Tab** on your keyboard.
5. Enter any relevant item information.
6. Click **Save**.
7. Add any other items using the **Add Item** icon.
8. Click **Save** to the voucher window.
9. Add an assistant fee when prompted (if needed).
10. Click **Next**

**Step 3. Create the Claim**

1. Select *Now (Real Time) OR Later (Batch)*
2. Enter sender contact details if you wish.
3. Click **Transmit OR Store**.
4. Select to either **Print** or **Don't Print** the invoice.
QUICK GUIDE: Creating a PATIENT CLAIM IMC Invoice

Step 1. Basic Claim Details

1. Select Claim Type as *Patient Claim*.
2. Select other information as per the red text at the bottom of the window.
3. Show patient the IMC Patient Claim Consent and Declaration form.
4. Tick the *Patient's Verbal Consent Received* checkbox.
5. Click Close.
6. Click Next.

Step 2. Create the Voucher(s)

1. Click Add Item icon to add a voucher.
2. Select *Provider*, *Referring Doctor*, *Informed Financial Consent* etc. as appropriate.
3. Click the Add Item icon.
4. Enter the item number and press Tab on your keyboard.
5. Enter the *Charge Amount* and *Discount* (if applicable) and any other item information.
6. Click Save.
7. Add any other items using the Add Item icon.
8. Click Save to the voucher window.
9. Click Next.

Step 3. Make Any Payments

If claim is UNPAID:
1. Click Next.

If claim is PAID:
1. Tick the *Fully Paid* checkbox.
2. Enter the full payment amount into the *payment type* fields and press the Tab key on your keyboard OR Apply Deposit.
3. Click Next.

Step 4. Create the Claim

1. Select *Now (Real Time)* OR *Later (Batch)*
2. Enter sender contact details if you wish.
3. If unpaid, select the patient address that the provider cheque will be sent to. If paid, select which method of payment the patient would prefer for their refund.
4. Click Transmit OR Store.
5. Select to either Print or Don't Print the invoice.
**Reporting**

The ECLIPSE IMC reporting is accessed by going to File > Maintenance and Reports, selecting the **Daily** tab and clicking on the **ECLIPSE IMC Transmission** icon.

This opens the IMC Claims Control window.

From this window you can sort claims by provider, transmit stored claims, retrieve reports, view claim details, access the Account History window, receipt claims and delete claims. These functions are performed either by using the buttons at the top of the window or by right-clicking on a claim. The options in the right-click menu will change according to what Claim Status window you are in.

More than one claim can be highlighted by either holding **Ctrl** and clicking on the claims you wish to select, or by clicking the first claim you require, then holding **Shift** and clicking on the last claim to highlight all claims. This is useful when you want to get reports for several claims at once.
Claim Status

Once a Scheme or Agreement claim is submitted it gets processed between Medicare and the health fund until a processing report and remittance advice are available. See the section on Report and Process Status for more information.

The claim will move through a variety of statuses throughout this process, as indicated in the Claim Status drop-down menu.

NOTE: Patient Claims get moved straight to Exceptions to Review if there is a problem, or Finalised once they have been processed.

<table>
<thead>
<tr>
<th>Status</th>
<th>Meaning</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submitted</td>
<td>The claim has been transmitted to Medicare but no processing report is available at this time.</td>
<td>See if the processing report is available by highlighting the claim in the list and clicking the Get Report Status button.</td>
</tr>
<tr>
<td>Awaiting Processing Report</td>
<td>The processing report for the claim is ready and available to be retrieved from the Medicare servers.</td>
<td>Retrieve the processing report by highlighting the claim in the list and clicking the Get Processing Report button.</td>
</tr>
<tr>
<td>Exceptions to Review</td>
<td>The processing report has been retrieved and the report indicated that there are some problems with the claim.</td>
<td>Review the exceptions by highlighting the claim in the list and clicking the Review Exceptions button. The action to take will depend upon the nature of the exceptions.</td>
</tr>
<tr>
<td>Awaiting Remittance Advice</td>
<td>Any exceptions with the claim have been dealt with but the ECLIPSE Remittance Advice (ERA) has not been received for the claim.</td>
<td>See if the ERA is available by clicking the Get Remittance Advices button. This will retrieve all ERAs which have been produced since the last time this button was clicked.</td>
</tr>
<tr>
<td>Ready to Receipt</td>
<td>The claim's ERA has been retrieved and it is ready to be receipted.</td>
<td>Receipt the claim by highlighting it in the list and clicking the Receipt button.</td>
</tr>
<tr>
<td>Part Paid</td>
<td>The claim has been receipted but there is still a balance outstanding from either Medicare or the health fund.</td>
<td>Apply for a top-up payment from the fund or Medicare and receipt the balance when you receive it through Open &gt; Account Holders or credit the balance through the Account History.</td>
</tr>
<tr>
<td>Finalised - All</td>
<td>The claim has been fully processed and receipted.</td>
<td>None.</td>
</tr>
<tr>
<td>Stored</td>
<td>The claim has been created but has not yet been transmitted to Medicare for processing. A claim is given this status if Later (Batch) is selected when you transmit the claim.</td>
<td>Transmit the claim by highlighting it in the list and clicking the Transmit button.</td>
</tr>
<tr>
<td>Deleted - All</td>
<td>The claim has been deleted, and is stored within this section for future reference. The claim retains previously retrieved reports in a read-only state.</td>
<td>None.</td>
</tr>
</tbody>
</table>

Other options in the Claim Status drop-down menu are:

- **Finalised - Last 3 Months Only** will show your finalised claims for the last three months. This can be useful as the **Finalised - All** status contains all your claims and can take a long time to load.
- **Error** will store claims in which the health fund details are incorrect or out of date.
- **Search by Claim ID...** allows you to search for a particular claim number in any of the claim status’.
- **Search by Payment Reference...** allows you to find the claims associated with the reference number that will be shown on your bank statement and Genie Banking report.
- **Delete - Last 3 Months Only** will show your deleted claims for the last three months. Like the **Finalise - Last 3 Months Only** status, this prevents slowness when loading past claims.
ECLIPSE Reporting Process
# Report and Process Status

When a claim is submitted, the *Report Status* and *Process Status* columns in the IMC Claims Control window will be blank until the **Get Report Status** button has been clicked. The appropriate action to take will be determined by the *Report Status* and *Process Status*.

<table>
<thead>
<tr>
<th>Report Status</th>
<th>Process Status</th>
<th>Meaning</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROCESSING</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RECEIVED</td>
<td></td>
<td>The claim has been received and accepted for processing.</td>
<td>Click the <strong>Get Report Status</strong> button again at a later time.</td>
</tr>
<tr>
<td>MEDICARE_UNVERIFIED</td>
<td></td>
<td>The Medicare patient details verification has failed.</td>
<td>Click the <strong>Get Report Status</strong> button again at a later time.</td>
</tr>
<tr>
<td>MEDICARE_VERIFIED</td>
<td></td>
<td>The patient details have been successfully verified with Medicare and are currently being checked with the health fund.</td>
<td>Click the <strong>Get Report Status</strong> button again at a later time.</td>
</tr>
<tr>
<td>HEALTH_FUND_UNVERIFIED</td>
<td></td>
<td>The health fund patient details verification has failed.</td>
<td>Click the <strong>Get Report Status</strong> button again at a later time.</td>
</tr>
<tr>
<td>HEALTH_FUND_VERIFIED</td>
<td></td>
<td>The patient details have been successfully verified with the health fund.</td>
<td>Click the <strong>Get Report Status</strong> button again at a later time.</td>
</tr>
<tr>
<td>MEDICARE_ASSESSING</td>
<td></td>
<td>The claim is currently being assessed by Medicare.</td>
<td>Click the <strong>Get Report Status</strong> button again at a later time.</td>
</tr>
<tr>
<td>HEALTH_FUND_ASSESSING</td>
<td></td>
<td>The claim is currently being assessed by the nominated health fund.</td>
<td>Click the <strong>Get Report Status</strong> button again at a later time.</td>
</tr>
<tr>
<td><strong>READY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MEDICARE_REJECTED</td>
<td></td>
<td>The claim has been rejected by Medicare and a report is available</td>
<td>Click the <strong>Get Processing Report</strong> button. The claim status will change to <em>Exceptions to Review</em>.</td>
</tr>
<tr>
<td>HEALTH_FUND_REJECTED</td>
<td></td>
<td>The claim has been rejected by the health fund and a report is available.</td>
<td>Click the <strong>Get Processing Report</strong> button. The claim status will change to <em>Exceptions to Review</em>.</td>
</tr>
<tr>
<td>COMPLETE</td>
<td></td>
<td>The claim assessment is complete and a report is now available.</td>
<td>Click the <strong>Get Processing Report</strong> button. The claim status will change to <em>Exceptions to Review, Awaiting Remittance Advice</em> or <em>Ready to Receipt</em>.</td>
</tr>
<tr>
<td>REPORTED</td>
<td>MEDICARE_REJECTED, HEALTH_FUND_REJECTED or COMPLETE</td>
<td>The Processing Report has been retrieved</td>
<td>Action according to the claim status.</td>
</tr>
</tbody>
</table>

**NOTE:** You will not receive a processing report or remittance advice for Patient Claims. Once the claim has been processed, clicking the **Get Report Status** button will move the claim to either *Exceptions to Review* if there is a problem or *Finalised*. *It will never move to Awaiting Processing Report or Ready to Receipt.*
Exceptions

Claims that have been successfully processed with no exceptions will have a green background and will be moved to either *Awaiting Remittance Advice* or *Ready to Receipt*. If a claim has exceptions, it will be moved to *Exceptions to Review* and will have a pink background. The background colour will remain pink even if you deal with the exceptions to indicate that this claim did have exceptions.

To review exceptions, select *Exceptions to Review* from the *Claim Status* drop-down menu. Select the claim and click the *Review Exceptions* button.

**Note:** Patient Claims do not get issued with a processing report. Any rejected claims will need to be followed up directly with either Medicare or the health fund.

Exceptions can be raised by Medicare and/or the health fund and can be either a Claim Level Exception or a Service-Level (Item) Exception.

We will now go through some different exception scenarios.
Scenario 1: All Items Fully Paid

In this particular situation the claim has been fully paid but there is a Claim Level Exception as indicated by the red text next to Medicare Card Status in the Claim Level Messages section. To fix the issue number on the Medicare card, you can simply drag and drop the Medicare Medicare No. over the Genie Medicare No. in the patient details section in the top right of the window. You could also click the Edit Patient button at the bottom of the window and make the change manually.

Once you have fixed the problem you can click Close and the claim will automatically move to Awaiting Remittance Advice, Ready to Receipt or Finalised depending on whether a remittance advice has been retrieved and whether the claim has already been receipted.
Scenario 2: Paid and Unpaid Items

In this exception the claim itself is fine (as shown by no error in the Claim Level Messages section) but the Service Level Messages indicate that one item has been paid and one has not. The problem item is displayed in red and by clicking on it, it will show in the health fund message box that the patient is not covered for the item.

To receipt the payment on this claim you first need to remove the unpaid item. To do this, highlight the item and click the Remove Item from Claim button. This will give the item a grey background and change the text to italics. You can return any removed items to the claim using the same button which will have changed to Return Item to Claim. Items that have been deleted from the patient's Account History will have a red background and cannot be returned to the claim.

Once you have removed the unpaid item from the claim you can click Close which will move the claim into either Awaiting Remittance Advice or Ready to Receipt. If the claim does not move it means that you have not dealt with the exception correctly, so you will need to go back into Review Exceptions and fix the problem.

Now you will need to fix the problem item through the patient's Account History, which can be done by clicking the Show in Acct Hx button in the IMC Claims Control window. In this case, because the patient was not covered for the item, you would need to credit the item off the health fund invoice. To do this, slow double-click (click-pause-click) in the Credit column for that item, type the amount, press Enter or Tab on your keyboard, enter a reason in the window that appears (e.g. Patient not covered, patient invoiced) and click OK. You could then create a new invoice addressed to the patient for that item.
If for some reason you wanted to resubmit that particular item to the health fund this can be done through the Account History window by highlighting the item in the invoice and clicking the **Resend IMC Exceptions** button.

Note: When resending items via the **Resend IMC Exceptions** button for assist fees and locum items, the Resend window will show the **Servicing Provider** as the assistant/locum from the invoice, whether this is a user in the practice or a contact from the Address Book. The **Principal Provider** field will show the Principal Provider originally selected in the Basic Claim Details page of the IMC Invoice Wizard when the claim was created.
Scenario 3: Items Paid a Different Amount to Claimed

This scenario is common around the time that health funds change their fee schedules. In the Service-Level Messages the items are red, indicating a discrepancy. You can see there is a difference between the Orig. Charge and the Total Benefit. To change the fee to match the Total Benefit, highlight the item and click the Update Item button.

The item text will change to blue in the Service-Level Messages section to show that the fee charged has changed from the original amount.

Once you close out of the Processing Report window, provided you have dealt with your exceptions properly, the claim will move from Exceptions to Review to Awaiting Remittance Advice or Ready to Receipt. If the claim does not move it means that you have not dealt with the exception correctly, so you will need to go back into Review Exceptions and fix the problem.

Part Paid Claims

If there is a large discrepancy, like when the fund reverts to paying the schedule fee when a patient has not served their waiting period, then the item should not be updated as you are not accepting that amount as full payment. Instead, once you have received the remittance advice, receipt the amount paid by Medicare or the health fund and the claim will move to the Part Paid claim status. You will then either apply to the health fund for a top-up payment or re-address the invoice to the patient via the Account History and have them pay the difference. Once the outstanding balance on the account is receipted (done outside of ECLIPSE via Billing > Receipt) or credited off, the claim will automatically move to Finalised.
Scenario 4: No Items Paid

In this scenario you can see there is a Fund Error Status saying the health fund membership has been suspended or cancelled in the Claim Level Messages and none of the items have been paid in the Service Level Messages section. The claim itself will need to be deleted as it is not going to be paid. So Close the Processing Report window and click the Delete Claim button in the IMC Claims Control window.

You will be asked if you are sure about deleting the claim and more importantly about deleting the invoice.

In most cases you would Keep the invoice as you would either be resubmitting the claim using the Resend IMC Exceptions button in the Account History, or printing the account to send to the fund or patient. You would usually Delete the invoice if it is a duplicate account or if you needed to recreate the transmission due to a locum or assist being on the account, as these items cannot be resubmitted using the Resend IMC Exceptions button in Genie 9.0.1 and earlier. If you are running Genie 9.0.2 or later, items where an Assistant, Locum or ‘Other’ Provider Type has been selected can be re-sent using the Resend IMC Exceptions button.

In the above scenario you would probably Keep the invoice and readdress it to the patient so they could sort it out with the health fund or pay the account themselves.
Example Exceptions

The below exceptions are examples only. If you are not sure how to deal with a particular exception refer to the previously outlined Exception Scenarios or contact the Genie Support team for assistance.

<table>
<thead>
<tr>
<th>Exception</th>
<th>Meaning</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1001 – Fund Payee ID not recognised by fund or other issues</td>
<td>For Medibank Private and AHM this error occurs because claims were sent as an Agreement rather than a Scheme claim type. For BUPA and their subsidiary funds this error occurs when Payee ID is not entered or is incorrect. For any other fund this error usually relates to an issue with fund registration.</td>
<td>See exception Scenario 4: No Items Paid to deal with this rejected claim. Then, refer to the ‘AHM &amp; Medibank Private ECLIPSE Claiming’ guide in your ECLIPSE pack for instructions on correctly submitting Medibank Private and AHM claims through ECLIPSE. Refer back to the Setting Up Providers for ECLIPSE Claiming section. Payee ID must be entered against BUPA and all subsidiary funds for all providers. If it is entered and is correct, contact the fund. If it is incorrect, amend and resubmit the claim. Contact the health fund to find out where the problem lies and have it resolved. Then, resubmit claims for payment.</td>
</tr>
<tr>
<td>2016 – Benefit for this service has been previously paid</td>
<td>Medicare believe a payment for this particular service has already been made.</td>
<td>See exception Scenario 4: No Items Paid to deal with the rejected claim. If you do not believe the claim has been previously paid, or there is no record of this payment in Genie, contact the health fund to obtain a payment report. Once payment is confirmed, receipt invoice manually outside of ECLIPSE. If account has been previously paid and is recorded in Genie against a duplicate of the account, delete the unpaid version of the invoice so only the original, fully paid, version remains in the system.</td>
</tr>
<tr>
<td>Receipting Error. The amount claimed does not equal the amount paid for at least one of the services in the X claims(s) paid by this Remittance Advice. There may be Exceptions to Review. (Cancel Receipt)</td>
<td>Claims are linked by the ERA (electronic remittance advice) for receipting purposes. One of the claims on the remittance still needs to be reviewed.</td>
<td>Click View Payment and ascertain exactly which claims are associated with this Remittance Advice. Locate each claim in ECLIPSE and check whether Claimed and Paid amounts are equal. Once the problem claim is identified click Review Exceptions (if claim is in Exceptions to Review) or View Processing Report (if claim is in Awaiting Remittance Advice or Ready to Receipt). Determine which Exception Scenario the claim fits in to (e.g. Scenario 2: Paid and Unpaid Items) then follow the steps in that section to resolve.</td>
</tr>
</tbody>
</table>
Receipting

At any stage throughout the ECLIPSE reporting process you can retrieve ECLIPSE Remittance Advices (ERAs) using the Get Remittance Advices button.

You do not have to have a claim selected to do this as it will retrieve any outstanding remittance advices from the Medicare servers since the last time they were retrieved. It will often retrieve more than one remittance advice, including claims which may not have a received a processing report. However, only claims that have been dealt with correctly or do not have any exceptions will move into Ready to Receipt after getting the remittance advice.

To view details of the payment, highlight the claim and click the View Payment button.

To receipt the claim, go to Ready to Receipt, highlight the claim and click Receipt. This will open up the normal Genie Receipt window. The payment amounts will have automatically been filled in from the information in the Processing Report. If you are satisfied that the payment amounts have been allocated correctly, simply Print or Store the receipt. The claim will then be moved to Finalised Claim Status.

NOTE: The receipt window will contain services from all claims that have been paid by the remittance advice for the highlighted claim. For this reason you may not be able to receipt a claim until you have dealt with the exceptions for the other claim/s in the remittance advice.

For Scheme (Known Gap Claims):
If the patient has paid their gap amount in full then the claim will be moved Finalised.

If the patient is yet to pay their gap then you will be prompted once you have receipted the claim that the account has been reassigned to the patient. It also allows you to reprint the invoice to send to the patient. The claim is then moved to Finalised.
Note: if you can’t Receipt it’s probably because there are outstanding Exceptions for another claim on the same Remittance Advice. Go to Exceptions to Review to fix the problem.