

Australian Standard™

**Guide to implementation of an
electronic medical claim message for
simplified billing in Australia**

This Australian Standard was prepared by Committee IT-014, Health Informatics. It was approved on behalf of the Council of Standards Australia on 5 April 2003 and published on 8 May 2003.

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Australian Medical Association
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Medical Software Industry Association
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Australian Standard™

Guide to implementation of an electronic medical claim message for simplified billing in Australia

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PREFACE

This Standard was prepared by the Standards Australia Committee IT-014-10-02, Finance and Billing Working Group under the direction of the Australian members of the Joint Standards Australia/Standards New Zealand Committee IT-014 on Health Informatics. After consultation with stakeholders in both countries, Standards Australia and Standards New Zealand decided to develop this Standard as an Australian Standard rather than an Australian/New Zealand Standard.

The objective of this Standard is to provide business and technical managers with an understanding of the scope of the simplified billing message for medical services and define the basic data structure of a medical message for simplified billing.

This Standard should be read in conjunction with AS 4937 *Electronic messages for exchange of claim and related information*.

CONTENTS

	<i>Page</i>
FOREWORD.....	4
1 SCOPE	5
2 REFERENCED DOCUMENTS.....	6
3 DEFINITIONS	6
4 STRUCTURE OF A MEDICAL CLAIM MESSAGE	7
5 TECHNICAL GUIDELINE FOR SIMPLIFIED BILLING MESSAGE	8

FOREWORD

A complete electronic commerce solution comprises several components—network infrastructure, data security measures and standard data formats.

For more information on data security measures, please refer to HB 174 *Information security management—Implementation guide for the health sector*.

The messages are designed to cover the transmission of claims for in-hospital medical services from medical practices to billing agents or health funds and from billing agents or health funds to the Health Insurance Commission.

The message upon which this Standard is based is MEDRUC (medical resource usage and cost message), a UN/EDIFACT (United Nations Electronic Data Interchange for Administration Commerce and Transport) Standard Message designed to send healthcare claims for the purposes of reimbursement. A complete description of the MEDRUC structure is available at (http://www.unece.org/trade/untidd/dlast/trmd/medruc_d.htm). It is a *bi-directional message* so it is also designed to cover response messages detailing benefits paid. This specification includes two additional guidelines for the response message using MEDRUC (giving detailed claim-level reconciliation advice) and a remittance advice (REMADV) that provides top-level details on payment to the claimant's bank account. The latter message is also a United Nations Standard Message in the UN/EDIFACT D.97B directory.

Codes and details of message senders and recipients may differ according to the user of the messages within the proposed message flows detailed below but the message structure will remain essentially the same.

UN/EDIFACT syntax is a message format endorsed by Standards Australia and published as AS/NZS 3801:1995. AS/NZS 3801 is an adoption of ISO 9735:1988/Amd.1:1992. The relevant EDIFACT directory is D.97B.

It was decided not to include hospital and medical services in a single message at this time for the following reasons:

- (a) The widespread use and acceptance of the NCG hospital claim message and its close relationship with the Hospital Casemix Protocol data formats legislated by the DHA (Department of Health and Ageing).

NOTE: It is planned to move to UN/EDIFACT when the business needs of current users are no longer met by the current hospital claim formats.

- (b) Hospital and medical claims will not always be sent to the funders at the same time or by the same party.

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Guide to implementation of an electronic medical claim message for simplified billing in Australia

1 SCOPE

This Standard defines the basic data structure of a medical message for simplified billing and suggests a method for billing agent implementation.

The simplified billing message is designed to transmit claims relating to *medical services* and transmit information about the benefits paid.

NOTE: A complete definition of Simplified Billing is given in Clause 3.

Data element summaries are provided for:

- (a) Simplified Billing Medical Claim using MEDRUC (medical resource usage cost message) D.97B version.
- (b) Response to Simplified Billing Medical Claim using MEDRUC.
- (c) REDMADV (remittance advice message) D.97B version.

MEDRUC and REDMADV are standard messages from UN/EDIFACT Directory D.97B.

This Standard does not include claims for those hospital services (including theatre, accommodation, critical care, prostheses, pharmaceuticals, and other non-medical services) currently covered by the NCG hospital claim message.

NOTE: Separation of hospital and medical claim data for the purposes of EDI does not preclude a billing agent from providing a single account for hospital and medical services to the patient if they are a hospital billing agent. The EDI data flows are independent of the final paperwork presented to the patient.

Other business procedures that are outside the scope of this Standard are :

- (i) Health fund eligibility information for providers.
- (ii) Error information provided to the sender if data received is missing or corrupted.

NOTE: This will be covered by an application error and acknowledgement message (APERAK) that will be the subject of a separate Standard.

- (iii) Financial/billing information internal to an organization such as a hospital.

The data flows for messages within the scope of this Standard are defined in Figure 1 which shows the flows which may occur for simplified billing depending on what type of process is being followed. It covers the third party billing agent, medical purchase provider agreement (MPPA), HPPAs with Practitioner agreements and Gap Cover Schemes.

The flows are self-explanatory and are implemented by utilizing the data formats set out in this Standard.

NOTE: It will be necessary to contact the Health Insurance Commission to determine any special requirements that may need to be taken into account.

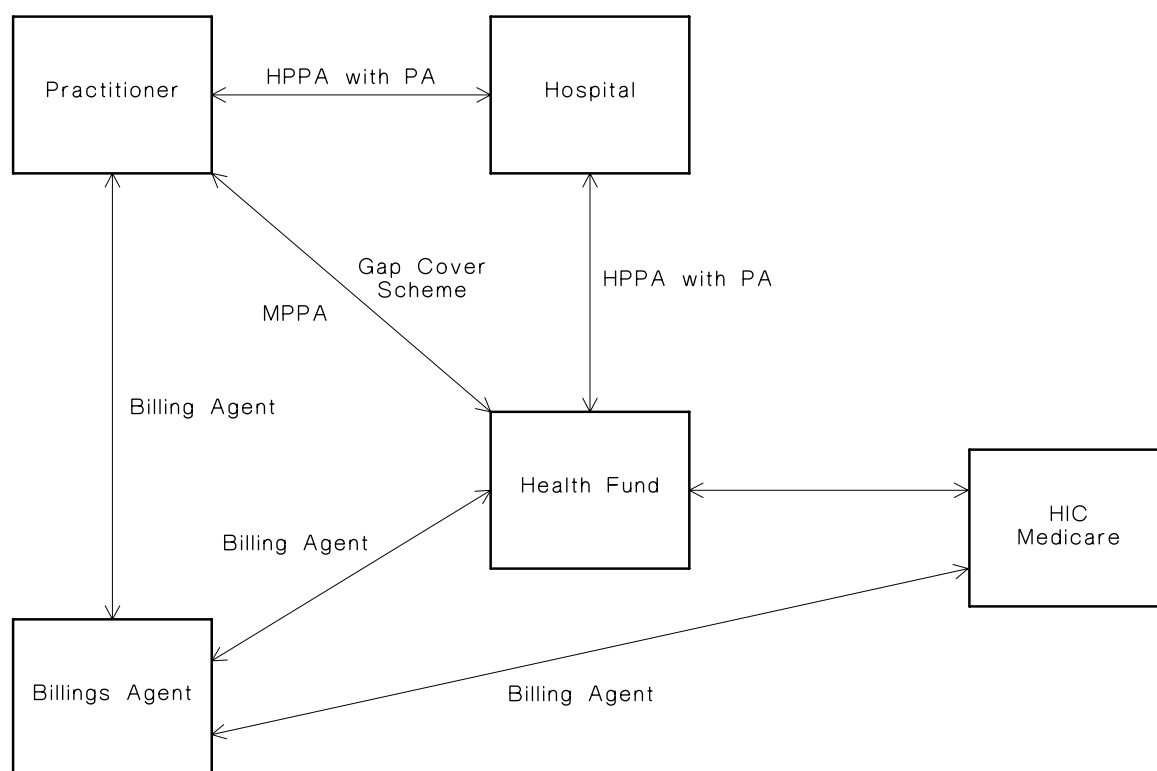


FIGURE 1 DATA FLOW FOR SIMPLIFIED BILLING

2 REFERENCED DOCUMENTS

AS/NZS

3801 Electronic data interchange for administration, commerce and transport (EDIFACT)—Application level syntax rules

4937 Electronic messages for exchange of claim and related information

HB

174 Information security management—Implementation guide for the health sector

ISO

9375 Electronic data interchange for administration, commerce and transport (EDIFACT)—Application level syntax rules

AIHW National Health Data Dictionary

NCG Guide to EDI. Implementation of a Medical Claim Message for Simplified Billing in Australia. Position paper on Data Transmission, Data Security and Data Standards

UN/EDIFACT D.97B directory

3 DEFINITIONS

Unless otherwise stated the definitions of AS/NZS 3801 and the following apply.

3.1 Simplified Billing

Simplified Billing is the term given to the process which can be used to claim Medicare and, where applicable, private health insurance benefits for professional services rendered while hospital treatment (i.e. accommodation and nursing care) is provided to a patient who has been admitted to a hospital or day hospital facility as a private patient.

The process applies to claims made under—

- (a) a Medical Purchase Provider Agreement (MPAA);
- (b) a Hospital Purchase Provider Agreement (HPPA) with a Practitioner Agreement (PA);
- (c) a Gap Cover Scheme operated by a Private Health Fund; or
- (d) an arrangement with a Registered Billing Agent.

It does not cover non-medical services such as ancillary services or hospital accommodation charges.

4 STRUCTURE OF A MEDICAL CLAIM MESSAGE

Figure 2 shows the generic structure of a medical claim message. Claim information is grouped first according to the patient and their attendance/episode details. Attendance/episode details have been limited in this Standard since medical claims are service-related. Practitioner information is repeated within the patient and attendance loop. Individual service information is repeated within the practitioner loop. The practitioner loop contains details of other related practitioners such as referring/requesting practitioner, according to the legislative requirements for some medical claim assessments. Charges are normally assigned to individual services.

The practitioner loop also contains details of the health fund contributor (if they are different from the patient) so that these details are nested under the patient level information.

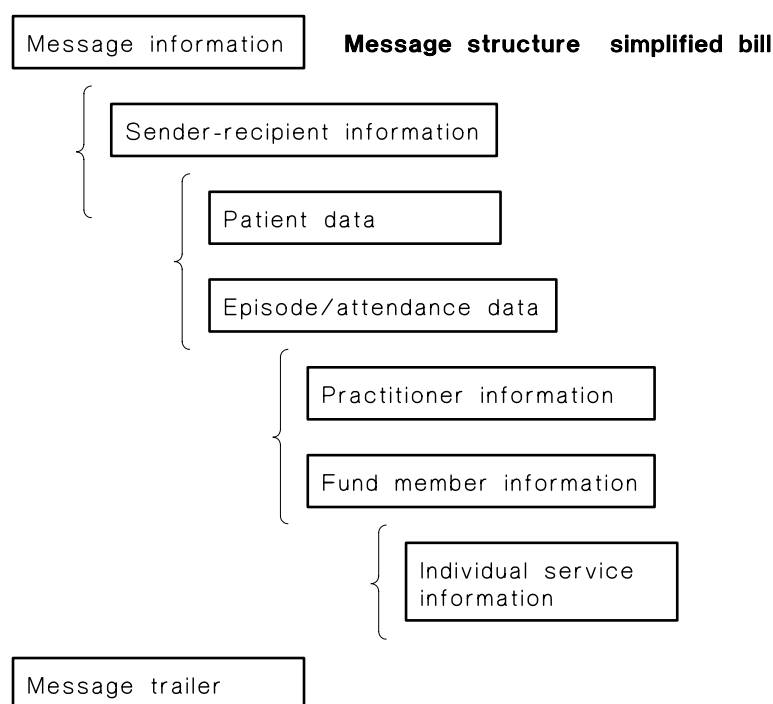


FIGURE 2 GENERIC STRUCTURE OF SIMPLIFIED MEDICAL CLAIM

5 TECHNICAL GUIDELINE FOR SIMPLIFIED BILLING MESSAGE

5.1 Objective and assumptions

The purpose of the technical guideline is to provide IT specialists and software vendors with sufficient detail to develop a message or integrate UN/EDIFACT compliant translator software directly into their application. At least a basic understanding of EDI is assumed as is experience with either the NCG hospital claim or the HIC's MedClaims formats for other EDI implementations.

NOTE: A list of EDI translator software products supporting UN/EDIFACT syntax and available to Australian businesses is available from Tradegate ECA (Electronic Commerce Australia).

5.2 Structure of MEDRUC

The structure of the entire MEDRUC message has not been included in this specification, but the structure of the local message specification for private inpatient medical claiming is included in Table 5.5.1.

5.3 Example of claim message

Figures 3, 4 and 5 give examples of the syntax used in a claim to HIC, a response from HIC to a claim, and a remittance advice. Clause 5.4 lists segment groups within MEDRUC. A number of characteristics of EDIFACT syntax should be noted—

- (a) segment terminators are apostrophes (there are no carriage returns within the message);
- (b) segment tags are always a three character alpha-numeric;
- (c) composite data elements within a segment are delimited with a plus (+) sign;
- (d) individual data elements within composites are delimited by a colon (:);
- (e) absent data elements can be absent from the syntax if they come after a required data element within a segment;
- (f) absent data elements will be denoted by the number of relevant delimiters for each absent element if they precede a required data element within a segment; and
- (g) translator software wraps the entire message in an envelope that contains interchange level information and details of delimiters, allowing users to change the default delimiters if required.

NOTE: Information about enveloping of UN/EDIFACT messages is available from the HIC. Enveloping segments are included in the example syntax. If other clarification is required, please contact the NCG or HIC EDI liaison officer.

5.4 Segment groups within MEDRUC

The following is a list of the segment groups contained within this implementation of MEDRUC, together with their logical function.

UNH-BGM-DTM-RFF-CNT provides details of the message such as sender's unique reference, date/time of message preparation, references to previously sent or received messages, message name, version information and control totals such as total number of patients within this message.

Segment Group 1 is a conditional segment group that allows message senders to tally all claims within the message and provide a total dollar amount associated with this message.

Segment Group 2 identifies senders and recipients of messages, and claimants where they differ from the sender. The segment group also allows for the provision of address information as a crosscheck for identification and contact information in the event of a query on a claim or payment. Details of the relevant financial institution to which payment should be made can also be optionally provided within this segment group.

Segment Groups 3 and 4 of the MEDRUC message are not required for this implementation.

Segment Group 5 optionally provides information about financial charges but in this implementation is used simply as a shell in which the patient data are contained.

Segment Group 6 of the MEDRUC message is not required for this implementation.

Segment Group 7 is nested under SG5 and identifies the patient by any number of reference IDs and can also provide their address details, date of birth and sex for cross-matching purposes.

Segment Group 8 is nested under SG5 and is used to provide information about the practitioners involved in the care of the patient. Treating and referring providers can be named and identified. Health fund contributor details (where they differ from the patient) may also be included at this level with simple addressing information also included (postcode).

Segment Group 9 is nested under SG8 and is used to provide details of episode or attendance including dates of admission and discharge where appropriate, service delivery setting and other information as required.

Segment Group 10 is also nested under SG8 and is used to provide monetary amounts associated with the services of an individual treating provider.

Segment Group 12 provides details of individual services performed by the treating provider in SG8. MBS Items and dates of service are provided within this group along with information about quantities for relevant claims.

Segment Group 13 is nested under SG12 and is used to provide monetary amounts associated with individual services in SG12.

Segment Group 14 is nested under SG12 and is used to provide information about special requirements and conditions associated with the individual service (such as not normal after care, Rule 3 Exemption, etc).

Segment Group 15 is nested under SG12 and is used to provide details of equipment required for some radiation oncology procedures.

UNT contains some relevant control totals (e.g., number of segments within the message) and completes the message transmission.

Characteristics of the data elements in each Segment Group for MEDRUC (medical resource usage and cost message) are set out in Table 5.5.1; for the response to MEDRUC in Table 5.6.1; and for REMADV (remittance advice message) in Table 5.7.1. The message format is taken from the D.97B version of the EDIFACT directory.

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DTM+534:21071998:AAA '
MOA+23:2000 '
FCA+7 '
PNA+LK+++++1:SMITH+2:JOHN+8:F '
RFF+ADE:98/SJF00179477 '
ADR+++BLI BLI+4560 '
DTM+329:30031946:AAA '
PDI+1 '
PRC+GP '
PNA+LM+0123456K:BZ '
CLI+3 '
IMD+++33 '
DTM+534:20071998:AAA '
QTY+2:3 '
MOA+23:5000 '
CLI+3 '
IMD+++33 '
DTM+534:21071998:AAA '
QTY+2:1 '
MOA+23:5000 '
UNT+80+317631 '
UNZ+1+5 '

FIGURE 3 EXAMPLE OF A CLAIM TO HIC

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MOA+23:7000 '
 MOA+58:5715 '
 MOA+11:4290 '
 PRC+PT '
 PNA+LM+7777777K:BZ '
 PAS+10 '
 MOA+23:3200 '
 MOA+58:2005 '
 MOA+11:1510 '
 CLI+3 '
 IMD+++65017 '
 DTM+534:21071998:AAA '
 MOA+23:1200 '
 MOA+58:990 '
 MOA+11:745 '
 CLI+3 '
 IMD+++73912 '
 DTM+534:21071998:AAA '
 MOA+23:2000 '
 MOA+58:1015 '
 MOA+11:765 '
 FCA+7 '
 FTX+ACD++N '
 PNA+LK+++++1:SMITH+2:JOHN '
 RFF+ACL:7000187471 '
 RFF+AGU:1 '
 RFF+ADE:98/SJF00179477 '
 PRC+GP '
 PNA+LM+01234576K:BZ '
 PAS+10 '
 MOA+23:10000 '
 MOA+58:6940 '
 MOA+11:5230 '
 CLI+3 '
 IMD+++33 '
 DTM+534:20071998:AAA '
 MOA+23:5000 '
 MOA+58:2720 '
 MOA+11:2065 '
 CLI+3 '
 IMD+++33 '
 DTM+534:21071998:AAA '
 MOA+23:5000 '
 MOA+58:4220 '
 MOA+11:3165 '
 UNT+100+846209 '
 UNZ+1+16 '

FIGURE 4 EXAMPLE OF A RESPONSE FROM HIC TO A CLAIM

```

UNA:+.? '
UNB+UNOB:2+SENDER ID+RECIPIENT ID+980818:0924+26'
UNH+846536+REMADV:D:97B:UN:0100A'
BGM+SB1+345++AB'
DTM+138:18081998:AAA'
RFF+MR:BIL00001'
FII+MR+123456789:B.A. TRUST ACCOUNT 1+:::234567'
DOC+SB1+17631'
MOA+11:23710'
DTM+384:16081998:AAA'
DOC+SB1+17632'
MOA+11:5635'
DTM+384:17081998:AAA'
UNS+D'
MOA+11:29345'
UNT+14+846536'
UNZ+1+26'

```

NOTE: The carriage returns in the example syntax do not form part of the message string. Also note that the blank in the UNA segment is a required part of the syntax.

FIGURE 5 EXAMPLE OF A REMITTANCE ADVICE FROM HIC

5.5 Simplified Billing Medical Claim MEDRUC

The MEDRUC syntax is taken from UN/EDIFACT Directory D.97B.

5.5.1 *Message purpose*

The purpose of the medical resource usage cost message is—

- (a) to enable providers and other parties (such as billing agents) to send claims for in-hospital medical services to payers including Medicare and private health insurance funds; and
- (b) to enable payors such as private health insurance funds to exchange claims data with the Health Insurance Commission.

NOTE: This Standard does not contain segments, elements and composites that are part of the MEDRUC message but not required for this implementation. Missing data elements are denoted using additional plus signs or colons within the example syntax. A guideline with all unused elements also printed is available from NCG.

TABLE 5.5.1
SYNTAX FOR MEDRUC

	Pos. No	Seg. ID.	Name	Req.des	Max. use	Group repeat
Must Use	0010	UNH	Message Header	M	1	
Must Use	0020	BGM	Beginning of Message	M	1	
Must Use	0030	DTM	Date/Time/Period	C	9	
	0040	RFF	Reference	C	9	
Must Use	0060	CNT	Control Total	C	9	
	0070		Segment Group 1: MOA	C		9
Must Use	0080	MOA	Monetary Amount	M	1	
	0100		Segment Group 2: PNA-ADR-CTA-COM-RFF-FII	C		999
Must Use	0110	PNA	Party Name	M	1	
	0130	ADR	Address	C	9	
	0140	CTA	Contact Information	C	9	
	0150	COM	Communication Contact	C	9	
	0160	RFF	Reference	C	99	
	0230	FII	Financial Institution Information	C	9	
	0320		Segment Group 5: FCA-SG7-SG8	C		999
Must Use	0330	FCA	Financial Charges Allocation	M	1	
	0390		Segment Group 6: RCS	C		99
	0400	RCS	Requirements and Conditions	M	1	
	0420		Segment Group 7: PNA-RFF-ADR-DTM-PDI	C		999
Must Use	0430	PNA	Party Name	M	1	
Must Use	0440	RFF	Reference	C	99	
	0450	ADR	Address	C	9	
	0470	DTM	Date/Time/Period	C	99	
	0480	PDI	Person Demographic Information	C	1	
	0530		Segment Group 8: PRC-PNA-ADR-DTM-RFF-SG9-SG10-SG12	C		99
Must Use	0540	PRC	Process Identification	M	1	
Must Use	0580	PNA	Party Name	C	99	
	0590	DTM	Date/Time/Period	C	99	
	0600	RFF	Reference	C	99	
	0640		Segment Group 9: PAS-DTM-RFF	C		99
Must Use	0650	PAS	Attendance	M	1	
	0670	DTM	Date/Time/Period	C	9	
	0680	RFF	Reference	C	9	
	0690		Segment Group 10: MOA	C		99
Must Use	0700	MOA	Monetary Amount	M	1	

(continued)



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TABLE 5.5.1 (continued)

	Pos. No	Seg. ID.	Name	Req.des	Max. use	Group repeat
	0750		Segment Group 12: CLI-IMD-DTM-FTX-QTY-SG13-SG14-SG15	C		999
Must Use	0760	CLI	Clinical Intervention	M	1	
Must Use	0780	IMD	Item Description	C	1	
Must Use	0810	DTM	Date/Time/Period	C	99	
	0820	RFF	Reference	C	99	
	0830	FTX	Free Text	C	99	
	0840	QTY	Quantity	C	99	
	0870		Segment Group 13: MOA	C		99
Must Use	0880	MOA	Monetary Amount	M	1	
	0900		Segment Group 14: RCS	C		99
Must Use	0910	RCS	Requirements and Conditions	M	1	
	0930		Segment Group 15: EQD	C		99
Must Use	0940	EQD	Equipment Details	M	1	
Must Use	1340	UNT	Message Trailer	M	1	

Summaries of the data elements in each segment are set out in Tables 5.5.1.1 to 5.5.1.37. Some segment IDs are repeated in a number of different segment groups; the characteristics vary in each group.

5.5.1.1 *Message header***Segment:** UNH**Position:** 0010**Group:** 0**Level:** Mandatory**Usage:****Max use:** 1**Note:** Provides version information on the message.**Example:** UNH+0123456789+MEDRUC:D:97B:UN:0100C'

TABLE 5.5.1.1
UNH DATA ELEMENT SUMMARY

	Data element attributes	Component element	Name	Attributes
M	0062		MESSAGE REFERENCE NUMBER	M an..14
M	S009		MESSAGE IDENTIFIER	M
M		0065	Message type identifier MEDRUC Medical Resource usage and cost message	M an..6
M		0052	Message type version number D Draft version/UN/EDIFACT Directory	M an..3
M		0054	Message type release number 97B Release 1997 - B	M an..3
M		0051	Controlling agency UN UN/ECE/TRADE/WP.4	M an..2
		0057	Association assigned code 0100C First implementation of MEDRUC for simplified medical billing claim(s) – code assigned by NCG	C an..6

5.5.1.2 *Beginning of message***Segment:** BGM**Position:** 0020**Group:****Level:** 0**Usage:** Mandatory**Max use:** 1**Note:****Examples:** BGM+SB1+89987+9+AC'

BGM+SB2+89987++AC'

TABLE 5.5.1.2
BGM DATA ELEMENT SUMMARY

Data element	Component element	Name	Attributes
C002		DOCUMENT/MESSAGE NAME	C
	1001	Document/message name, coded	C an..3
	SB1	Simplified medical billing (Billing Agent)	
	SB2	Simplified medical billing (Medical Purchaser Provider Agreement or HPPA with Practitioner Agreements)	
C106		DOCUMENT/MESSAGE IDENTIFICATION	C
	1004	Document/message number	C an..35
		NOTES:	
	1	Message ID unique to message sender e.g. lodgement reference or claim ID.	
1225	2	For HIC use the claim ID in format 99999	
		MESSAGE FUNCTION, CODED	C an..3
		NOTE: The HIC will ignore this field and treat all messages as originals	
	1	Cancellation	
4343	5	Replace	
	9	Original	
		RESPONSE TYPE, CODED	C an..3
		NOTE: Default for transmissions to the HIC is AC (acknowledge with detail and change).	
	AB	Message acknowledgement	
	AC	Acknowledge - with detail and change	
	NA	No acknowledgement needed	

5.5.1.3 *Date/Time/Period***Segment:** DTM**Position:** 0030**Group:****Level:** 1**Usage:** Conditional (Required)**Max use:** 9**Note:** Used to specify the date and/or time that the message was prepared**Example:** DTM+97:21071998:AAA'

TABLE 5.5.1.3
DTM DATA ELEMENT SUMMARY

	Data element	Component element	Name	Attributes
M	C507		DATE/TIME/PERIOD	M
M		2005	Date/time/period qualifier	M an..3
		97	Transaction creation date	
			NOTE: For transmissions to the HIC, this should be the date the transmission is sent (originally).	
M		2380	Date/time/period	C an..35
M		2379	Date/time/period format qualifier	C an..3
		2	DDMMYY	
		102	CCYYMMDD	
		203	CCYYMMDDHHMM	
		AAA	DDMMCCYY	
		AAB	DDMMCCYYHHMM	

5.5.1.4 Reference**Segment:** RFF**Position:** 0040**Group:****Level:** 1**Usage:** Conditional (Optional)**Max use:** 9**Note:** Used to specify related message references (previous messages sent or messages to which the user is responding).**Example:** RFF+AGO:74737'

TABLE 5.5.1.4
RFF DATA ELEMENT SUMMARY

	Data element	Component element	Name	Attributes
M	C506		REFERENCE	M
M		1153	Reference qualifier	M an..3
		ACW	Reference number to previous message. NOTE: If this message is a replacement, this will reference the previously sent message.	
		AGO	Sender's reference to the original message. NOTE: If this message is a reconciliation statement, this will reference the claim message.	
		FV	File version number NOTE: Used to allow version control information at the application level after message headers removed. Should be same as value in association assigned code in UNH above - 0100C in the case of MEDRUC for simplified medical billing.	
		1154	Reference number	C an..35

5.5.1.5 *Control total***Segment:** CNT**Position:** 0060**Group:****Level:** 1**Usage:** Conditional (Required)**Max use:** 9**Note:** Count of number of patients within this message.**Example:** CNT+PAT:1

TABLE 5.5.1.5
CNT DATA ELEMENT SUMMARY

	Data element	Component element	Name	Attributes
M	C270		CONTROL	M
M		6069	Control qualifier	M an..3
		PAT	Total number of patients this message.	
			NOTE: This is the count of PNA segments at position 430 in the message	
M		6066	Control value	M n..18

5.5.1.6 *Monetary amount*

Segment: MOA

Position: 0080 (Trigger Segment)

Group: Segment Group 1 (Monetary Amount)Conditional (Optional)

Level: 1

Usage: Mandatory

Max use: 1

Notes: 1 Used to provide the total amounts for this claim message.
2 For HIC use one segment - qualifier 140

Examples: MOA+140:38000'
MOA+139:28500'

TABLE 5.5.1.6
MOA DATA ELEMENT SUMMARY

	Data element	Component element	Name	Attributes
M	C516		MONETARY AMOUNT	M
M		5025	Monetary amount type qualifier	M an..3
		136	Total invoice additional amount NOTE: Total gap amount paid by fund for all providers, patients and services in this message.	
		139	Total payment amount NOTE: Total amount paid by Medicare for all patients, providers and services.	
		140	Total service charge.	
		5004	Monetary amount NOTE: In cents (i.e. strip decimal point for transmission).	C n..18

5.5.1.7 Party name

Segment: PNA

Position: 0110 (Trigger Segment)

Group: Segment Group 2 (Party Name) Conditional (Optional)

Level: 1

Usage: Mandatory

Max use: 1

Note: Used to identify the message sender, message recipient, and the claimant. Only the PNA+MS segment with DPS identifier required by HIC (as per second example).

Examples: PNA+MS+BRY782:AGN++++10:ACME BILLING'
PNA:MS+AHF00001:DPS'

TABLE 5.5.1.7
PNA DATA ELEMENT SUMMARY

	Data element	Component element	Name	Attributes
M	3035		PARTY QUALIFIER	M an..3
		MR	Message recipient	
		MS	Document/message issuer/sender	
	C206		IDENTIFICATION NUMBER	C
M		7402	Identity number	M an..35
			NOTE: Either be the HIC code or the PHIAC issued registration number for billing agents or the DOH three letter alpha code for health funds and other institutions (e.g. HIC).	
		7405	Identity number qualifier	C an..3
		AGN	Agent Identity No.	
			NOTE: Use PHIAC Registration No.	
		BO	Fund	
			NOTE: Health fund (use 3 alpha-mnemonic).	
		DPS	DPS Minor Customer ID	
			NOTE: Use for transmissions to HIC.	
		HOS	Hospital Identification No.	
		PRA	Medical Practice Identification	
	C816		NAME COMPONENT DETAILS	C
			NOTE: Not used by HIC.	
M		3405	Name component qualifier	M an..3
		10	Whole name	
			NOTE: This is used to transmit the name of the organization.	
		3398	Name component	C an..70

5.5.1.8 Address**Segment:** ADR**Position:** 0130**Group:** Segment Group 2 (Party Name) Conditional (Optional)**Level:** 2**Usage:** Conditional (Optional)**Max use:****Notes:** 1 Used to specify the address of the party identified in PNA where required.

2 Not used by HIC.

Example: ADR+:1+5:5 ALBION ROAD+ALBION+4010++:::QLD'

TABLE 5.5.1.8
ADR DATA ELEMENT SUMMARY

	Data element	Component element	Name	Attributes
	C817		ADDRESS USAGE	C
		3131	Address type, coded	C an..3
		1	Postal address	
			NOTE: If not present, then the business address is assumed.	
	C090		ADDRESS DETAILS	C
M		3477	Address format, coded	M an..3
		5	Unstructured address	
M		3286	Address component	M an..70
		3286	Address component	C an..70
	3164		CITY NAME	C an..35
			NOTE: Suburb/locality.	
	3251		POSTCODE IDENTIFICATION	C an..9
	C819		COUNTRY SUB-ENTITY DETAILS	C
		3228	Country sub-entity	C an..35
			NOTE: State/Territory – use 2 or 3 alpha-mnemonic NSW, VIC, QLD, SA, WA, TAS, NT, ACT	

5.5.1.9 *Contact information***Segment:** CTA**Position:** 0140**Group:** Segment Group 2 (Party Name) Conditional (Optional)**Level:** 2**Usage:** Conditional (Optional)**Max use:** 9**Notes:** 1 Used to specify the name of the person at the preceding organization to contact in case of any queries on amount claimed or amount paid.

2 Not used by HIC.

Example: CTA+IC+:MARY CITIZEN'**TABLE 5.5.1.9****CTA DATA ELEMENT SUMMARY**

Data element	Component element	Name	Attributes	
3139		CONTACT FUNCTION, CODED	C	an..3
		IC Information contact		
C056		DEPARTMENT OR EMPLOYEE DETAILS	C	
	3412	Department or employee	C	an..35
		NOTE: Person at the message sender's organization for queries regarding this claim.		

5.5.1.10 *Communication contact***Segment:** COM**Position:** 0150**Group:** Segment Group 2 (Party Name) Conditional (Optional)**Level:** 2**Usage:** Conditional (Optional)**Max use:** 9**Notes:** Communication details of the preceding contact person.
Not used by HIC.**Examples:** COM+MARY@EMAIL.COM.AU:EM'
COM+07 9059 4070:FX'**TABLE 5.5.1.10**
COM DATA ELEMENT SUMMARY

	Data element	Component element	Name	Attributes
M	C076		COMMUNICATION CONTACT	M
M		3148	Communication number	M an..512
M		3155	Communication channel qualifier	M an..3
		EM	Electronic mail	
		FX	Telefax	
		TE	Telephone	

5.5.1.11 *Reference***Segment:** RFF**Position:** 0160**Group:** Segment Group 2 (Party Name) Conditional (Optional)**Level:** 2**Usage:** Conditional (Optional)**Max use:** 99

Notes: 1 This is for the sender's reference, if they wish to make use of it.
 2 Not used by HIC.

TABLE 5.5.1.11
RFF DATA ELEMENT SUMMARY

	Data element	Component element	Name	Attributes
M	C506		REFERENCE	M
			NOTES:	
			1 Used to provide additional reference numbers, other than identity number in PNA.	
			2 Example: RFF+ADE:UB35724'.	
M		1153	Reference qualifier	M an..3
		ADE	Account number	
			NOTE: Consolidated Account reference number for all patients contained in this message, if required.	
		1154	Reference number	C an..35

5.5.1.12 *Financial institution information***Segment:** FII**Position:** 0230**Group:** Segment Group 2 (Party Name) Conditional (Optional)**Level:** 2**Usage:** Conditional (Optional)**Max use:** 9

Notes: 1 This segment may be used to flag changes to financial details held on recipients' files. However, this usage is subject to agreement between trading partners using the message. Use may be subject to message being encrypted or digitally signed or other requirements specified by payers.

2 Not used by HIC.

Example: FII+MS+76241982:Trust Account #1+:::0021'

TABLE 5.5.1.12
FII DATA ELEMENT SUMMARY

	Data element	Component element	Name	Attributes
M	3035	PARTY QUALIFIER		M an..3
		MR	Message recipient	
		MS	Document/message issuer/sender	
	C078	ACCOUNT IDENTIFICATION		C
		3194	Account holder number	C an..35
		3192	Account holder name	C an..35
			NOTE: Account Name for EFT – line 1.	
		3192	Account holder name	C an..35
			NOTE: Line 2.	
	C088	INSTITUTION IDENTIFICATION		C
M		3434	Institution branch number	C an..17
			NOTE: BSB	

5.5.1.13 *Financial charges allocation***Segment:** FCA**Position:** 0330 (Trigger Segment)**Group:** Segment Group 5 (Financial Charges Allocation) Conditional (Optional)**Level:** 1**Usage:** Mandatory**Max use:** 1**Note:** This segment only required for message structure purposes. See example syntax for structure.**Example:** FCA+7'

TABLE 5.5.1.13
FCA DATA ELEMENT SUMMARY

	Data element	Component element	Name	Attributes
M	4471		SETTLEMENT, CODED	M an..3
		7	Optional	