HBF ANCILLARY PROVIDER REQUIREMENTS

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1. Registration and Provider Numbers

1.1. Your Provider Number(s)

Each provider number is unique to a specific individual provider and the individual private practice location at which that provider provides services. Therefore, if you already work, or intend to work, at more than one private practice location, you will require a separate provider number for each individual private practice location at which you provide services.

Provider numbers are unique to each individual provider and each private practice location and are not to be used by any other provider with the exceptions listed in 1.5 and 1.6 of this document.

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1.2. Eligibility for Registration with HBF

To be eligible for registration with HBF, providers must be registered with the relevant registration board and/or professional body. Our provider registration rules comply with the requirements of the Private Health Insurance (Accreditation) Rules. These Rules specify the qualifications and/or affiliations required for a Fund to register providers.

1.3. Processing Time for Registrations

Providers should allow up to **14 business days** for new registrations including locums, temporary and new to practice providers. Benefits cannot be processed for services that are performed by providers who are not registered with HBF.

1.4. Temporary Provider Numbers

HBF reserves the right to issue “temporary” provider numbers in certain circumstances. These provider numbers have a definitive “start date” and “end date”. Once a “temporary” provider number expires, the submission to HBF of a further application for provider registration is required if the provider wishes to continue rendering services at the location for which the temporary provider number was issued initially.

1.5.Locums

HBF defines a ‘locum’ as a provider who is substituting for another provider whose usual practice hours cannot be fulfilled, for example due to annual leave, maternity leave, sick leave or study requirements, and who is not already registered with HBF at the practice to which the locum duties relate.

A locum may use the provider number of the principal of the practice for a maximum period of up to four weeks. If a locum is required for a period exceeding four weeks, then an application must be submitted to HBF for provider registration at that location.

1.6. New Providers to a Practice

New providers have four weeks to register with HBF from their start date and should begin the registration process as soon as they are aware they will be starting. During this period the ‘new provider’ may use the provider number of the principal of the practice, whilst they apply to HBF for provider registration. This four week period commences on the first day that the new provider commences practice at that particular location.

2.0. Changes in the Circumstances of Your Practice

HBF relies on having accurate provider contact details to communicate with health care providers. It is your responsibility to ensure that your provider number and practice address for each practice location registered with HBF is correct.

It is important if you have more than one practice location registered with HBF, that you keep your postal address up to date. This is the address that HBF will use for all written communication.

Examples of changes in circumstances of your practice that would require you to contact HBF include

- A sale, purchase or change in the partnership or principal, associates or professional employees at a practice location; or
- A cessation of practice at a location for any reason, e.g. retirement

Should you commence practice at a location not previously registered under your name with HBF, you will be required to apply for a new provider number for that location.

Please contact HBF if you need to confirm, or make amendments to your practice location, email address, telephone number, facsimile number and corresponding provider number(s).

3. Payment of HBF Benefits

HBF pays benefits for services rendered in a private practice by a provider who has been approved by HBF. It should be noted that not all services attract a benefit from HBF.

In the event of a dispute regarding any aspect relating to the provision of these services to HBF members, the matter may be referred to an appropriate professional body for advice. The decision however, as to whether a benefit should be paid for a service, remains at all times one for HBF in its absolute discretion.

3.1. Services Rendered to a Relative

No benefit will be payable for any services rendered by a provider to a relative when the relative is included on the same HBF membership as the treating provider.

3.2 Reasonability Rules

Most modalities have associated HBF reasonability rules usually pertaining to areas such as multiple consultations on the same day or performing two services that do not complement each other. If you have any questions about the following rules please contact HBF.

3.3 Same Day Consultations

Where an individual consultation occurs twice in one day for the same service there must be a two hour break between the end of the first treatment and the beginning of the second for a benefit to be paid. No break is required between individual and group consultations. This rule does not apply to Dental and Optical item numbers or to Yoga and Pilates programs.

3.4 Initial Consultations

If the item number for an initial consultation is different from the item number used for subsequent consultations no benefit will be paid for more than one initial consultation per calendar year.

3.5 Consultation Definitions

Consultation

The personal attendance of an Approved Provider upon the individual Member (except in the case of Clinical Psychology Consultation) on a one to one basis, exclusive of all others, for the purpose of providing a Medically Necessary Essentials treatment.

The treatment rendered must be in accordance with accepted principles of professional practice and the Approved Provider must be in attendance for the duration of the consultation (except in the case of a Class, Group or Small Group Physiotherapy Consultation).

This excludes any personal attendance on the same day as a previous attendance unless the later attendance commences at least 2 hours after the first attendance finishes.

Clinical Psychology Consultation
The attendance of an Approved Provider upon the Member, or where clinical circumstances require, a person responsible for support or care of the member, on a one to one basis, exclusive of all others, for the purpose of providing a Medically Necessary clinical psychology treatment.

Class/Group Physiotherapy Consultation
The personal attendance of an Approved Provider for the purpose of simultaneously providing a homogenous Medically Necessary treatment to four or more individuals, where there has been an individual assessment by a physiotherapist.

Small Group Physiotherapy Consultation
The personal attendance of an Approved Provider for the purpose of simultaneously providing a Medically Necessary treatment to no more than three individuals, where there has been an individual assessment by a physiotherapist.

Group, Family or Class Consultation
The attendance of an Approved Provider for the purpose of simultaneously providing a Medically Necessary treatment to more than one individual (except in the case of Class, Group and Small Group Physiotherapy Consultations).

4. Electronic Claiming

HBF members are able to claim benefits for selected Ancillary Services directly utilising Electronic Claiming.

The terms and conditions of use for your Electronic Claiming Service Provider should be read in conjunction with and are supplementary to these HBF Provider Registration Requirements.

Please be aware that failure by a provider to adhere to conditions set out in either the Electronic Claiming Service Providers terms and conditions (where applicable) or the requirements set out in this document may result in the suspension of the ability to submit electronic claims and/or HBF cancelling a providers registration or issuing a compliance notice pursuant to HBF Fund Rules E.3.3.6 and E.3.3.7 respectively.

4.1. Authority to Claim via Electronic Claiming

It is important that you ensure that the member making an electronic benefit claim matches the member that has been issued the HBF member card. This is the member whose name appears on the front of the member card.

Additionally, it is essential that a member making an electronic claim, whether for themselves or a dependant named on the card, has signed the reverse side of their HBF member card, and that this signature matches that given by the member on an electronic claim transaction receipt. A member with an unsigned member card cannot make claims electronically.

Please check the member's card for a signature before processing an electronic claim, a member must have a signed card to be entitled to claim electronically.

4.2. Suspension of Electronic Claiming

HBF can, at its discretion, suspend a provider from performing electronic claims for HBF members. A provider that has been suspended from performing electronic claims by HBF will be notified by mail. This action will generally take place if HBF identifies inappropriate use of the Electronic Claiming terminal by a provider.

5. Issuing Accounts for Member Benefits

5.1. HBF's Account Information Requirements – Electronic Claims

HBF requires the following information to be correctly entered when processing the members claim via Electronic Claiming:

- The member number as it appears on the HBF member card
- The member, partners and dependants as listed on the rear of the card
- The provider. Note *(Although arrangements can be made for all payments to be made to the principal provider the service must be reflected against the provider conducting the service)*
- Item number for service(s) rendered (*the item number must accurately reflect the service rendered*)
- Date on which the service was provided. (*HBF does not pay benefits in advance for services being provided*)
- Fee charged for the particular item of service. Any discounts (*including services with no charge*) provided to the patient must be reflected in service costs entered into the electronic claiming terminal.

Where there is more than one provider at the practice and the patient has seen one or more providers during the same visit, a separate account for each provider should be issued.

Any request by HBF for records regarding a benefit that was paid electronically will be made in accordance with the terms and conditions governing that providers registration under HBF Fund Rules and their Electronic Claiming Service Provider

5.2. HBF's Account Information Requirements – Manual Claims

HBF has developed an example of an acceptable account, which includes all the information required by HBF to promptly manually process a member's claim. Where providers' accounts do not include the required information, providers will be notified and requested to alter their accounts within a set time period. Where a provider does not comply with such a request HBF may issue a compliance notice pursuant to HBF Fund Rules E.3.3.6 which may result in cancellation of a provider's registration pursuant to HBF Fund Rules E.3.3.7.

ACCOUNT EXAMPLE Member Name Address (5)			Provider Name (1) Address (2) Telephone Number (3) Fax Number (3) Provider Number (4)		
Item Number (6)	**Item Description (7)**	**Name of Member (8)**	**Date of Service (9)**	**Charge (10)**	**Provider (11)**

Required Account Information

1. Full name of provider conducting the service
2. Address of providers practice where the service was rendered (no PO Box numbers)
3. Provider's practice telephone number and/or fax number
4. Provider number. Ensure the provider number shown is the number registered for that location and relates to the person providing the service. Where there is more than one provider at a surgery, it is important to clearly specify the provider number of the provider who has conducted the service (see item 11)
5. Name and address of person(s) responsible for the account (in full)) Note *(In the case of a dependant this may be different to the member treated)*
6. Item number for service(s) rendered (the item number must accurately reflect the service rendered and in the case of dental treatment also show the tooth number where relevant)
7. Item Description
8. Full name of member to whom service was rendered
9. Date on which the service was provided. (*HBF does not pay benefits for services not yet provided*)
10. Fee charged for the particular item of service. Any discounts (including services with no charge) extended to the patient must be reflected on the account.
11. Where there is more than one provider at the practice and a separate account for each provider is not issued, please indicate the provider of the service rendered

When a paid account is received by HBF, a payment is made directly to the member. When an unpaid account is received by HBF the payment will either directly credited into the providers account or a cheque will be drawn in favour of the nominated provider and posted or given directly to the member.

It is the responsibility of the member to remit the payment to the provider together with any outstanding balance, and it is the provider's responsibility to obtain that payment.

We request that you review this required information with your practice staff in order that they may be fully aware of the account information required by HBF. HBF consider the provider and not their employees to be solely responsible for account errors. Should you or your staff have any questions regarding your account format please contact HBF Provider Registration.

5.3. Recommendations for Account Presentation – Manual

The following recommendations will assist us to reduce the number of queries raised by HBF and in turn result in accelerated payments to our members and/or providers.

1. Computer generated accounts/receipts must be identifiable as originating from the provider and should be on preprinted stationery or stamped with provider details.
2. Computer generated, duplicate or altered accounts/receipts must be signed by the provider or an authorised person.
3. Where a second copy of an account/receipt is required, for whatever reason, it should be endorsed "***copy account/receipt***" and signed by the provider or an authorised person.
4. Hand written accounts must be legible and written in English.

5.4. Accounts That Cause Processing Delays – Manual

The following are examples of accounts that may cause delays in processing and which therefore, may cause delays to the provision of payments.

1. Tax invoices/receipts, which are purchased at a news agency (unless it has an official endorsement, e.g. rubber stamp with profession, provider number, name and address of provider)
2. Altered tax invoices/receipts
3. Use of correcting fluid

Altered tax invoices/receipts will only be considered for HBF benefit when duly endorsed with the original signature (not initials) by the provider who has rendered the service. These may still be subject to a query from HBF as to the authenticity of the amendments.

5.5. Fee Discrimination

Although HBF understands that providers are often bound to multiple service schedules of fees and that this may result in different fees for patients that are members of different Private Health Insurers, unless subject to a separate agreement it is not acceptable practice for different fees to be charged to patients that are HBF members.

HBF has adopted the policy that it is unacceptable practice to raise different fees for insured and uninsured members or indeed members with different levels of HBF cover.

Where there is evidence of fee discrimination, HBF will seek a specific explanation as to why the discrimination occurred.

An unsatisfactory explanation may result in HBF issuing a compliance notice pursuant to HBF Fund Rules E.3.3.6 which may result in cancellation of a provider's registration pursuant to HBF Fund Rules E.3.3.7.

6. Fraud

Fraudulent/inappropriate claims, whether written or electronic, have the potential to substantially increase the costs incurred by HBF.

HBF has a moral and legal obligation to investigate possible fraudulent/inappropriate claiming activities and to pursue the prosecution of any individuals believed to be engaged in fraudulent activities.

HBF may determine whether a provider has engaged in unlawful, improper or unprofessional conduct, may declare that provider as an unacceptable provider and may cancel the provider's registration. In making that determination HBF may have regard to, but is not obliged to have regard to, how a court, relevant statutory board or tribunal or professional association may view the facts under consideration,

Please refer to Section 8 Important Rules Governing your Provider Registration.

6.1. Your Responsibility

It is the responsibility of the provider to educate all staff in the correct presentation of all documentation.

All providers have a responsibility to ensure that all documentation, including clinical records and accounts, are maintained in a true and accurate manner.

6.2. Common Types of Fraud

Experience has shown that providers and HBF members are not always aware of what constitutes fraud or inappropriate claiming. In relation to claiming benefits, fraudulent or inappropriate behavior is defined as the member or provider, individually or in collusion, knowingly or recklessly giving, supplying or providing information, whether written, electronic or verbal, that is intended or likely to mislead HBF into paying a level of benefit to (or on behalf of) the member, to which they would otherwise not be entitled. Misleading information on accounts/receipts may include

- Treatment not actually provided
- Incorrect itemisation/description of treatment
- Incorrect dates the services were completed
- Incorrect patient name
- A fee for a service that was not what the patient was actually charged e.g. the patient was charged less than the fee documented on the account, however the 'discount' given to the patient was not disclosed on the account
- Incorrect provider identification

The result of such behavior is the payment of invalid/inappropriate claims. This leads to increased costs, which affect the overall viability of HBF, and ultimately leads to increased member premiums.

It is essential that providers are aware of the importance of supplying accurate information relating to claims for benefits and that where as a result of such billing HBF may look to recover losses from the provider.

7. Audit Procedures

HBF conducts regular reviews of its claims database in order to determine the treatment patterns of individual providers as well as groups of providers.

This information is reviewed primarily by the HBF Group Loss Prevention & Awareness team. On some occasions during these reviews, it is necessary to seek further information from providers in regard to particular claims or their treatment profiles.

These requests are usually made in writing and it is a condition of registration as a provider that you comply with these requests and co operate in good faith with HBF. Failure to comply with such requests may result in HBF issuing a compliance notice pursuant to HBF Fund Rule E.3.3.7.

During a review HBF may, depending on the nature of the review, contact members subject to the claim. The health care provider may not always be contacted prior to such an approach to the member.

A health care provider registered with HBF is considered responsible for any actions by staff members or locums who are practising under his/her provider number.

7.1. Clinical Records

All providers registered with HBF are required to keep and maintain clinical records of treatment provided to HBF members. These clinical records are to be maintained in English and include the date of service as well as the relevant details of the service rendered in accordance with accepted principles of professional practice and the relevant professional or registration body requirements. Records should be retained in accordance with relevant legal requirements.

7.2. Access to Clinical Records

Providers that are registered with HBF must comply with the authority obtained by HBF from the member and/or any dependants on the membership to obtain information including clinical records and other information integral to the raising of the account for benefit purposes. This authority may be obtained from a number of documents, including the HBF claim form, cash claim advice or cheque claim advice, or in the case of electronic claims, the applicable terms and conditions of the Electronic Claiming Service Provider to release information regarding the claim and the signing of the consent contained within the electronic claims receipt.

HBF takes its Privacy obligations very seriously and will ensure that it complies with the Privacy Act and National Privacy Principles in carrying out audits and requesting clinical records.

Failure to maintain and produce such records on request by HBF (with the relevant proper member authorisation) in accordance with the terms and conditions governing that providers registration and with their Electronic Claiming Service Provider, may result in HBF issuing a compliance notice pursuant to HBF Fund Rule E.3.3.7.

8. Important Rules Governing your Provider Registration

The registration of a provider with HBF is governed by the HBF Fund Rules. Below is a summary of your rights and obligations within the Fund Rules which can be found in full at www.hbf.com.au

8.1. Registration as a Provider

Benefits are not payable for treatment unless the provider is registered as a provider with HBF. The decision whether to register a provider is at the absolute discretion of HBF.

To become registered, a provider must complete an application form or submit their Medicare Australia letter to HBF Provider Registration, for each location at which they intend to practice.

Registration may be granted by HBF subject to certain conditions specified from time to time, such as the requirements set out in this document. Conditions may be imposed at the time a provider is registered and at any time while the provider remains so registered. These conditions may include, but are not limited to, requirements in relation to billing and accounting, the provision of treatment records and the repayment of benefits paid to the provider contrary to HBF Fund Rules.

8.2. Withdrawal of Registration

HBF may cancel the registration with HBF if the provider has not complied with conditions specified by HBF arising from

- The requirements set out in this document and any other document describing the relationship between HBF and the provider.
- The regulations of the applicable Electronic Claiming Service Provider.
- Any HBF Fund Rules.
- Any other requirements as advised by HBF from time to time.

When a provider has not complied with HBF's conditions, the following process will apply

- HBF will serve a formal written notice requiring compliance with the conditions
- Failure to comply with this notice will entitle HBF to cancel the registration of the provider.
- Within 7 days after the notice declaring that the registration is cancelled, HBF will notify the provider that the registration has been cancelled and that no benefits will be payable to HBF members for services provided later than 2 months after the declaration date.
- Within 14 days of cancellation of registration HBF will notify relevant HBF members who have received services from the provider within 1 year prior to the declaration of the decision to cancel registration ad that benefits are no longer payable

8.3. Reinstatement of Cancelled Registration

When HBF has cancelled registration in accordance with the above process, a provider may, subject to any time restrictions imposed at the time of cancellation apply to HBF Provider Registration, in such form and accompanied by such evidence as required by HBF, to re register as a provider. The provider will need to demonstrate that the reasons for cancellation no longer exist. The decision whether to re register the provider is at the absolute discretion of HBF.

Re registration may be granted by HBF subject to certain conditions specified from time to time.

Throughout this process, HBF may communicate with the providers relevant board or associations in order to ensure that they are fully aware of events. HBF may also invite the board/association to make a submission on behalf of a provider whose registration with HBF is subject to review.

8.4. Unacceptable Providers

If:

a) a provider is found by any court, relevant statutory board or tribunal or professional association to have; or

b) HBF is otherwise satisfied that a provider has,

engaged in unlawful, improper or unprofessional conduct, HBF may declare, in its absolute discretion, that provider to be unacceptable and cancel the provider's registration. For the avoidance of doubt in determining whether a provider has engaged in unlawful, improper or unprofessional conduct, HBF may have regard to, but is not obliged to have regard to, how a court, relevant statutory board or tribunal or professional association may view the facts under consideration.

This procedure is reserved only for serious matters. Hence, generally, HBF would not make such a declaration unless the provider has been found guilty of unprofessional conduct by the relevant board or association or any court or HBF has determined the provider has acted fraudulently or inappropriately or repeatedly refused to follow HBF's directions to rectify conduct. In addition, before such a declaration is made, the provider concerned, will be given the opportunity to provide in writing reasons why such a declaration should not be made.

Where a provider has been declared an unacceptable provider by HBF, the following process will apply

- Within 7 days after the notice declaring that the provider is an unacceptable provider, HBF will notify the provider that decision and that no benefits will be payable to HBF members for services provided later than 2 months after the declaration date
- HBF will within 14 days of declaration notify HBF members who have received services from the provider within 1 year prior to the declaration of the decision to no longer pay benefits.

8.5. Removal of Unacceptable Provider Status

When HBF has declared a provider an unacceptable provider in accordance with the above process, a provider may, (subject to any time restrictions imposed at the time of being declared unacceptable) apply to HBF Provider Registration in such form and accompanied by such evidence as required by HBF to revoke the declaration as an unacceptable provider.

The provider will need to demonstrate that the reasons for declaration as an unacceptable provider no longer exist. The decision whether to re register the provider is at the absolute discretion of HBF. Revocation of a declaration may be granted by HBF subject to certain conditions specified from time to time.

In some cases HBF may take into consideration any periods of suspension imposed by the relevant Registration Board when it is determining the length of time a provider should be deemed an unacceptable provider.