From the end of November 2019, nib introduced upfront claiming rules that we hope makes it easier for providers to claim correctly, reduces auditing and improves the member's experience.

From this time if you submit a claim and/or eligibility check that falls outside of these rules your claim may be declined. You will then need to resubmit the claim once billed correctly.

To assist you to understand the possible reasons claims may be declined we have created a table to be used as a guide. Please note this does not list all possible reasons.

Response Description	**Possible Reason for claim (item) being declined**
Pros. Item charged exceed number allowed	Prosthesis replaced within Warranty Period
Charge raised does not match contract	Fixed price service billed incorrectly SDEX rate not charged as per contract Type C theatre charged incorrectly
Date of service exceeded period from contract	Claim received was greater than agreed payment terms
No benefit amount charged invalid	Claim has too many theatre items to be submitted via Eclipse – resubmit manually
Item/service is intrinsic to items paid	MBS billed not in accordance with the MBS description or billing guidelines
Item not paid by Medicare – nil benefit	
Items cannot be claimed together	
Length of procedure requirements not met	
No benefit prerequisite service required	
Service exceeds number of times permitted	
Date of service cannot be claimed together	
No benefit age restriction applies	

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Response Description	Possible Reason for claim (item) being declined
Time in theatre requirement not met	The claim has not met the minimum time in theatre required in accordance with the HPPA for the rates claimed
Length of admission requirement not met	The claim has not met the minimum length of admission required in accordance with the HPPA for the rates claimed
Multidisciplinary treatment requirement not met	The claim has not met the minimum requirements for multidisciplinary treatment in accordance with the HPPA for the rates claimed
Too many procedures	The claim has more than 14 procedures, please submit claim manually
No benefit prerequisite service required	Disposable item billed without applicable MBS
Medical certificate required	Claim submitted without required certificate
No benefit - benefit previously paid	Claim previously paid (including where bundled into another claim)
Claim not payable item number listed as Band 1 only	Claim not payable as Band 1 rates required for same day Type B or C item.
Coding submitted does not support ECT chrg raised	Procedure codes for ECT are not present in coding.
Palliative Care Days indicated	Where for medical accommodation has been billed but the provider had Palliative care rates
No benefit payable prosthesis coding not present in episode	A prosthesis has been claimed and the MBS and/or ACHI provided do not match and support billing