Certification Criteria - iClient - Health

This document specifies the minimum criteria that needs to be met by the implementation of each the given features from the Tyro integration feature-set, for the PMS integration to be considered fit for certification.

Given below is a summary of the health feature-set along with the requirement level associated with them

Features	Requirement level (Optional/Compulsory/Recommended)
Basic Purchase/Refund features	
Integrated Purchases*	**Compulsory**
Integrated Refunds*	**Compulsory**
Integrated Receipts	Optional
POS Information*	**Compulsory**
Integrated Surcharging*	**Highly Recommended**
Integrated Reports	Optional
Integrated Manual Settlement	Optional
Tyro Settings Page	**Compulsory**
Value-add features	
Integrated Split Payments	Optional
Headless Pairing	**Compulsory**
Headless transactional User Interface (UI)	Optional
Health features	
Integrated Multi-Merchant*	**Compulsory**
Healthpoint claims	Optional
Healthpoint claim cancellation	**Compulsory**
Healthpoint Rebate estimate	Optional
Healthpoint Preferred providers (ICD codes)	Optional
Medicare Easyclaim - Fully-paid	Optional

Medicare Easyclaim - Part-paid	Optional
Medicare Easyclaim - Bulk-billed	Optional
Technical Features	
POS Information	**Compulsory**
API key configuration	**Compulsory**

Feature descriptions and examples

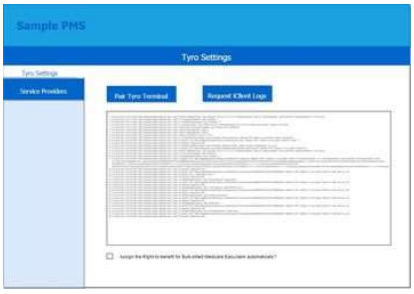
Each of the Tyro integration features from the feature-set must meet a certain criteria in terms of functionality, workflow, and outputs/end result delivered to stand eligible for certification for a given feature. This section defines each feature in terms of their functionality, and gives specific examples of the deliverables that the PMS must provide, as well as the ideal end-result that is to be achieved.

Tyro Settings Page

The Tyro settings page is a compulsory feature for your POS integration which is designed to provide a simplified, unified interface allowing all Tyro settings to be toggled from a single location within the POS UI. This will not only make it easier for our mutual merchants to change the settings for themselves, but also for our Customer support department to provide support for your POS system. The criteria is as follows:

1. The Settings section UI within your POS contains a “Tyro settings“ page.
2. This page contains the following:
    1. The Tyro Pairing UI allowing the pairing process to be initiated, and handled.
    2. A mechanism e.g. a button and iframe to display the Tyro iClient logs on the POS UI. the mechanism can also be a button that has a link to the iClient logs web page

A sample UI can be seen below:



Integrated Multi-Merchant.

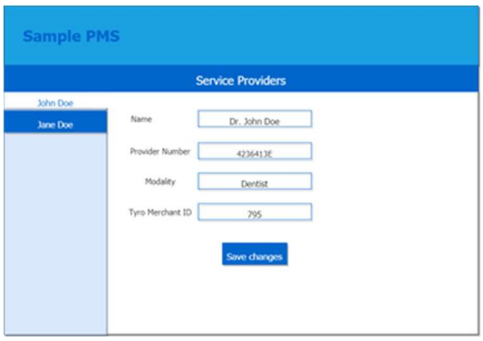
Integrated multi-merchant is a mandatory health feature from the Tyro integration feature suite. Integrated multi-merchant essentially allows the PMS to explicitly specify the merchant ID (MID) and the terminal ID (TID) in the claim or transaction request, the merchant IDs on the terminal are linked to individual bank accounts, this allows the merchant to process transactions with multiple merchant IDs for multiple service providers and settle into multiple bank accounts.

In terms of workflow and deliverables, the criteria for the multi-merchant feature is given below:

1. The PMS must have a mechanism within the interface that allows provider details to be specified, provider details must include the following at a minimum:
    1. The service provider's name.
    2. The Medicare provider number for the service provider.
    3. The service provider's type or modality (for Healthpoint only)
    4. The Tyro merchant ID for the service provider.
    5. **Optionally**, The Tyro terminal ID for the service provider if the PMS is storing the integration keys for the individual pairings made.

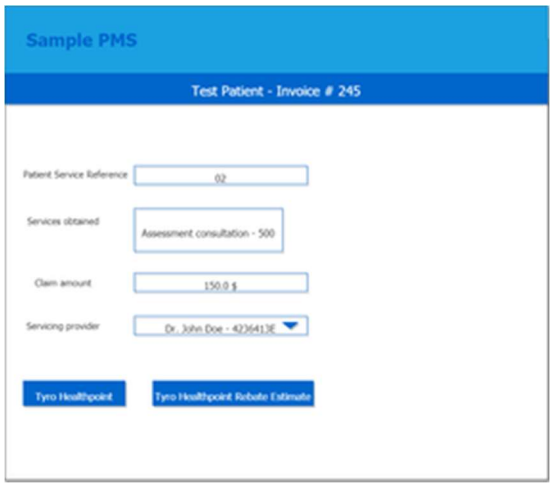
    Please note that this entails an implementation of the "Headless Pairing" feature - the list of criteria items that apply to headless pairing can be found here.

    A variety of approaches can be chosen for the user interface constructs, however, an example is given below:



    An example, if multiple terminal pairing credentials are being allowed:

2. The PMS must also have a suitable mechanism through which the the servicing provider for the claim or transaction can be chosen by name and provider number, an example is given below where this has been implemented through a drop-down menu from which the servicing provider can be chosen at the time of processing the claim.



3. The PMS must have suitable validation rules and an input mask applied to the provider number fields:
    1. The validation rules must prevent the input of special characters, spaces, and alphabets in the body of the provider number, and display a suitable error message advising the user that the provider numbers must be between 1 and 5 characters and be numerical only should they attempt to input these in the item number field.
    2. The validation rules must parse out any leading and lagging spaces.
    3. The input mask must dictate that the provider number must be 8 characters with the first 7 characters being numbers and the last being an upper-case alphabet - NNNNNNNA e.g. 4236413E
    4. The validation rule must also enforce that zero padding is not allowed.
4. The PMS must use the `mid` and `tid` parameters in the `requestParams` object of the claim or transaction request to specify the MID and TID associated with the chosen provider in the claim or transaction request. These parameters are present in all the relevant functions for:
    1. Purchase - `initiatePurchase ( requestParams transactionCallbacks )`
    2. Refund - `initiateRefund ( requestParams transactionCallbacks )`
    3. Healthpoint claims - `initiateHealthPointClaim ( requestParams transactionCallbacks )`
    4. Rebate estimate - `initiateHealthPointRebateEstimate(requestParams, transactionCallbacks)`
    5. Medicare Easyclaim - `initiateFullyPaidEasyclaim ( requestParams transactionCallbacks ) , initiatePartPaidEasyclaim ( requestParams transactionCallbacks ) , initiateBulkBillEasyclaim ( requestParams transactionCallbacks )`
5. When refunding amounts e.g. the gap amount paid by a patient on an Healthpoint claim the user must not have the ability to refund to a different Merchant ID, and must use only the Merchant ID that the associated purchase transaction was made with.

Healthpoint

Healthpoint claiming is an optional health feature from the Tyro integration feature suite. It allows Tyro merchants to make integrated claims with private health funds and pay any outstanding gap amount through their Tyro terminals.
In terms of workflow and deliverables, the criteria for the Healthpoint feature is given below:

1. The PMS requires the following fields to make a Healthpoint claim:
    1. Health Fund membership number – this is obtained from the patient's Health Fund card being swiped through the terminal.
    2. The service type or modality (the `serviceType` parameter in the `requestParams` object)
    3. Family member number (the `patientId` parameter in the `requestParams` object) – the 2 digit number on the front or rear of the membership card corresponding to this patient
    4. Service Provider number (the `providerId` parameter in the `requestParams` object) – unique Medicare or Health fund supplied no. associated with the Health provider at this point of service
    5. Date of service (the `serviceDate` parameter in the `requestParams` object)
    6. Service Item(s) number(s) (the `serviceCode`parameter in the `requestParams` object) and associated cost of service(s)
    7. Body part number or Tooth number associated with service item where applicable (the `serviceReference`parameter in the `requestParams` object)

    Barring the Health fund membership card number all other parameters must be specified in the PMS, the PMS must therefore contain reasonable means for the storage and declaration of these items when creating a claim, the parameters pertaining to the claim and the patient (c,b,e,g) must be specified when compiling the invoice for the claim, the provider number (d) can be specified as per point 1 from the **Integrated Multi-merchant section** above when making the claim, the service items (f) for the claim and their cost must also be specified at the time of the claim, the PMS must also have a list of stored service items per modality supported.
2. The PMS must have the option to have only one modality or service type specified per claim - a single Healthpoint claim can not have multiple modalities.
3. The PMS must have suitable validation rule/s on the `serviceDate` field (if the field is editable) that prevent future-dated claims from being transmitted, this is a Healthpoint and private health fund requirement, the service date must not be in the future. The PMS must display a suitable error message or notification advising the user of the same. The PMS must display a suitable error message or notification advising the user of the same if the user attempts to set the date as such.
4. The PMS must have suitable validation rule/s on the `serviceDate` field (if the field is editable) that prevent claims back-dated more than 12 months from being transmitted, this is a Healthpoint and private health fund requirement, the service date must not be in more than 12 months in the past. The PMS must display a suitable error message or notification advising the user of the same if the user attempts to set the date as such.

5. The PMS must have suitable validation rules on the the health fund item number fields (if the field is editable):
    1. The validation rules must prevent the input of special characters and alphabets, and display a suitable error message advising the user that the item numbers must be between 1 and 5 characters and be numerical only should they attempt to input these in the item number field.
    2. The validation rule must also enforce that zero padding is not allowed.
6. Healthpoint claims involve a potential payment of any gap amount that remains outstanding once the claim has been made, the PMS must develop and implement a suitable workflow that allows for:
    1. The claim to be made through the Tyro terminal.
    2. **If the claim is 'Approved' by the health fund:**
        1. The PMS to update the outstanding amount using the `healthpointGapAmount` field from the `transactionCompleteCallback` response.
        2. If applicable, The PMS to subsequently obtain any outstanding amount through the standard payment methods offered including an integrated Tyro EFTPOS purchase transaction, before closing the invoice.
    3. **If the claim is 'Rejected' by the health fund:**
        1. The PMS must revert back to the claim screen so that either the claim can be filed again with any required adjustments made or the patient can choose to make no further claim submissions, pay the full service fee, and file the claim directly with their health fund.
7. The PMS must use the `healthpointRefTag` field from the `transactionCompleteCallback` of the `initiateHealthpointClaim` request and include it in the `healthpointTransactionId` field in the subsequent gap payment request if the gap payment is being done through the Tyro terminal. an example is given below
    1. A Healthpoint claim is made with the following response being returned showing a $ 50.0 gap to be paid:


```
{
    "result": "APPROVED",
    "transactionId": "c312560986e08e48fee8644b253037e1ccf3",
    "healthpointRefTag": "0946923",
    "healthpointTotalBenefitAmount": "100",
    "healthpointSettlementDateTime": "20210420132034",
    "healthpointTerminalDateTime": "20210420132034",
    "healthpointMemberNumber": "0000000000",
       "healthpointProviderId": "4334433F",
       "healthpointServiceType": "D",
       "healthpointClaimItems": [
           {
               "claimAmount": "100",
               "rebateAmount": "100",
               "serviceCode": "00001",
               "description": "SKULL XRAY",
               "serviceReference": "01",
               "patientId": "02",
               "serviceDate": "20210420",
               "responseCode": "0000"
```

```
            }
        ],
        "healthpointGapAmount": "50",
        "healthpointPhfResponseCode": "00",
        "healthpointPhfResponseCodeDescription": "APPROVED",
        "healthpointHealthFundName": "ISOFT FUND",
        "healthpointHealthFundIdentifyingDigits": "0099"
    }
```

29. The subsequent gap of $ 50.0 is paid off via the following purchase transaction:

```
    initiatePurchase({amount: "5000", integratedReceipt: false,
mid: 795, tid: 12, healthpointTransactionId: "0946923"}, {
        statusMessageCallback: yourPosCode.handleStatusMessage,
        questionCallback: yourPosCode.handleQuestion,
        receiptCallback: yourPosCode.handleReceipt,
        transactionCompleteCallback: yourPosCode.handleComplete
});
```

8. Healthpoint claims contain claim item details as a JSON string in the `claimItems` parameter in the `initiateHealthpointClaim()` request. This JSON string is then encoded into XML by the Tyro API when the PMS submits the request, when submitting the request the PMS must ensure that the JSON string contains the following XML-safe parsed versions of these characters so that the JSON string is XML-safe.

character	XML parsing
<	<
&	&
>	>
"	"
'	'

9. The PMS must only allow refunds of gap payments only, the refund of the total claim amount i.e. claim amount + benefit/rebate amount must not be allowed.
10. The PMS must only allow up to and inclusive of a maximum of 16 items in a single claim, if there are greater than 16 items in a claim the PMS must either split the claim into multiple claims (each with a maximum of 16 items per claim), or a suitable error message/notification be displayed advising the merchant that no more than 16 items can be claimed in one claim request.
11. Any claim reports and claim invoices developed by the partner within the PMS for Healthpoint must clearly identify and record the following data items:
    - Servicing Provider's name.
    - Servicing Provider's provider number.
    - Health fund name.

- Claim modality.
- Service Date.
- Service description/s and item number/s claimed for.
- The total claim amount, benefit amount, and gap amount clearly labelled.
- Result e.g. 'Approved'.

Healthpoint Rebate Estimate

Healthpoint Rebate Estimate is a mandatory health feature from the Tyro integrated health feature suite. Healthpoint rebate estimate feature allows merchants to retrieve an estimate of the gap amount for a health point claim. It functions in very much the same way as a normal Healthpoint claim with the only difference being that the claim is not finalized and no transfer of funds occurs.
In terms of workflow and deliverables, the criteria for the Healthpoint Rebate Estimate feature is given below:

1. There must be a separate button on the interface that is used to initiate a Healthpoint Rebate estimate, the button must be labeled suitably e.g. ‘Healthpoint Rebate Estimate’, 'Health fund claim estimate'.
2. The term “quote” must not be used to refer to the Healthpoint rebate estimate feature within the PMS menus, interface, workflows, or specification.
3. Please ensure that the rebate estimate request is initiated using the `initiateRebateEstimate()` function and that this workflow does not trigger a Healthpoint claim.
4. The rebate estimate response will be displayed to the user on the interface, please ensure that the workflow takes the user back to the invoice screen from where the user can initiate the Healthpoint claim.
5. If the rebate estimate responses are stored in the PMS, they should be stored in such a way that they are clearly identified as rebate estimate requests and distinguished from claim requests.

Healthpoint Claim Cancellation

Healthpoint claim cancellation is a mandatory, but recommended feature for Healthpoint integration. This feature allows the PMS to request for the cancellation of a completed Healthpoint claim with the Health fund.
The following criteria applies to this feature:

1. The claim cancellation must be requested using the `cancelHealthpointClaim(requestParams, tranasctionCallbacks)` function.
2. The original claim’s reference tag must be included in the `healthpointRefTag` parameter of the claim request.
3. The PMS workflow must have suitable measures in place to ensure that the claims are marked as cancelled once the cancellation has been confirmed, and any gap amount

refunded back to the merchant using the same payment type that the original purchase was made using.

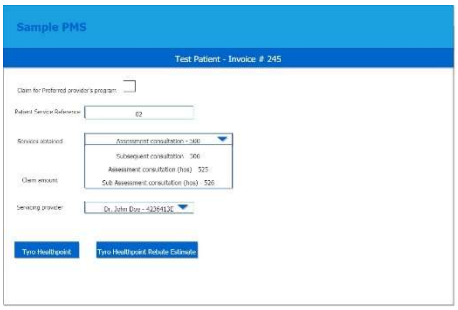
Healthpoint preferred providers (ICD codes)

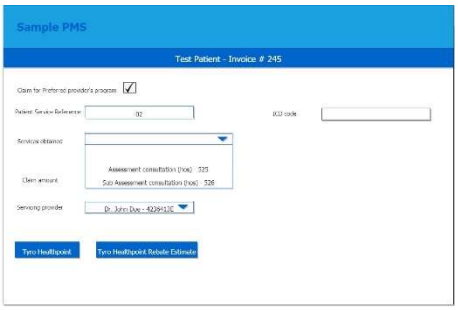
Preferred providers programs may reduce or eliminate out-of-pocket gap payments when ICD codes are provided as part of the health claim. PMS providers will need to make sure their software can handle the ICD code in the Tyro HealthPoint request and response. The HCF 'More for' program is an example of such a claim where an ICD is required. Please see below for our implementation guides. To certify your PMS product for Preferred providers, please contact partner support at integrationsupport@tyro.com.
It is required Tyro HealthPoint be able to receive additional PMS data for initial consult claims to support Provider participation in programs such as but not limited to the HCF More For program.

Submission of this data may facilitate a 'No-Gap' assessment by HCF for their members:

The following criteria applies to this feature:

1. Only selected items are valid and eligible for Preferred provider programs (ICD codes), there must be appropriate validation on the interface constructs to ensure that only eligible items can be chosen for any given modality if the claim is being made for the preferred providers program, an example is as given below:





In the example above, it can be seen that there is a checkbox that is used to determine whether the claim is for the "preferred providers" program, it can be seen that when the checkbox is unchecked, the ICD code field is unavailable and all relevant item numbers are available, in the second image, when the preferred providers checkbox is checked, the ICD code is required and the field becomes available, only item numbers eligible for the preferred providers program remain available in the item numbers list.

2. Two claim items need to be specified in the `payload`, there must be appropriate interface constructs that allow for the ICD code to be specified in the `serviceCode` element of the `claimItems` array for the second item.
3. The `serviceReference` for the second claim item is required to be 'ZZZ' there must be appropriate interface constructs that allow for this take place.

4. The`description` field of the `claimItems` array for the second claim item can not be blank or a null value, please ensure that it is populated with a suitable description e.g. *"ICD code item"*.

Medicare Easyclaim

Medicare Easyclaim is an optional health feature of the Tyro integration feature suite, Medicare Easyclaim using Tyro allows patients to make fully-paid, partially-paid, or unpaid claims for services obtained with Medicare Australia, with the both the payments being obtained and the claims being filed through the Tyro terminals.

In terms of workflow and deliverables, the criteria that broadly applies to all Medicare Easyclaim feature is given below:

1. A minimum set of parameters are required to perform a Medicare Easyclaim, these are:
    1. Patient's Medicare Card details - the 10-digit `memberNum` element of the `patient` node in the `payload` request XML
    2. Family member number – the 1 digit number on the front of the Medicare card corresponding to this patient found in the `memberRefNum` element of the `patient` node in the `payload` request XML.
    3. Service Item(s) number(s) and associated cost of service(s) - the 6 character alphanumeric `mbsItemNum` and the 7 digit `chargeAmount` element of the `service` node in the `payload` request XML.
    4. Provider number which is the unique Medicare or Medibank private supplied number associated with the Health provider at this point of service - the 8-character `providerNum` element of the `servicingProvider` node in the `payload` request XML
    5. Date of Service - the 8 character date element `dateOfService` from the `service` node in the `payload` request XML specifying the date of service.
    6. Service type - the 1 alphabet `serviceTypeCde` element of the `claim`node in the `payload` request XML specifying the type of service.

    All of the above parameters must be specified in the PMS, the PMS must therefore contain reasonable means for the storage and declaration of these items when creating a claim, the parameters pertaining to the claim and the patient (c,e,f) must be specified when compiling the invoice for the claim, the provider number (d) can be specified as per point 1 from the **Integrated Multi-merchant section** above when making the claim, the service items (c) for the claim and their cost must also be specified at the time of the claim, for storage the PMS must also have a list of stored service items. Patient details such as patient name, Medicare Card details, and Family member number (a,b) must be declared in the claim and for storage must have a separate patient details list.
2. The PMS must have suitable validation rules and an input mask applied on the the Medicare item number fields:
    1. The validation rules must prevent the input of special characters and alphabets, and display a suitable error message advising the user that the item numbers must

be between 1 and 5 characters and be numerical only should they attempt to input these in the item number field.
    2. The validation rule must parse out leading or lagging spaces.
    3. The input mask must dictate that the item number must be no more than 5 digits in length.
3. The PMS must have suitable validation rules and an input mask applied on the the Medicare card number fields for patients:
    1. The validation rules must prevent the input of special characters and alphabets, and display a suitable error message advising the user that the card numbers must be 10 characters in length and be numerical only should they attempt to input these in the card/patient number field.
    2. The validation rule must parse out all spaces, leading, lagging, as well as in-body spaces.
    3. The input mask must dictate that the card number must be 10 digits in length and be numerical only.
4. The PMS must have suitable validation rules and an input mask applied to the provider number fields:
    1. The validation rules must prevent the input of special characters, spaces, and alphabets in the body of the number, and display a suitable error message advising the user that the provider numbers must be between 1 and 5 characters and be numerical only should they attempt to input these in the item number field.
    2. The validation rules must parse out leading and lagging spaces.
    3. The input mask must dictate that the provider number can be 8 characters with the first 7 characters being numbers and the last being an upper-case alphabet - NNNNNNNA e.g. 4236413E.
5. The PMS must adhere to the following Medicare business rule requirements regarding the item numbers that can and can not be claimed through Medicare Easyclaim.

Rule Number	Services Not Accepted Through Easyclaim	Medicare Clarification of Business Rule and Interpretation
1	In-hospital items	
2	Australian Childhood Immunisation Register (ACIR) information	
3	bulk bill claims more than two years from date of service	
4	patient claims more than two years from date of service	

5	time duration dependent items	Time dependent duration item numbers relate to the Relative Value Guide (RVG) structure, which is based on a unit system to reflect the complexity of the service and the time taken in a procedure. Eg, Anaesthetic items, 21482, 23043, 22031 If your require further information, please see the Medicare Benefits Schedule link. http://www.mbsonline.gov.au/
6	Notional charges (e.g. provider has raised a total charge to cover a group of services)	
7	Patient claims for pathology items excepting Group 9 items	Item numbers 73801-73837 are claimable through Medicare Easyclaim, all other pathology item numbers in category 6 are not claimable through Medicare Easyclaim Self-deemed code SD = self-deemed SS = substituted service SD is an optional element. However, conditions apply depending on the SD value selected. SD applies to both pathology and diagnostic claims. When the SD value is present, request details **cannot** be set. Pathology claims may only have an SD indicator. SS only applies to diagnostic claims. When the SS value is present, request details **are** required. There may be claims where neither the request details nor request override type code are set, instead a self-deemed value of SD applies. *Pathology item numbers 73801-73837 are basic simple tests that can be performed at the premises of the practice. As they are simple basic tests Tyro does not need to be accredited for these item numbers (Category 6 Pathology Services, Group 9 Simple Basic Pathology tests). However for all other pathology item numbers that can be transmitted through Medicare Easyclaim, Tyro will need to obtain accreditation for pathology.*

8	Bulk bill pathology items which are self deemed or Rule 3 exemptions	*See response above for Rule Number 7*
9	Patient claims and bulk bill claims with non-standard referrals	A 'Standard referral' is a current and valid referral from a GP which has a 12 month/Indefinite duration or from a Specialists which has a 3 month referral period. To claim through Medicare Easyclaim the referring Dr must have a current and valid registration and provider number at the date of referral. Other referral types such as Emergency, Lost, etc are accepted just not the one called 'Non-standard'. e.g. An Emergency referral is used for patients who were seen in hospital and who requires an urgent outpatient appointment with either a Specialist, Allied Health professional or a consulting physician. An emergency referral must have 'emergency' stated on the referral letter or discharge letter. A lost referral would be used in conjunction with a standard referral where the original referral was lost. A 'non-standard' referral is a referral letter without any referral periods. A 'non-standard' referral letter will not be accepted through Medicare Easyclaim as the referral has no date and duration of referral.
10	Items where the charge exceeds $9999.99	
11	GP multiple attendance items (e.g. MBS item 24, 35 etc)	Any GP consult item number that requires the number of patients seen is not claimable through Medicare Easyclaim. Example: If a GP visits a nursing home and sees 10 patients on the one occasion they will not be able to transmit those claims through Medicare Easyclaim.

12	Separate sites override—unless the item is listed under Restrictive override code in the 'General terms explained' list.	Under certain circumstances, providers are required to provide additional information on an account to enable assessment of a service. Omission of this information would result in either a rejection or further contact with the practice for clarification. The restrictive override code will enable providers to submit the additional information, for specific situations, through a two character indicator that will enable the correct assessment and payment for the service. Separate sites—when this indicator is set, item numbers 30071, 30061, 30192 and 30195 will automatically override where: • the services are within one claim and are for the same patient, provider and date of service • there are combinations of items 30071 and 30061 plus only 1 x 30195 and/or only 1 x 30192 • there are multiples of items 30071 and 30061 within one claim. Note: the time dependency restrictions for items 30192 and 30195 will continue to apply. *Q:Does this mean that only items 30071, 30061, 30192 and 30195 can be sent with Override codes via Easyclaims and all other item numbers will be rejected?* No, as per the below description, any procedural item numbers that can be performed by a GP or a specialist in their consulting rooms that requires additional information for a specific situation the provider can use the restrictive override code to allow payment and correct assessment of the service provided. Item numbers 30071, 30061, 30192 and 30195 are very common procedural items used by practitioner's. **Restrictive override codes:** NC=Not for comparison SP=Separate sites NR=Not related (care plans for allied health)

		NC is only used for diagnostic claims only, this override code will not apply to Tyro SP & NR indicator is normally used at general practices, specialist practices etc **Scenario 1: Separate sites—when the indicator SP is set, item numbers 30071, 30061, 30192 and 30195 will automatically override where:** • the services are within one claim and are for the same patient, provider and date of service • there are combinations of items 30071 and 30061 plus only 1 x 30195 and/or only 1 x 30192 • there are multiples of items 30071 and 30061 within one claim. Note: the time dependency restrictions for items 30192 and 30195 will continue to apply. **Scenario 2: Not related (care plans for allied health)** This indicator/override code is used for GP's who completes 2 separate care plans for a patient where the care plans are not related to the same condition.
13	Assisted Reproductive Technology (ART) services	Items 13200 - 13221 All Assisted Reproductive Technology (ART) Services cannot be claimed through Medicare Easyclaim. To define the ART services they are located in the online Medicare Benefits Schedule under Category 3, Group T1, Miscellaneous Therapeutic Procedures under Sub Group 3 – Assisted Reproductive services. These items are unable to be transmitted through Medicare Easyclaim
14	Claims requiring text	Claims requiring free-form text cannot be sent through Easyclaim. Claims with standard text can be processed through Easyclaim e.g. Not Duplicate Service, Not Normal Aftercare. This uses the item override codes, **Values** AO = not normal aftercare and AP = not duplicate service (am/pm)

Criteria specific to the three types of supported Easyclaim is given below:

Fully-paid Medicare Easyclaim

1. The workflow implemented by the PMS must allow:
    1. The payment of the full claim amount to be obtained upfront (through the payment methods on offer for standard purchases including Tyro eftpos) and registered before the claim request can be initiated.
    2. The fully-paid claim to then be initiated, the PMS must compile the XML payload string (`payload` parameter from the `requestParams` object) in accordance with the element formatting standards and specification laid out by Medicare Australia in the Medicare Easyclaim Logic Pack, please refer to *"Appendix B. Data Elements B.1.1. Patient Claim (PCe) Request Data Elements"*
    3. The claim request is then accepted or rejected by the Tyro integration server, if it is accepted then the claim flows beyond this point, otherwise the relevant error message is displayed and the claim does not start.
    4. **If the claim is 'Accepted' by Medicare:**
        1. The rebate amount is returned in the response and can be claimed by the patient through the terminal.
        2. The claim invoice is closed off with the result clearly communicated to the user through the interface.
    5. **If the claim is 'Rejected' by Medicare:**
        1. The PMS should display the error code and a description of the error code e.g. *"9632: Duplicate Service already paid. If not duplicate, resubmit with appropriate indication"*, the respective descriptions for the codes can be found at: https://www.servicesaustralia.gov.au/organisations/health-professionals/topics/medicare-digital-claiming-return-codes/33171#fourdigitreturncodes
        2. Depending on the claim outcome the PMS should either allow the user to adjust the claim and re-submit the claim, or to print the claim invoice and advise the patient to contact Medicare.
2. If the PMS is storing the 24-digit Easyclaim Transaction ID then the PMS must store it correctly and there must not be any character or field size limitations that prevent the ID from being stored or displayed correctly.
3. The invoice and any PMS reports must display the following information clearly and accurately labeled for each claim:
    1. Patient Name
    2. Medicare card details
    3. Provider Name
    4. Provider Number
    5. Claim Date
    6. Claim Total
    7. Patient Contribution
    8. Benefit paid by Medicare
    9. Claim Result
    10. List of service items claimed along with their amounts.
    11. Clear specification of the type of claim it is "Fully-paid"

Part-paid Medicare Easyclaim

1. The workflow implemented by the PMS must allow:
    1. The payment of a patient contribution towards the claim amount which must be **less** than the claim amount, the user interface and validation rules implemented must allow for this to take place.
       The PMS must specify this amount in the `patientContribAmt` element of the `service` node of the `payload` request XML.
    2. The part-paid claim request to then be initiated.
    3. **If the claim is 'Accepted' by Medicare:**
        1. The confirmation response is passed back to the PMS - the PMS must display the result correctly and clearly on the interface for the user's reference.
        2. The PMS must mark the claim as approved with status 'PDVC' i.e 'Pay Doctor via claimant'
        3. A cheque will then be made out to the patient who will bring it to the practice, along with any outstanding balance, the invoice can then be marked with the cheque amount and the outstanding balance payment.
        4. The PMS closes the invoice.
    4. **If the claim is 'Rejected' by Medicare:**
        1. The PMS should display the error code and a description of the error code e.g. *"9632: Duplicate Service already paid. If not duplicate, resubmit with appropriate indication"*, the respective descriptions for the codes can be found at: https://www.servicesaustralia.gov.au/organisations/health-professionals/topics/medicare-digital-claiming-return-codes/33171#fourdigitreturncodes
        2. Depending on the claim outcome the PMS should either allow the user to adjust the claim and re-submit the claim or to print a normal invoice and advise the patient to contact Medicare.
2. The invoice and any PMS reports must display the following information clearly and accurately labeled for each claim:
    1. Patient Name
    2. Medicare card details
    3. Provider Name
    4. Provider Number
    5. Claim Date
    6. Claim Total
    7. Patient Contribution
    8. Benefit paid by Medicare
    9. Claim Result
    10. List of service items claimed along with their amounts.
    11. Clear specification of the type of claim it is i.e. "Part-Paid'.

Bulk-Billed Easyclaim

1. The workflow implemented by the PMS must ensure:
    1. That no payment either partial or full can be made towards the claim amount by the patient.

2. The bulk-billed claim request to then be submitted.
3. The claim request is then accepted or rejected by the Tyro integration server, if it is accepted then the claim flows beyond this point, otherwise the relevant error message is displayed and the claim does not start.
4. **If the claim is 'Accepted' by Medicare:**
    1. The confirmation response is passed back to the PMS - the PMS user must accept the claim and the patient must assign their right to the benefit on the terminal.
    2. The PMS must display the result correctly and clearly on the interface for the user's reference.
    3. The PMS must close the invoice down and mark the `benefitAssigned` amount as the amount due payable to the service provider from Medicare.
5. **If the claim is 'Rejected' by Medicare:**
    1. The relevant error code is returned in the response payload this must be displayed clearly on the interface for the user's reference, along with the respective descriptions for the code can be found at: https://www.servicesaustralia.gov.au/organisations/health-professionals/topics/medicare-digital-claiming-return-codes/33171#fourdigitreturncodes
    2. The PMS should allow the user to adjust the claim and re-submit the claim.

2. Please note that to assign the right-to-benefit when making the claim through Medicare online or manual claiming the claimant has to submit a completed "approved assignment of benefit form", with Medicare Easyclaim the patient assigns their right to a Medicare benefit by pressing the "OK" button on the Tyro terminal.
   To assign the right-to-benefit on the terminal the `rightsAssigned` string from the `requestParams` object of the `initiateBulkBillEasyclaim()` request must be set to "false" in the claim request.
3. As a feature option, this can be also done on the PMS before making the claim request by setting the `rightsAssigned` string from the `requestParams` object of the `initiateBulkBillEasyclaim()` request to "true" in the claim request.
4. The PMS must have appropriate user interface construct (as shown highlighted as part of the "Tyro Settings Page") to allow toggling the feature option from point 3 on or off as shown below, please ensure that the setting applies globally to all patients in the PMS.