Information Sheet

01 Navigating Medicare Rules

July 2024

This information sheet provides a brief summary of the relevant legislation relating to the billing of professional services to Medicare in a private general practice. As Medicare rules change frequently, practice managers should regularly monitor updates and inform health practitioners at the centre.

Overview

Part II of the *Health Insurance Act 1973 (Cwlth)* provides for the payment of a benefit to an eligible person who has incurred a medical expense for a professional service. Services Australia is the Australian Government agency responsible for the administration of Medicare in accordance with the Act.

An eligible person means an Australian resident, an eligible overseas representative or a citizen of a country with whom Australia has a reciprocal health care agreement[1].

The professional services for which a benefit is payable are set out in the Medicare Benefits Schedule MBS). The benefit payable is a percentage of the scheduled fee, though cannot exceed the medical costs incurred.

Private practice fees are set independently to recover practice operating costs and provide a profit for the practice principals (potentially to reinvest into practice operations). These fees are commonly levied above the MBS scheduled fee resulting in an out-of-pocket cost (gap between the scheduled fee and the benefit payable). Patients' out-of-pocket costs can be minimised by attending a practice that bulk bills (see below) or when the family group has reached the Medicare Safety Net[2].

Section 20A allows a person to enter into an agreement to assign their benefit to a health practitioner in full payment of the medical expense (commonly known as ***bulk-billing***).

Practices commonly offer to bulk-bill concession card holders and services rendered to children under 16. An additional fee cannot be charged when bulk-billing a patient.

[1] Australia presently has reciprocal Medicare agreements with 11 countries https://www.servicesaustralia.gov.au/when-reciprocal-health-care-agreements-apply-and-you-visit-australia?context=22481

[2] www.servicesaustralia.gov.au/what-are-medicare-safety-nets-thresholds?context=22001

To avoid 'double dipping', a Medicare benefit is not payable to a service or organisation (such as a hospital) that is already funded to provide the service (or where the professional service is compensable) [3]. The Minister may (and has) grant(ed) exemptions to this, commonly referred to as **Section *19(2) Exemptions***.

An exemption is not required for medical practitioners exercising private practice rights granted under their employment conditions, as their private practice is rendered under a contract between the patient and the practitioner and *not by, for, on behalf of, or under an agreement with, the government or a HHS* that has granted the private practice[4].

Clause 8 of the Addendum to the National Health Reform 2020-2025[5] provides that patients should be able to access services historically provided in a hospital free of charge. To avoid any doubt, private general practice services undertaken in a HHS facility (co-located in a hospital or a HHS managed facility in the community) must be clearly signed to show the general practice services are private and not part of the hospital's activities. Importantly, patients must not be directed from an emergency department to the private practice (except as a private patient alternative).

1. Summary of Medicare rules

Health practitioners

- Health practitioners must be registered or licenced (doctors, nurse practitioners, midwives, allied health professionals, Aboriginal and Torres Strait Islander Health Workers).
- Each health practitioner must have a separate Medicare provider number for each location from where they provide private services.
- Provider numbers may be granted to overseas trained doctors on temporary visas, doctors in vocational training pathways and junior doctors in areas of workforce shortage.
- A provider number should be cancelled whenever a practitioner exits the location.
- A benefit is not payable where a professional service is provided by a suspended or disqualified practitioner.
- Practices (and hospitals) should maintain a register of practitioners and their provider numbers, including past practitioners, to assist with claim resubmissions.

Medicare eligible items

- Professional services for which Medicare benefits are payable are listed in the Medicare Benefits Schedule. The Schedule is available online at http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home
- Contemporaneous clinical notes must be made on a patient file or in the electronic medical record to support each professional service claimed.

3 Section 17, *Health Insurance Act 1973* www.legislation.gov.au/C2004A00101/latest/text

4 *Private Practice in the Queensland public health sector framework*, Department of Health, March 2019 p.12

5 https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/NHRA_2020-25_Addendum_consolidated.pdf

- A claim should be complete and include each professional service provided to the patient (for example, the consultation, bulk-billing incentive and an ECG).
- A claim can be made for multiple attendances on the same day, providing they are separate attendances, a reasonable time period separates them, and the latter attendance is not a continuation of the same professional service.
- There are some items that cannot be claimed in the same visit or on the same day (for example, a consultation item and a GP management plan unless the reason for consultation is separate and unrelated to the GP management plan and appropriate notation is made on the patient's Medicare claim) and in the patient's clinical record.
- A Medicare benefit is not payable where the medical expense is compensable.
- Medical benefits are also not payable for examinations for life insurance/superannuation purposes, or examinations, health screenings and tests that are not reasonably required to manage a condition, unless otherwise directed by the Minister.
- A medical practitioner must inform a patient if a professional service is ineligible for a Medicare benefit due to a fault with their provider number.

Bulk billing

- To bulk-bill a professional service, a person must enter into an agreement to assign their benefit to the health practitioner. The practitioner also accepts the assignment as full payment of the medical expense.
- A bulk-billed patient cannot be charged any additional fees or co-payments associated with the professional service (for example, dressings), other than a privately purchased vaccine.
- Bulk-billed patients (or their guardian) must sign the agreement to assign their benefit to the practitioner (Medicare Webclaim form DB020).
- Alternatively, the bulk billed patient can press the 'OK' button on an Easyclaim device to demonstrate their agreement to assign their benefit.
- Signed DB020 forms must be retained for 6 years under State archives legislation, unless a valid exemption is granted, otherwise retained for 2 years.

Importantly, health practitioners remain responsible for billings made in their name and should always review the daily billing list. Medicare uses provider profiles to compare billing practices and investigate variations.

MyMedicare

MyMedicare[6] is a voluntary patient registration model introduced in the 2023-24 federal budget which aims to strengthen the relationship between patients, their general practice, their general practitioner and their primary care team.

[6] www.health.gov.au/our-work/mymedicare

Through MyMedicare, patients can experience greater continuity of care through their relationship with their regular general practice and practitioners and will be able to access services such as longer telehealth items. Registered practices will have more information about their regular patients, be able to claim the triple bulk billing incentive for longer telehealth items and be eligible for the general practice in Aged Care incentive from August 2024 and blended funding arrangements from 2024-25.

Practices must register through the Organisation Register in Health Professional Online Services (HPOS) and link their eligible practitioners. Patients can register through their Medicare Online account or Medicare Express app or by completing a manual form at the practice (DVA patients will need to complete the manual registration form).

Provider Digital Access (PRODA)

Service Australia's Provider Digital Access (PRODA) is an online identity verification and authentication system. It lets the practice securely access government online services, including Health Professional Online Services (HPOS), Medicare Online, PBS Online, the Australian Immunisation Register and the Practice Incentives Program.

PRODA enables a practice to be registered as an organisation, obtain provider numbers for health practitioners and claim Medicare benefits for the services they provide.

2. Medicare items commonly billed in a general practice

General consultation fees, (levels A-E) are based on time spent with a patient and will comprise the majority of the practice's billings.

- It is important to accurately record the time spent with the patient in the medical record.
- Different billing codes are used for consultations in the practice, at an aged care facility, or at the patient's home.
- Higher benefits are paid for after-hours consultations.

The full Medicare benefit is payable for almost all general consultation items.

Common diagnostic items in a practice may include spirometry, ECG and blood pressure monitoring and certain point of care testing.

The practice can offer immunisation services, minor procedures including excisions, lacerations and wound care, and provide women's health services including birth control, pregnancy management and antenatal care.

Benefits payable for procedural and diagnostic items are 75% of the schedule fee for a non-vocationally trained doctor and 85% for a vocationally trained doctor.

The ***MBS Quick Guide***[7] is published monthly by Australian Doctor on its AusDoc community platform, providing a schedule of commonly billed practice items.

7 Ausdoc MBS Quick Guide available to members or through PHN sites such as www.ourphn.org.au/mbs-guides/

A full range of telehealth consultation items have been available since the commencement of the COVID-19 pandemic.

- Telephone and video consultations are available to patients with an established practice relationship who have attended face to face in the past year (with some exceptions including children <12mths, patients under COVID-19 public health orders, natural disaster affected area and others).
- Telephone consultations are limited to not more than 6 minutes (up to 20 minutes in MMM 6 and 7). Patients registered with their practice under MyMedicare also qualify for Level C and D telehealth consultations.
- Benefits are paid at 100% of the scheduled fee.

The ***MBS COVD-19 and Telehealth MBS Items Quick Guide***[8] is published monthly by Australian Doctor, providing a schedule of commonly billed telehealth practice items.

3. Enhanced primary care management items

Enhanced primary care items encourage and support a planned and coordinated approach to patient care, particularly for people who are vulnerable or experiencing chronic disease and disability.

Health care assessments and care planning should be routinely planned into practice rosters and operations to reduce reactive and emergency care demands.

In general, chronic disease management items cannot be billed on the same day as a general consultation, though exceptions apply in a small number of cases where the reason for consultation is separate and unrelated to the GP management plan.

From November 2024, chronic disease management items will be linked to a patient's registration in MyMedicare to support continuity of care for people with chronic and complex conditions. A rebate will not be available for a chronic disease item provided by a provider at another practice. Patients who have not registered in MyMedicare can still receive chronic disease management care through their regular practitioner.

Health Assessments

Health assessments[9] aim to better target health care by looking at a patient's health, physical, psychological and social function.

There are MBS items covering health assessments for specific target groups including First Nations peoples, the elderly, people with or at risk of chronic disease, aged care residents, people with intellectual disability, refugees and veterans.

The assessment should be prepared by the patient's 'usual' medical practitioner, with parts of the assessment able to be completed by a practice nurse or Aboriginal and Torres Strait Islander Health Practitioner.

8 Ausdoc MBS COVID-19 and Telehealth Quick Guide available to members or through PHN sites such as www.ourphn.org.au/mbs-guides/

9 www.servicesaustralia.gov.au/health-assessments-and-your-record-keeping-responsibilities

A patient's consent to the health assessment must be noted in the medical record after the medical practitioner has explained the process and expected benefits. A copy of the health assessment should be offered to the patient and added to the medical record.

Only a single health assessment can be claimed within a 12-month period (9-months for First Nations health assessments) unless the patient becomes eligible in another group. A health assessment cannot be billed if the patient has already had an assessment completed by another medical practitioner.

Items can be claimed based on the duration of the assessment (brief through to prolonged), with separate items for assessments of First Nations people and people at risk of cardio-vascular disease.

Chronic Disease / Complex Care Management

A General Practice Management Plan (GPMP)[10] should be prepared with patients experiencing (or likely to experience) chronic conditions for at least 6 months to better coordinate their care and reduce the need for ad hoc consultations.

The plan should be prepared by the patient's 'usual' medical practitioner, though ideally, a Practice Nurse or Aboriginal and Torres Strait Islander Health Practitioner will complete much of the plan's details for review by the medical practitioner.

The plan should describe the patient's healthcare needs and relevant conditions, management goals and actions for your patient, the treatment to be provided and the arrangements to review the plan.

When the patient agrees with the plan, they should receive a copy with another placed in their medical record.

A GPMP may be claimed once every 12 months and reviews not more than once every 3 months, unless there is a significant change in the patient's condition.

Team Care Arrangements

A benefit is payable when establishing a Team Care Arrangement (TCA)[11] to enhance multi-disciplinary care for a patient.

The TCA will involve the patient's usual medical practitioner and at least two collaborating health care providers.

The TCA will document treatment and service goals, the treatment and services that collaborating providers have provided, the actions the patient needs to take, and important review dates.

Copies of the TCA should be provided to the patient and collaborating health provider and a copy added to the medical record.

A TCA may be claimed once every 12 months with reviews once every 3 months, unless there is a significant change in the patient's condition.

10 www.servicesaustralia.gov.au/chronic-disease-gp-management-plans-and-team-care-arrangements
11 www.servicesaustralia.gov.au/chronic-disease-gp-management-plans-and-team-care-arrangements

GP Mental Health Treatment Plans

A GP Mental Health plan (GPMHTP)[12] may be used to help patients (including patients in a residential aged care facility) to manage their condition and coordinate treatment.

The patient must have a medical disorder and be likely to benefit from a structured approach to their care.

The GPMHTP should be prepared by the patient's usual doctor.

The plan enables referrals for a course of treatment to be made to a clinical psychologist or another practitioner or allied health professional for focussed psychological strategies.

There are applicable limits to the number of sessions that can be referred and annual limits on services.

Only one GPMHTP can be claimed within 12 months and not earlier than 3 months after the last review. A review item can be claimed every three months, though no earlier than 4 weeks after the start of a new plan.

4. Medicare incentives

A range of incentives are available to practices, many of which require a practice to be accredited.

Rural Bulk-billing Incentives

Bulk Billing Incentives[13] encourage medical practitioners to provide bulk billed services to vulnerable patient groups, including pensioners, people with concession cards and children under 16 years of age.

Higher loadings are applied to the bulk billing incentive based on the rurality of the practice location. From 1 January 2020, the classification system used to determine eligibility for higher incentives changed to the Monash Modified Model. The 2023-24 federal budget increased rural loadings to the bulk billing incentive as a component of the government's Strengthening Medicare strategy, tripling the previous rates payable and bringing the Medicare rebate for these patients closer to fee levels charged in mixed billing practices.

Both the professional service(s) provided and the incentive may be claimed when bulk-billing for the patient.

Practice Incentives Program

The Practice Incentives Program (PIP)[14] encourages general practices to continue providing quality care, improve access and health outcomes for patients and defray higher costs of rural health care. PIP participation is essential to the continued viability of the general practice.

12 www.servicesaustralia.gov.au/better-access-initiative-supporting-mental-health-care
13 www.health.gov.au/initiatives-and-programs/rural-bulk-billing-incentives
14 www.servicesaustralia.gov.au/practice-incentives-program

To be eligible, the practice must continuously:

- maintain accreditation, or be registered for accreditation to RACGP standards
- have one or more registered medical practitioners providing face to face services to patients at the main physical location
- hold at least $10 million in public liability insurance cover
- have professional indemnity insurance cover for all practitioners and nurse practitioners

The practice can apply for PIP through their PRODA online account.

Practices registered in the PIP may attract incentive payments for eHealth, quality improvement (QI), teaching, Indigenous health, after hours care, rural and remote procedural, surgical and obstetric activities and rural loadings of between 15-50% for rural and remote locations[15]. A new General Practice in Aged Care incentive will be introduced on 1 August 2024 following the May 2023 federal budget for practices registered in MyMedicare.

PIP payments are made quarterly and calculated automatically by Medicare based on the practice patient cohort and standardised whole patient equivalent (SWPE) claims, except for teaching where the number of sessions can be lodged using payment claim form (IP006).

Workforce Incentive Program

The Practice Stream of the Workforce Incentive Program (WIP)[16] provides financial incentives to help general practices with the cost of engaging nurses, allied health professionals and/or Aboriginal and Torres Strait Islander health workers and health practitioners. The incentive can also be used to engage a private allied health professional on a sessional basis to deliver care to practice patients who cannot afford private services or convene group-based education sessions.

To be eligible for WIP, the practice must:

- participate in PIP,
- employ a medical practitioner,
- engage in at least one eligible service,
- hold a current public liability insurance certificate, and
- confirm and return the quarterly statement sent by Medicare.

WIP cannot be claimed for after-hours services or in cases where the practitioner is already billing Medicare or being paid by a State or Commonwealth program.

The amount of WIP is based on size of the practice, the hours worked by eligible health professionals at the practice and the location of the practice (to a maximum of $130,000 per annum).

A WIP – doctors stream is also available, providing incentives to medical practitioners who have continuous years of providing services in a practice in an MMM 3-7 location. The maximum incentive payable is $60,000 per annum.

15 www.servicesaustralia.gov.au/types-practice-incentives-program-payments?context=23046
16 www.health.gov.au/initiatives-and-programs/workforce-incentive-program/practice-stream

A further incentive stream is available for advance skills qualified rural GPs working in MMM3-7 locations between 2023 and 2025. The WIP – Rural Advanced Skills[17] payment aims to support access to health care in rural and remote communities and recognise GPs who work in primary care and use advanced skills in hospital or after-hours settings. The incentive rewards investment in GP specialist qualifications, accredited training and credentials, and encourages more doctors with these advanced skills to work in rural and remote areas. Subject to eligibility, qualifying service and location, a maximum payment of up to $21,000 may be claimed each year.

[17] www.health.gov.au/our-work/workforce-incentive-program/workforce-incentive-program-rural-advanced-skills-stream