RACGP

PONC23 – Demystifying Medicare

Responses to questions from attendees

General comments

Many of the questions received during the Demystifying Medicare session at the Royal Australian College of General Practitioners' (RACGP) Practice Owners National Conference 2023 (PONC23) relate to Medicare Benefits Schedule (MBS) interpretation. As with all specialist medical colleges, **the RACGP has no legal authority to interpret MBS rules and regulations. There is no guarantee that Medicare will consider the use of an MBS item number appropriate, even if the RACGP does.**

It is the responsibility of the treating practitioner to ensure that any service billed to Medicare meets the item descriptor in the MBS and any eligibility requirements in full. You should maintain appropriate patient notes to demonstrate how you meet the descriptor of any Medicare service billed. For further information, see the RACGP's statement on Medicare interpretation and compliance.

The RACGP recently published a new webpage with links to Medicare and compliance education resources. Collating resources in a central location means that you don't have to search across multiple websites to find what you're looking for. We've grouped links under key themes listed in alphabetical order so you can easily locate the information you need. The resources come from the Department of Health and Aged Care (the Department), Services Australia and RACGP and include MBS explanatory notes, fact sheets, education guides, eLearning programs, infographics and case studies.

Responses to questions/comments

The responses below have been grouped together under common themes for ease of reading. We have also provided responses to some of the comments and observations made by PONC23 attendees where we felt that additional information or clarification would be helpful. *Case studies/questions are presented in italics.*

A number of the questions raised are generic in nature, and the responses provided may not cover different clinical scenarios which may be present in the circumstances described. Each billing decision is based on the specific clinical situation for each patient and requires a clinical diagnosis to determine whether the services would be appropriate in a particular situation.

Chronic disease management

- *Case study 1 can have a 721 for asthma and COPD – just not 723.*

For those who didn't attend the conference, case study 1 asked attendees to answer the following question:

Your 72-year-old patient with COPD and asthma presents with knee pain after a fall four months ago.
Their physiotherapist has suggested they are eligible for five Medicare rebated allied health sessions. After you complete a care plan can you claim items 721 and 723?

The correct answer is **no.***

Firstly, the knee pain is not related to a chronic condition. Secondly, even if the patient had pre-existing arthritis there is only one team member in addition to the GP. While a chronic disease management (CDM) item can't be billed for knee pain unrelated to a chronic condition, you could prepare a care plan and bill item 721 for the patient's asthma or COPD.

You can only bill a CDM item if the patient is suffering from at least one medical condition that has been present (or is likely to be present) for at least six months or is terminal. When billing item 723, you must consult with at least two collaborating providers, each of whom will provide a different kind of treatment or service to the patient, and one of whom may be another medical practitioner, when planning multidisciplinary care of the patient.

*We note the case study above may not capture the whole clinical scenario. The knee pain is a symptom and requires a clinical diagnosis to determine required treatment options. For example, the knee pain may be an exacerbation of osteoarthritis pain, precipitated by the fall, or may be interfering with the patient's ability to do exercise to manage other presenting chronic conditions. As such, there may be scenarios where it would be clinically relevant and appropriate to provide these services.

- *Re case study 1 – if the patient had been diagnosed with osteoarthritis in the past, will they be eligible for physiotherapy under item 723? You need to wait six months since the injury.*

Yes.

However as noted the patient's medical condition needs to have been present for at least six months. If they need ongoing treatment from a multidisciplinary team, they are also eligible for Team Care Arrangements (TCAs).

- *When claiming item 721 and 723, does the symptom have to relate to the chronic condition (eg sore knee with asthma and COPD)?*

Yes.

A patient presenting with knee pain needs to have been diagnosed with a chronic condition that has been present for at least six months to qualify for CDM services under Medicare. Knee pain in itself is not sufficient to access these items.

- *For TCAs, will a referral to a physiotherapist and a specialist make it valid?*
- *Can a specialist be used in TCAs?*
- *How many providers are required for item 723? Do we need a letter from allied health providers to claim 723?*

You must consult with a multidisciplinary team when developing TCAs. A multidisciplinary team includes the patient's usual medical practitioner and at least two other collaborating health or care providers, one of whom may be another medical practitioner. This is usually a non-GP specialist or consultant physician rather than another GP. Each member of the team will provide a different kind of treatment or service to the patient. More information is available on the Services Australia website.

A letter from an allied health provider is not required to bill item 723. The relevant MBS explanatory note does not specify how you must consult with other providers, however you should document how the consultation occurred in your clinical notes. When coordinating TCAs, you must also record the patient's agreement to develop TCAs in the document you prepare outlining their treatment and service goals.

COVID-19 vaccinations

- *Just last week Medicare rejected co-claiming a consultation item and COVID vaccine item number at our clinic. Is there consistency to co-claiming rejections?*
- *Medicare will often reject the 23 and 93644. You have to notate them as not related.*

You can co-claim a COVID-19 vaccine support item with a general attendance item where this action is clinically indicated by the health needs of the patient. When seeking to co-claim for an unrelated attendance at the same time as a vaccine suitability assessment service, it is recommended that GPs include a note stating that *"The additional service [MBS item...] is clinically relevant but not related to the vaccine suitability assessment service [MBS item...]."* See page 12 of the Department of Health and Aged Care's FAQs on Medicare support for COVID-19 vaccinations for more information.

Further information about MBS co-claiming is included in the AskMBS Advisory for General Practice Services #2.

- *Can a GP who has not completed mandatory COVID vaccination training claim a COVID vaccine assessment item number (eg 93644)?*

No.

Vaccination of a patient who has received a vaccine suitability assessment service can be provided by a GP, other medical practitioner or a health professional who is appropriately qualified and trained to provide immunisations. This includes having completed any mandatory Commonwealth training associated with the delivery of COVID-19 vaccines, and meeting any state or territory legislative requirements.

Dermatology

- *Do items 31377–31383 apply if you perform a shave or punch biopsy for clinically suspected melanoma?*

As per advice provided by AskMBS, the answer to this question is **no.**

Items 31377–31383 do not apply if a shave or punch biopsy is performed for clinically suspected melanoma. The ideal method for skin lesions suspected of being melanoma is complete surgical excision.

In regard to 'surgical excision' for a clinically suspected melanoma (31377–31383), the intent of this phrase is to describe an excision aimed at removing the whole lesion and not a partial biopsy that may adversely affect outcomes in melanoma management. The Department of Health and Aged Care considers that for Medicare billing purposes, medical practitioners who suspect a lesion to be melanoma or melanoma in situ may perform a local surgical excision of the lesion to determine histopathology and claim one of the MBS items for the initial excision of clinically suspected melanoma. Once melanoma, or melanoma in situ, is proven by histopathology the practitioner would then perform a definitive wide excision of the lesion, including excision of the primary tumour bed and claim the definitive excision item (31371–31376), based on the defect size and an appropriate margin of healthy tissue needed for complete surgical excision.

- *When excising a melanoma following confirmation of malignancy with a clinically suspected melanoma item number, is the initial tissue removed included in the defect size for the second procedure?*

No.

For the purposes of determining which item to claim for a re-excision of a clinically suspected or histologically proven melanoma, the necessary excision diameter is based on the defect size of the re-excision. This should not include the previous excision diameter of the initial excision.

AskMBS have also provided the following advice. Measurements should be taken prior to the initial excision of clinically suspected melanoma. The recommendations for the width of melanoma excision margins are based on the Breslow thickness of the primary melanoma at its thickest depth of invasion, as determined by histological assessment of the initial excision biopsy. The margin size needs to be determined in line with the *Clinical practice guidelines for the diagnosis and management of melanoma*.

Further information on calculating defect sizes can be found in MBS Note TN.8.125 as well as in the *Determining lesion size for MBS items 31356 to 31388 selection* fact sheet.

- *A patient booked in to have a skin lesion excised. During the consultation a previous test was discussed, and the patient was given a script. Can I bill a consultation item for this?*

Yes – if the test result and script provided are unrelated to the procedure and this is documented in your clinical notes.

Ideally, the two issues would be clearly separated – for example by closing one consultation and opening another. Some software programs allow a separate tab to be opened when there is more than one issue managed on the same day.

You can bill attendance items in association with another MBS item if the attendance is clinically relevant and you meet the item descriptor for all items. However, there are certain restrictions that prevent billing attendance items in association with other MBS items. You can't count the time spent performing non-attendance items when selecting the appropriate attendance item to bill. See Services Australia's education guide on billing multiple MBS items for more information.

- *A consultation and skin tear repair takes 40 minutes. Do we claim item 44 and the wound repair item or item 23 and the wound repair item?*

You can't claim a general attendance item to compensate you for time spent discussing or performing a dermatology procedure.

If you are co-claiming an attendance item with a wound repair item, the two items must be for separate clinically relevant services. If the two services are separate, you should bill the relevant time-based attendance item for the general consultation only – not for the combined time spent consulting with the patient and performing the procedure.

- *I have just changed over to privately billing consults. What is the best way to start privately billing skin procedures? The challenge in my area is that if I charge a $50 gap on a skin flap, the patient may need to pay $700 upfront.*

The RACGP does not provide advice on recommended fees, as this is a matter for individual GPs and practices to determine. You may wish to consult the Australian Medical Association (AMA) Fees List, which is a schedule of items and fees for over 5,000 medical services. The Fees List is a resource provided for free to AMA members and as a paid annual licence for non-AMA members. Further information is available via the links below.

Fees List website
Demonstration YouTube video
Contact email address: feeslist@ama.com.au

When a claim is lodged with Services Australia for an unpaid or partially paid medical account, Services Australia will send the patient a Pay Doctor Via Claimant (PDVC) cheque. The patient has to forward the cheque to you for payment. If you don't get the cheque or you haven't banked it after 90 days, it is cancelled and you will be paid the Medicare schedule fee using Electronic Funds Transfer (EFT). Visit the Services Australia website for more information on the 90 day pay doctor cheque scheme.

Co-claiming / Billing multiple MBS items

- *Can we co-claim a 23 or 36 with 2712, 2713 or 732?*

Yes, in some cases.

You can claim a general attendance item with a mental health item in some circumstances. As per MBS Note AN.0.56, the GP Mental Health Treatment Plan, Review and Consultation items cover the consultations at which the relevant items are undertaken, noting that:

- if a GP Mental Health Treatment item is undertaken or initiated during the course of a consultation for another purpose, the GP Mental Health Treatment Plan, Review or Consultation item and the relevant item for the other consultation may both be claimed
- if a GP Mental Health Treatment Plan is developed over more than one consultation, and those consultations are for the purposes of developing the plan, only the GP Mental Health Treatment Plan item should be claimed
- if a consultation is for the purpose of a GP Mental Health Treatment Plan, Review or Consultation item, a separate and additional consultation should not be undertaken in conjunction with the mental health consultation, unless it is clinically indicated that a separate problem must be treated immediately.

As per MBS Note AN.0.47, co-claiming a general attendance item with CDM items 721, 723, or 732 is not permitted for the same patient on the same day.

Further information about MBS co-claiming is included in the AskMBS Advisory for General Practice Services #2.

- *Can you co-claim item 721/723 and 10997 if the nurse administered a vaccine or provided wound care on the same day?*

Yes, provided the items are for separate, clinically relevant services.

Claiming item 10997 with a CDM item for the same patient on the same day is not restricted, however item 10997 shouldn't be billed if the nurse supports you to prepare or review a care plan. Minister Butler has clarified that you can claim both items provided they are for separate services.

The Department of Health and Aged Care is developing a new fact sheet on item 10997 and CDM services which the RACGP will be providing feedback on. The RACGP is seeking greater clarity on how to correctly bill item 10997 and what constitutes separate services. We've also highlighted the contradictory nature of explanatory materials.

Much of the confusion around item 10997 stems from the explanatory note, which states that the item may be billed for the collection of information to support GP/medical practitioner reviews of care plans. Despite this, we would encourage members to follow the most recent advice issued by the Department, which is that practice nurse support provided as part of the development and review of care plans should not be itemised separately under item 10997. The intention of item 10997 is to provide additional support and monitoring for patients with chronic health conditions in between the more structured reviews of their care plan by their GP.

- *If you read the 10997 MBS statement, it does not say you cannot bill this item with items 721/723. And if this was not allowed why does Medicare not reject the claims?*

In an open letter to Minister Butler about the 10997 compliance letters sent to around 600 GPs earlier this year, the RACGP called on the Department of Health and Aged Care to investigate options for automatically rejecting incorrect claims when they are submitted, rather than allowing these to be processed and leading GPs to believe they have billed correctly. We acknowledge there are challenges associated with this, particularly when co-claiming is allowed in limited circumstances.

The RACGP welcomed the recommendations from Dr Pradeep Philip's final report from the Review of Medicare Integrity and Compliance, released in April 2023. Dr Philip called for enhancements to the end-to-end claiming journey to strengthen the first line of defence position and enable continuous monitoring of all MBS claim transactions. The RACGP supports the principles of continuous monitoring and early identification. Where feasible, enabling claiming channels to

instantly reject claims that are non-compliant would prevent a great deal of stress and worry, and provide instant information for GPs regarding non-compliant billings.

- *How do you co-claim the smoking cessation items? Practice software seems to reject these.*

The RACGP is not able to comment on why these claims are being rejected. We would advise you to contact the relevant software vendor for advice.

- *If a procedure does not involve any other problem as part of the consultation, is it invalid to bill item 23 for patient education or discussion about the procedure?*

Yes, this is invalid.

You can't bill a general attendance item to cover the time spent discussing the procedure with the patient. Patient education or discussion about the procedure is part of the procedure itself, and should have been covered during the consultation when the procedure was arranged. Obtaining patient consent is also a key part of this discussion. The relevant procedural item covers the complete service, including patient education and the actual procedure.

- *I have a 70-year-old patient who requested a dementia screen, Mental Health Treatment Plan referral, an assessment for obstructive sleep apnoea and finally a referral to a sleep doctor. What is the appropriate item number to claim? I just claimed a 44.*

This question implies that the Mental Health Treatment Plan was developed at an earlier consultation and the GP is just writing a referral. In this case it is appropriate to bill item 44, provided the consultation lasts longer than 40 minutes. In addition, if history taking is one of the activities performed during the consultation, this needs to be an extensive patient history. See the descriptor of item 44 for more information.

Mental health

- *When do you bill item 2713 or item 36 if mental health is involved?*

Item 2713 is for an extended consultation with a patient where the primary treating problem is related to a mental disorder, including for a patient being managed under a GP Mental Health Treatment Plan. This item may be used for ongoing management of a patient with a mental disorder. The item should not be used for the development of a GP Mental Health Treatment Plan. More information is available in MBS Note AN.0.56.

You should not bill item 36 if the primary treating problem is related to a mental disorder, despite the rebate being slightly higher than the rebate for item 2713. It is a principle of the MBS that the item that best describes the service is the item that should be billed.

Bulk billing and additional charges

- *Our practice charges a one-off registration fee for new patients and the consultation is bulk billed. Is this allowed?*

No.

If you are going to impose any sort of charge on the patient, such as a registration fee or consumables such as bandages or dressings, you cannot bulk bill the patient. You can incorporate these charges into the cost of the consultation, and when the patient pays the full amount (rebate + gap fee) they will receive their rebate back from Medicare.

See this fact sheet on Medicare bulk billing and additional charges for more information.

- *Our practice charges $1 for masks if the patient forgets their mask. Is that allowed if that patient gets bulk billed afterwards?*

Charging patients a fee for masks raises ethical questions about whether this arrangement constitutes patient-centred care. You could obtain legal advice to determine if this breaches any rules around bulk billing and raising additional charges. Or you could simply give out masks which would be much cheaper. Another option would be to have a jar at the front desk and ask for a gold coin donation. Funds collected in this way could then be donated to a local charity.

Split billing

- *Can you charge a 23 or 36 privately and then bulk bill 10997 for the Prolia or B12 injection administered by the nurse on the same day?*

Yes.

Where you provide a number of services on a single occasion, you can choose to bulk bill some or all of those services. The exception is when the Multiple Operational Rule affects the services. In this case the provider can use only one claiming channel. This also applies to the diagnostic imaging multiple services rules (DIMSR).

Where some but not all of the services are bulk billed, a fee may be privately charged for the other service or services. This fee can't be used for additional charges in relation to a bulk billed service. See the Services Australia website for more information.

You should note item 10997 is restricted to patients being managed under MBS CDM arrangements.

Practice nurses

- *When will nurses be able to bill an item number for immunisations etc without the doctor having to physically see the patient?*

It is possible to bill MBS items for practice nurse support if the GP does not physically see the patient. Item 10997 may be claimed by a medical practitioner, where a monitoring and support service for a person with a chronic disease care plan is provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of that medical practitioner.

According to MBS Note MN.12.4, supervision by the GP or medical practitioner at a distance is recognised as an acceptable form of supervision. This means that the claiming GP or medical practitioner does not have to be physically present at the time the service is provided. However, the GP/medical practitioner should be able to be contacted if required.

MBS Note MN.12.4 relates only to item 10997. Services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner under this item should be consistent with the scope of the GP Management Plan, Team Care Arrangements, or Multidisciplinary Care Plan.

There are also two MBS items (93660 and 93661) which permit a COVID-19 vaccine suitability assessment service to be provided by a suitably qualified health professional on behalf of a GP, at a location other than the practice. For services rendered under these items, the GP is not required to be physically present at the location at which the service is provided but retains full responsibility for the clinical outcome.

Medicare compliance

- *What triggers a targeted awareness raising letter?*
- *How does the Department of Health and Aged Care know who to send letters to?*

The Compliance Assessment Branch of the Department sorts through data and billing trends before deciding on compliance interventions. The RACGP is not privy to this decision-making. Sometimes the RACGP is invited to meet with the Department to provide feedback on questionable billing trends that may be occurring, however there is no guarantee that a compliance activity will be undertaken.

In some cases, letters are sent to providers with high levels of claiming certain MBS items where it is not clear to the Department why this is occurring. The Department also receives 'tip-offs' from members of the public who have concerns about the services their GP has billed, which may prompt a compliance letter. More information about Medicare compliance is available on the Department's website.

- *Is it possible for the initial steps in the compliance process to be skipped and to receive a referral to PSR right off the bat?*

No, with the exception of suspected breaches of the 80/20 and 30/20 rules.

Before a request is made to the Director of the Professional Services Review (PSR), the Department will attempt to contact the provider under the Practitioner Review Program (PRP). The function of the PRP is to review a practitioner or corporate entity's Medicare servicing and PBS prescribing behaviour to determine whether a request should be made to the Director of the PSR for review under the PSR Scheme. The steps followed under the PRP vary according to the individual circumstances for each provider.

Participation in the PRP is voluntary but affords the provider the opportunity to provide information which may resolve the compliance concerns. If concerns cannot be resolved under the PRP, a request may be made by the Chief Executive Medicare or their delegate to the PSR Director to review the relevant services over a period of up to one year. If the Chief Executive Medicare becomes aware of a breach of the 80/20 or 30/20 rules, they must make a request to the PSR Director. The provider will be invited to provide a written submission under the PRP prior to the request which will be forwarded to the PSR Director.

- *Are there any mandatory reporting requirements if we suspect that a colleague could possibly be Medicare non-compliant?*

No.

You are not obligated to report your colleagues if you suspect they have breached Medicare billing rules, however you may choose to report your concerns using the Department of Health and Aged Care's health provider tip-off form. You can choose to remain anonymous when submitting a tip-off.

- *Is the 30/20 rule just for phone services or a combination of phone and video?*

The 30/20 rule only applies to phone (audio-only) consultations.

- *Sample note writing education organised by the RACGP would be very helpful as the meaning of complexity is not clear but the time requirement is quite clear.*

Thank you for this suggestion. The RACGP is looking to be more proactive in the MBS/compliance space to help our members bill correctly and meet their compliance obligations. As a first step, we have collated the following resources to assist with record keeping on our Summary of useful links webpage:

MBS Note GN.15.39 – Practitioners should maintain adequate and contemporaneous records
This note explains what is meant by 'adequate' and 'contemporaneous' records.

Administrative record keeping guidelines for health professionals
These guidelines provide useful information and tools to support good administrative record keeping within your practice.

Record keeping tips
These 10 simple tips will help you establish and maintain an effective administrative record keeping system.

The RACGP will consider the benefits of further education on record keeping. In the meantime, we encourage you to also have a look at MBS education developed by your medical defence organisation (MDO), and to speak with your MDO if you have any questions or concerns about record keeping.

- *Can individual doctors access their benchmarking of MBS data?*

There is a wealth of information available through the Medicare statistics website, which GPs could use to benchmark their own practice against. This website allows you to search for MBS item numbers during specific time periods to establish servicing ratios nationally. You can also receive a breakdown by patient age and gender.

The RACGP does not hold specific benchmarking data, however there is some information regarding average fees for Level B consultations as well as average bulk billing rates and types of services/patients bulk billed in our 2022 Health of the Nation report. The RACGP can break this down further, for example by location, practice type, GP gender and age. Please contact healthreform@racgp.org.au to find out more about this data and what we can provide to help you in your billing considerations.

The RACGP is currently meeting with several medical software vendors. We have been hesitant around using data for benchmarking as this could be seen as measuring performance which could then be linked to funding. However, members are becoming more interested in benchmarking, particularly in relation to workforce incentives. Current practice software systems are limited in that they cannot transfer patient records from practice to practice, so comparing other practice data in these systems is likely a long way off. Some Primary Health Networks (PHNs) do provide benchmarking reports to general practices using data aggregation software/middleware solutions such as POLAR, PEN CAT, Primary Sense and Cubiko. These products are dependent on data provided by practices.

MBS Online/AskMBS

- *The problem with MBS Online is that the explanations are subject to interpretation. This is a problem for the industry. When you call Medicare you will never get a consistent answer.*
- *I have used AskMBS a few times and no one replied.*

The AskMBS advice service, within the Department of Health and Aged Care, is an email-only service which does not provide telephone advice. AskMBS has no connection with the provider enquiry line (13 21 50) operated by Services Australia (and commonly referred to as 'Medicare'), and advice provided by that enquiry line should not be attributed to AskMBS. While these two services interact with each other, neither has direct visibility over what is being asked of, or the advice being provided by, either service.

Rather than calling Medicare, enquiries relating exclusively to interpretation of the MBS are best directed to AskMBS via askmbs@health.gov.au. AskMBS aims to respond to enquiries as soon as possible, usually within 15 working days. However, due to the high volume and complexity of the enquiries received, this is not always possible and your response may be delayed. If you have been waiting longer than 15 working days for a response, you can email AskMBS again and quote the reference number provided in their automatic reply to your original query. It is important that your question is specific, and that you ask exactly the same question if you contact AskMBS more than once. You can also check this collection of AskMBS advisories to see if your question is included.

Remember that if you have concerns about relying on advice received from AskMBS, you should contact your medical defence organisation.

Enquiries in relation to the administration of claims under Medicare, including questions regarding rejections, refunds and adjustments, or information regarding what additional notation should be included with claims to facilitate processing, should be directed to Services Australia via the Medicare Provider Enquiry Line (13 21 50).

AskMBS has indicated they would welcome the opportunity to review instances of possible inconsistent advice. Where a provider is aware of advice they consider to be inconsistent, AskMBS requests that this be forwarded to askmbs@health.gov.au for internal quality assurance purposes, and so that corrections or clarifications can be issued where required.

Billing resources

- *Is there either an easy GP based MBS advisory software, or consultants that can be used to maximise practice billings?*

The RACGP is not able to recommend a particular software provider or consultancy to maximise practice billings. You may wish to view our suite of resources to help GPs manage their billing. These include advice on transitioning to a mixed billing model, discussing fees with your patients, billing case studies, and resources aimed at patients.