Billing case studies

Updated 1 July 2024

The following case studies outline possible ways for GPs to introduce mixed billing in their work. They are examples only and are intended to provide different options for GPs to consider. Billing is a personal choice and there are many factors that may influence how a GP bills, including patient demographics, practice location and desired income. Whether GPs are in a position to privately bill some, or all patients will depend on these factors. However, the only Medicare Benefits Schedule (MBS) items that must be bulk billed are COVID-19 vaccination items.

Case study 1 – Bulk billing certain patients*

Dr Smith works 32 hours per week, with 28 hours of clinical time (consulting with patients). He sees an average of 112 patients a week. Dr Smith has been bulk billing every patient and decides to only bulk bill health care card holders (25% of patients) and charge all other patients a fee of $80 per standard consultation (Level B attendance).

This change results in Dr Smith's billings increasing from $171.40 to $275.40 per clinical hour. This amounts to an extra $3074.40 in billings per week and $147,571.20 per year. With an average of 40% of billings paid to the practice, Dr Smith earns $4626.72 per week and $222,082.56 per year before tax.

*Scenario based on MBS item 23 (Level B attendance lasting less than 20 minutes), which has a rebate of $42.85. It is assumed the GP takes four weeks of annual leave per year.

Case study 2 – Bulk billing specific services*

Dr Le has been providing a mix of face-to-face and telehealth services since the start of the COVID-19 pandemic. She decides to adopt a mixed billing model to cover practice costs.

Dr Le works 38 hours per week. On average, 30.5 hours of this is clinical time and 7.5 hours is spent on non-clinical work (eg paperwork, following up on test results, arranging care for patients at home). She sees around four patients per hour – a total of 122 per week. Dr Le bulk bills all telehealth services (approximately 50% of her caseload) and privately bills face-to-face consultations (50% of services), charging an average fee of $68.

As a result of this change, Dr Le's weekly billings increase from $5228 to $6762. This is an extra $1534 per week. Her annual billings increase by $69,100.80 from $250,944 to $324,576. Dr Le receives 65% of her billings, resulting in earnings totalling $210,974.40 before tax.

*Scenario based on MBS items 23 (Level B attendance lasting less than 20 minutes), 91891 (Level B phone consultation) and 91800 (Level B video consultation), which all have rebates of $42.85. It is assumed the GP takes four weeks of annual leave per year.

Case study 3 – Intermittent charging*

Dr Jones is a practice owner who identifies that a certain number of his patients can afford to contribute to the costs of their healthcare (ie those who aren't on any form of social support). He decides to charge $82 for the first consultation with these patients per financial year and bulk bill all subsequent consultations. This allows Dr Jones to accrue enough income to cover expenses, while continuing to provide access to affordable care for patients who cannot afford practice fees.

This means that Dr Jones' billings will increase as follows

Scenario	Before	After
Patient who attends two consultations	$85.70	$124.85

Patient who attends five consultations	$214.25	$253.40
Patient who attends 10 consultations	$428.50	$467.70

This concept can work in various ways. After the initial privately billed consultation, subsequent billing is at the GP's discretion. For example, the GP may continue to privately bill patients who don't qualify for the MBS bulk billing incentive and revert to bulk billing for those who are eligible.

*Scenario based on MBS item 23 (Level B attendance lasting less than 20 minutes), which has a rebate of $42.85.

Case study 4 – $16.15 fee*

Dr Brown is a rural GP who relies heavily on the MBS rural bulk billing incentive for Modified Monash Model (MMM) 2 areas, which pays $12.70 for services provided to patients under 16 and concession card holders. Approximately 30% of Dr Brown's patient caseload qualifies for this incentive.

To generate additional income to cover expenses, the practice introduces a $16.15 fee for all consultations with patients that don't attract the incentive payment. Privately billed patients pay $59 for a standard consultation and receive a rebate of $42.85, meaning they are $16.15 out of pocket.

Dr Brown works 40 hours (35 hours of this is clinical time) and sees an average of 140 patients a week. 42 of these consultations qualify for the bulk billing incentive, resulting in billings totalling $3,399.90. Dr Brown privately bills all other patients (charging a $16.15 fee), accruing $5,782. Dr Brown therefore accrues an extra $1582.70 in billings per week.

Dr Brown receives 65% of her billings. This means her annual income (before tax) would increase by more than $49,380.30 to $286,475.30.

*Scenario based on MBS item 23 (Level B attendance lasting less than 20 minutes), which has a rebate of $42.85, and MBS item 10991 (bulk billing incentive for MMM 2 areas), which has a rebate of $12.70. It is assumed the GP takes four weeks of annual leave per year.