# Q&A – Medicare Compliance

## Responses to webinar questions

### Webinar details

**Date:** 16 July 2025

**Time:** 7.00 pm – 8.00 pm AEST

**Facilitator:** Dr Michael Wright, RACGP President

**Presenters:** Dr Sarah Mahoney, Department of Health, Disability and Ageing
Matthew Williams, Department of Health, Disability and Ageing

**Recording:** Click here to view

### General comments

Many of the questions received during the webinar on 16 July 2025 relate to Medicare Benefits Schedule (MBS) interpretation. As with all specialist medical colleges, The Royal Australian College of General Practitioners (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 met the descriptor of any Medicare service billed. For further information, see the RACGP's statement on Medicare interpretation and compliance.

The RACGP has published a webpage with links to Medicare and compliance education resources. Collating resources in a central location means 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, Disability and Ageing (DoHDA), Services Australia, the Professional Services Review (PSR) and RACGP and include MBS explanatory notes, fact sheets, education guides, eLearning programs, infographics and case studies.

The DoHDA has been asked to provide advice and input to this document. **For clarity, the RACGP views and positions on MBS policy and compliance activities identified in this document do not represent the views of the DoHDA.**

Responses which feature RACGP opinion or information about our advocacy have been separated out for clarity. We have grouped questions together under common themes in alphabetical order for ease of reading.

### MBS interpretation questions

#### Activities that count towards the consultation time

- ***How do we justify billing item 36 for a flu consultation, even though I genuinely spent that much time because the patient's mum had anxiety? What type of record needs to be kept?***
- ***I see a lot of patients who are from a group home. They are usually accompanied by support workers who are unfortunately of a poor standard. As a result, it takes double the usual time to see these patients. Is it wrong to bill according to time?***

MBS Note AN.0.9 includes information on what activities count towards the consultation time. When claiming time-tiered MBS items, the total consultation time includes the time required to communicate effectively with the patient. Where more time than usual is required to communicate effectively with a particular patient, it is considered reasonable to claim a longer attendance item than might otherwise be expected for the service. This applies to both face-to-face and telehealth services.

Communicating effectively with patients is crucial to achieving clinical outcomes and a key part of a clinical service. A wide range of factors may affect the time needed to communicate effectively with a patient during a consultation. These include, but are not limited to, situations where a language barrier exists between the medical practitioner and patient (including when an interpreter is required), or when a patient has hearing problems, difficulty with speech, an intellectual disability, and/or dementia.

In such situations, medical practitioners and other providers should make a brief record in the patient's notes including details about why the additional time was required. For example, stating 'consultation extended due to use of interpreter' and, if relevant, citing the Translating and Interpreting Service (TIS) job number.

When calculating the duration of an attendance for the purpose of item selection, only the time spent in active attention on the patient can be counted. Time spent discussing the patient's care with, for example, a parent or carer, in the patient's absence, cannot be counted.

Please refer to MBS Note GN.15.39 for information on adequate and contemporaneous records. You may also find DoHDA's Administrative record keeping guidelines for health professionals and record keeping tips helpful.

***I have spent over 30 minutes syringing ears. Is this a Level B or C consultation?***

If you have spent 30 minutes with the patient and met the requirements of item 36, it is reasonable to bill this item. Please refer to MBS Note AN.0.9 for information on what activities count towards the consultation time.

The removal of uncomplicated wax in the absence of other disorders of the ear by operating microscope or endoscope, or the removal of wax by microsuction or syringing using any visualisation method may be claimed as part of an MBS general attendance item provided all other requirements of the item have been met.

***What about adding My Health Record upload time to the consult time with item number claiming?***

Time spent reviewing, creating or updating entries in the patient's My Health Record while the patient is present counts toward the consultation time.

Time taken to write clinical notes, complete forms, reports or other paperwork, upload records in My Health Record (or other systems), or talk to carers or relatives when the patient is not present cannot be included in the consultation time.

Guidance on the use of time-tiered general attendance items is available in MBS Note AN.0.9.

### Aftercare

***It is very common for specialists and especially hospitals to direct patients back to general practitioners (GPs) for wound dressings, removal of sutures or staples after surgery, which may be extensive aftercare. Is it correct that this can never be billed by the GP?***

Schedule fees for most surgical items include normal post-operative care. This means you can't bill attendance items for normal aftercare. However, if the MBS description of the surgical item you performed excludes aftercare in the item's description, you can bill attendance items for providing aftercare.

If your patient can't return to the same practitioner who performed the surgical item for aftercare, a different GP who was not the original proceduralist can bill attendance items for the aftercare they provide. Non-GP specialists and consultant physicians can't bill an attendance for normal aftercare services in this same situation. However, patients should not be routinely assigned to a GP who did not perform the original procedure to avoid the aftercare rules.

The *Health Insurance (Subsection 3(5) General Practitioner Post-Operative Treatment) Direction 2017* allows a medical practitioner working in general practice to use a general attendance item to provide aftercare provided they did not perform the initial service that caused the need for aftercare. See AN.0.71 for further information.

You can bill an attendance item during an aftercare period if the service isn't 'normal aftercare'. A service isn't normal aftercare if you see your patient for either:

- an unrelated condition
- complications from the operation.

See the Services Australia website and MBS Note TN.8.4 for more information.

### After-hours care

***If a consultation spills over into an after-hours period, which item should we bill?***

Attendances using urgent after-hours items (585, 594, 599) must be booked during the same unbroken urgent after-hours period.

For non-urgent services, when an attendance takes place over an in-hours and an after-hours period (in either order) the period in which the greater portion of the attendance took place determines the type of item to claim, for the total duration of the attendance.

### Aged care

***When we review aged care residents and document in the aged care system, do I need to copy the record to Best Practice again?***

There is no MBS rule that requires you to duplicate notes into a particular practice software (eg Best Practice). What matters is that you keep and can produce adequate and contemporaneous records that meet GN.15.39. Facility records created during or as soon as practicable after the attendance, with the patient's name, date and sufficient clinical detail, are acceptable evidence for substantiation. Practically, ensure you either (a) retain a copy (export/scan) of the residential aged care facility (RACF) note in your records, or (b) have reliable access to retrieve it promptly if required.

***I have a number of patients in residential aged care. Some facilities seem to fund podiatry care through requesting a care plan contribution for the five visits for all patients and an Enhanced Primary Care (EPC) form (now I guess a referral letter). What is your view about the appropriateness of this from the podiatrist perspective?***

*Please note that the Department no longer uses the term 'Enhanced Primary Care' or 'EPC' to refer to the MBS chronic condition management GP items or associated allied health items. The EPC planning items were removed from the MBS in 2005 and the term 'EPC plan' is now obsolete.*

Patients in RACFs are not eligible for a GP chronic condition management (CCM) plan or referred allied health CCM services through that pathway. However, where a GP contributes to a RACF patient's multidisciplinary care plan under item 731, the patient will be eligible for up to five referred allied health CCM services in a calendar year. Guidance on the use of item 731 is available in explanatory note AN.15.8.

The allied health services that are appropriate for an individual patient will depend on the patient's chronic condition. In some cases, it may be appropriate for the patient to access five allied health services of the same type.

Importantly, Medicare-rebateable allied health services should not replace services that are expected to be provided to residents by the RACF, as a requirement under the *Aged Care Act 1997*. Under this legislation, approved providers of residential aged care services are required to provide therapy services, such as recreational, speech therapy, podiatry, occupational therapy, and physiotherapy services, to certain residents (as defined by the resident's funding classification) at no additional cost. Services that may be included in this are:

- maintenance therapy delivered by health professionals, or care staff as directed by health professionals, designed to maintain residents' levels of independence in activities of daily living; and
- more intensive therapy delivered by health professionals, or care staff as directed by health professionals, on a temporary basis that is designed to allow residents to reach a level of independence at which maintenance therapy will meet their needs

If residents are entitled to receive the allied health services noted above at no additional cost to themselves through the RACF, those residents should not routinely be referred for allied health services under Medicare. The availability of allied health items under Medicare does not change the obligations of aged care providers under the Quality-of-Care Principles but enables residents to receive more Medicare-subsidised health services for treatment if required. Any allied health services supported by the MBS must be consistent with the patient's multidisciplinary care plan.

### AskMBS

- ***Who can give the correct, legal advice for an MBS item number?***
- ***How do we get legally binding advice? There are lots of item numbers and rules. It's not a simple, straightforward system.***

Due to the varying nature of clinical practice and an abundance of factors such as patient demographics, as well as the unique circumstances of each individual consultation, it is not possible to issue legally binding advice in relation to each MBS item number.

Responses from the DoHDA AskMBS email service are specific to the particular question asked and the relevant policy or legislation applying at the time the question is asked. Changes in policy or legislation may result in responses to the same issue varying over time.

DoHDA welcomes the opportunity to review instances of possible inconsistent advice by forwarding it to askmbs@health.gov.au for internal quality assurance purposes, and so that corrections or clarifications can be issued where required.

AskMBS aims to respond to enquiries as soon as possible, usually within 15 working days. You can also check this collection of AskMBS advisories to see if your issue is addressed there. AskMBS responses do not constitute legal advice, however they remain a useful tool to help you better understand Medicare billing rules and whether it is appropriate to claim certain items. If you have concerns about relying on advice received from AskMBS, you should contact your medical defence organisation (MDO).

### Billing multiple MBS items

- ***If I spend 10 minutes on the phone with a patient who then comes in face-to-face for another 15-minute consult on the same day, would you bill a Level C, a Level B + 91891, or just a Level B?***
- ***Could you please comment on multiple clinical encounters with a patient in one day? For example, seeing the patient in the morning, referring them for urgent blood tests/x-rays, and seeing the same patient again in the afternoon or via telephone for follow-up of results in the evening?***
- ***If I see a patient and at the end of the consultation they disclose they are depressed and need a GP Mental Health Treatment Plan (MHTP), why can't I bill both items? Sometimes we have to tell patients to come back another time because we can't address two concerns on the same day. Patients do not understand this, and it is difficult for us.***
- ***Is it okay to bill two items (eg MHTP and item 23 for an upper respiratory tract infection [URTI])?***

You can bill multiple attendances for the same patient on the same day if:

- the second (and any following) attendances are not a continuation of the initial or earlier attendances
- each service is distinct and clinically relevant
- the requirements of each item (including time requirements) are fully independently met
- there is no duplication of services.

A service is considered clinically relevant if it is generally accepted in the profession as necessary for the appropriate treatment of the patient.

If the second visit is a continuation of the first attendance, you should only bill one time-based attendance item. See AN.0.7.

Where a single attendance is conducted partly face-to-face and partly by telehealth, the modality through which the greater portion of the attendance is provided determines the type of item to claim, for the total duration of the service.

Where a practitioner determines that it is clinically relevant to provide multiple attendances, the patient's invoice/account should be annotated with 'separate' or 'unrelated' service, and the separate times of each service noted. The medical record should also reflect the clinical relevance of each service and details of the service provided to support your claiming practices in the event of an audit.

***Can one patient be billed by a practitioner using two different provider numbers in one day?***

You could potentially bill multiple services for the same patient on the same day but using two different provider numbers, provided each attendance was actually rendered and claimable in its own right (see response to the previous question).

Using two different provider numbers does not change the same-day rule: a later contact that is a continuation of the earlier one should not be billed as a separate attendance (see AN.0.7).

The provider number used on each claim must be the one linked to the location where that service occurred. Services Australia has information on provider numbers for different locations – Use your provider numbers.

***Can a MHTP and GP chronic condition management plan (GPCCMP) be billed together?***

There is nothing precluding a patient from having both a GPCCMP and a MHTP, provided they meet the relevant eligibility requirements for each plan. Whether either plan is clinically appropriate for an eligible patient remains at the clinical discretion of the relevant GP or prescribed medical practitioner (PMP).

Where both plans are in place, the patient would be eligible for the full allocation of referred allied health services under both plans. Currently, these allocations are:

- five individual allied health CCM services in a calendar year (10 for First Nations patients), and for patients with type 2 diabetes that are assessed as being appropriate for group services, up to eight group dietetics, diabetes education or exercise physiology services per calendar year
- 10 individual and 10 group therapy mental health treatment (Better Access) services in a calendar year.

For CCM a separate referral is required for each type of allied health service (eg separate referrals are required for physiotherapy and dietetics). Separate referrals are also required for CCM and Better Access services.

In addition to the referral requirements outlined in AN.15.6, under Better Access, the referring practitioner must include the patient's symptoms or diagnosis; a list of any current medications; the number of services the patient is being referred for; and a statement about whether the patient has had a MHTP or a psychiatrist assessment and management plan. The treatment provided by the allied health professional must be consistent with the range of acceptable strategies that has been approved for use be eligible health professionals utilising psychological therapy services and focussed psychological strategies.

***We often have patients who present with an acute issue when they are booked for a care plan and we do both, but only ever bill the care plan item and not the 23. Are you saying we can bill the 23?***

No. Planning and review items for GPCCMPs cannot be co-claimed for the same patient on the same day as general attendance items.

A list of attendance items that cannot be co-claimed with a GPCCMP item is available in MBS Note AN.0.47 (see 'Co-claiming restrictions').

***Can I co-claim item 23 and 16500?***

Co-claiming is permissible where you render two distinct, clinically relevant services on the same day: an antenatal attendance (16500) for pregnancy care and a separate general attendance (23) for an intercurrent condition unrelated to the pregnancy, consistent with TN.4.3(e) and the item 23 guidance on same-day services. Record separate times and ensure the second contact is not a continuation of the first (per AN.0.7).

You must not use item 23 to cover additional pregnancy-related work that is part of the same antenatal attendance. If the whole encounter is pregnancy care, bill 16500 only.

***More co-billing items to consider – 23 and 35503? 23 and 30071?***

In addition to the advice provided in earlier responses (see 'Billing multiple MBS items'), note that all MBS items, unless otherwise specified, are complete medical services. As such all procedural items, such as biopsy items and malignant skin excision items include any associated clinical interactions which would be reasonably required for the routine performance of the service, such as:

- obtaining informed consent
- routine pre-operative examination and post-operative review
- discussion with the patient of post-operative care
- unless otherwise stated, the provision of routine aftercare.

No additional MBS item attendance should be claimed where the clinical interactions with a patient do not extend beyond what would be reasonably required for the routine performance of the service.

However, where clinical interactions do extend beyond what would be reasonably required for the routine performance of the service, such as the discussion of results and management options regarding a lesion, an appropriate attendance item may be claimed. Please note that the attendance item requirements, as set out in the item descriptor and associated explanatory notes, must be met in full.

### Chronic condition management

***Could you please specify when item 10997 can be billed and how many times per year?***

Patients with a GPCCMP or a multidisciplinary care plan (MCP) can access up to five services per calendar year provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner to support management of their chronic condition (MBS items 93201 [video], 93203 [telephone] and 10997 [face-to-face]).

The services provided must be consistent with the patient's GPCCMP. Examples of the types of services that can be provided include but are not limited to:

- providing immunisations consistent with the plan
- monitoring a patient's progress between reviews and recording the results
- dressing wounds
- providing advice to the patient on the self-management of their condition.

The intent of item 10997 is to assist patients who require access to ongoing care, routine treatment and ongoing monitoring and support between the more structured reviews of the care plan by the patient's usual GP. Importantly, item 10997 cannot be used for a practice nurse or Aboriginal and Torres Strait Islander health practitioner's assistance with the preparation of a GPCCMP.

See MBS Note MN.12.4 and DoHDA's fact sheet for detailed information about the use of these items. Unused services do not roll over into the next calendar year.

***Are the allied health visits from January to December, or one year from the time of the plan?***

Patients with a GPCCMP can access up to five (10 for a person of Aboriginal or Torres Strait Islander descent) individual MBS supported allied health services per calendar year (i.e. from January to December).

***Can you bill item 10997 with item 965?***

Item 10997 and equivalents (93201, 93203) are intended for ongoing care, monitoring and support, as well as routine treatment consistent with the patient's chronic condition management plan, between more structured reviews of the plan.

Importantly, item 10997 cannot be used for a practice nurse or Aboriginal and Torres Strait Islander health practitioner's assistance with the preparation of a GPCCMP. Item 965 (and its equivalent items) is a complete medical service and is the only item that should be claimed for preparing a GPCCMP.

Co-claiming item 10997 with a planning or review item may be appropriate where the service provided by the practice nurse or Aboriginal and Torres Strait Islander health practitioner is separate from, but consistent with, the patient's plan development or review. Examples of scenarios where co-claiming would be appropriate are included in MBS Note MN.12.4.

***If a patient has type 2 diabetes, can they access up to eight group allied health services if they are assessed as suitable?***

Patients with type 2 diabetes can receive an assessment of their suitability for group dietetics, diabetes education or exercise physiology services and, if they are suitable, up to eight group services for the management of diabetes per calendar year.

***Do we need to annotate when billing item 965 to inform Medicare whether it is a new plan or review?***

No. Item 965 is only for the preparation of a GPCCMP. Item 967 should be billed for the review.

Detailed information on the new chronic condition management arrangements introduced on 1 July 2025 is available in fact sheets on MBS Online at Upcoming changes to the MBS Chronic Disease Management Framework and in explanatory notes AN.0.47 and AN.15.3–AN.15.8. Item descriptors and explanatory notes can be viewed by searching for the item or note number at www.mbsonline.gov.au.

- ***If a GP Management Plan (GPMP) was completed in June and I see the patient in July, can I complete a new GPCCMP or do I need to wait three months?***
- ***How long do we need to wait to bill item 965 if the patient had their GPMP/Team Care Arrangements (TCA) prepared or reviewed in June prior to the changes?***
- ***How soon after a GPMP and TCA can I prepare a GPCCMP?***

There is no prescribed minimum claiming period between putting a GPMP and TCAs in place prior to 1 July 2025 and transitioning to a GPCCMP after that date.

Under transition arrangements, patients with GPMPs and TCAs in place prior to 1 July 2025 can continue to access services that are consistent with those plans under transitional arrangements until 30 June 2027.

GPMP and TCAs can no longer be reviewed. When the patient is due for a review they should be transitioned to the new GPCCMP. While there is no minimum time between preparing a GPMP/TCA and a new GPCCMP, the service must be clinically relevant.

***I had a patient who changed doctors within the same practice to myself and came asking for an allied health referral. The GPMP/TCA were done in June 2025 by his previous GP. Should we wait three months to change it to a GPCCMP, or can it be done now under the new rules?***

You can continue under the existing GPMP/TCA and write allied health referral letters compliant with AN.15.6 until 30 June 2027; no immediate conversion to GPCCMP is required.

Convert by preparing 965 when clinically indicated (eg when a review would otherwise be due), noting old review items ceased and reviews of GPMPs and TCAs should not be claimed under the new review items (AN.15.5).

***How many GPCCMPs can we do safely in a day?***

There is no specific limit on the number of GPCCMPs you can prepare or review in a day. GPs must exercise their clinical judgement when determining how many of these services they can safely provide, ensuring each plan is delivered as a complete, clinically relevant service and meets all item requirements.

The 80/20 prescribed pattern of service rule applies generally to GP services. Any breaches of this rule will result in a referral to the PSR Director.

***Why does Medicare have the rule of not being able to bill 965 and another item number?***

The restriction on same day co-claiming of chronic condition plan and review items and attendance items is long standing. The restriction on item 965 is consistent with the restrictions that previously applied to items 721 and 723. The list of items that cannot be co-claimed is available in MBS explanatory note AN.0.47.

If needed, the attendance associated with a claim for item 965 can incorporate broader consideration of a patient's health needs. If the appointment is for a general consultation and the need to create a plan is identified, GPs can claim the attendance item and consider providing the plan at another time.

***When doing a care plan review, does that need to be in a form or in the patient's notes?***

The process of reviewing a GPCCMP must include:

- recording the patient's consent and agreement to the updates
- offering a copy of the updated plan to the patient and the patient's carer (if any) if the practitioner considers it appropriate and the patient agrees
- adding a copy of the updated plan to the patient's medical records.

While the RACGP and DoHDA don't have care plan templates available, most practice software companies have indicated they have or will update their templates to reflect the chronic disease management (CDM) framework changes.

***If the GPCCMP is developed on the day with the patient, the doctor writes the note but the actual paperwork is generated the next day by a nurse, is that compliant with MBS?***

An MBS item cannot be claimed unless all item requirements, as set out in the item descriptor and associated explanatory notes, have been met in full. As stipulated in note AN.0.47, the *Health Insurance (General Medical Services Table) 2021* (the Regulations) defines preparing a GPCCMP as the process whereby the GP or prescribed medical practitioner:

*a. prepares a written plan for the patient that describes*
*i. the patient's chronic condition and associated health care needs; and*
*ii. health and lifestyle goals developed by the patient and medical practitioner using a shared decision making approach; and*
*iii. actions to be taken by the patient; and*
*iv. treatment and services the patient is likely to need; and*
*v. if the patient would benefit from multidisciplinary care to manage the chronic condition, the services that the medical practitioner will refer the patient to (including the purposes of those services); and*
*vi. arrangements to review the plan (including the proposed timeframe for review); and*
*b. if the patient is to be referred to member of a multidisciplinary team for [management] of the patient's chronic condition:*
*i. obtains the patient's consent to sharing relevant information (including relevant parts of the plan) with the members of the multidisciplinary team; and*
*ii. if the patient so consents—provides relevant parts of the plan to the members of the multidisciplinary team; and*
*c. records the patient's consent and agreement to the preparation of the plan; and*
*d. offers a copy of the plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and*
*e. adds a copy of the plan to the patient's medical records.*

It would not be appropriate to delegate any of these activities to a practice nurse.

All requirements of an item must be completed before it can be billed. The items for developing a GPCCMP require that the plan is added to the patient's medical records and that a copy of the plan is offered to the patient and their carer (if relevant and the patient agrees). The item should not be claimed until these tasks are completed.

### Complete medical service

***Can you please further explain what a 'complete service' means?***

The principle of the complete medical service means that any tasks that would be considered integral to a particular service should not be claimed separately under another MBS item. As such, all procedural items include any associated clinical interactions which would be reasonably required for the routine performance of the service, including obtaining informed consent, routine pre-operative examination and post-operative review, discussion with the patient of post-operative care and, unless otherwise stated, the provision of routine aftercare.

Where the clinical interactions with a patient do not extend beyond what would be reasonably required for the routine performance of the service, no additional MBS item should be claimed. However, where clinical interactions do extend beyond what would be reasonably required for the routine performance of the service, then an appropriate attendance item for such a service may be claimed. An attendance item may also be claimed on the same day as a procedure where a separate and distinct clinical issue is being addressed. In both cases, the item requirements, as set out in the item descriptor and associated explanatory notes, must be met in full.

***Is 'time-banking' valid? Where you spend 10 minutes starting a MHTP last week (while the patient was here for something else), then you complete the MHTP this week with another 10 minutes and bill item 2715.***

If the second visit is a continuation of the first attendance, you should only bill one time-based attendance item. See AN.0.7. However, there should not be a duplication of service or time contributing to multiple services, i.e. the time spent for one service cannot be counted towards another service.

### Completion of forms/paperwork

- ***Does Medicare cover the completion of forms such as Centrelink, work, driver's licence?***
- ***I know we can't bill Medicare for insurance medicals that are for monetary gains. What about filling in National Disability Insurance Scheme (NDIS) or Centrelink forms?***
- ***Is it possible to bill Medicare for completing an application for a parking permit/Multi-Purpose Taxi Program?***
- ***Please advise what we can bill Medicare for (eg Disability Support Pension, Carer Allowance, supporting visa letter).***
- ***For completing any paperwork except Centrelink, can we do Medicare billing? Many of our patients come in for paperwork relating to vaccine status, university or employment applications.***

Medicare benefits are only payable for clinically relevant services. A medical service is considered clinically relevant if it is generally accepted in the medical profession as necessary for the appropriate treatment of the patient. Subsection 19(5) of the *Health Insurance Act 1973* (the Act) prohibits the payment of Medicare benefits for 'screening' services, defined as a medical examination or test that is not reasonably required for the management of the medical condition of the patient.

The completion of paperwork of any kind, as a standalone service with no clinical interactions, is not considered a clinically relevant service and is not eligible for Medicare benefits. However, where the paperwork is completed in the course of a broader attendance which is directly concerned with the management of the patient's condition, and the requirements of an attendance item are fully met, that attendance item may be claimed. Only the time spent in active attention on the patient can be counted towards the duration of the attendance for the purposes of determining the appropriate item. As always, the medical practitioner is responsible for assessing clinical relevance in individual cases.

As set out in MBS Note GN.13.33, there are a number of exemptions from the subsection 19(5) prohibition, including age or health related medical examinations to obtain or renew a licence to drive a private motor vehicle.

In addition, Subsection 19(3) of the Act prohibits the payment of Medicare benefits for medical services related to a person's employment. Specifically, benefits are not payable in respect of a professional service rendered to a person if:

(a) the medical expenses in respect of that professional service were incurred by the employer of that person; or
(b) the person to whom that professional service was rendered was employed in an industrial undertaking and that professional service was rendered to him or her for purposes connected with the operation of that undertaking.

Note that 'industrial undertaking' is to be interpreted broadly to include any form of paid employment.

### Health assessments

***In regard to health assessments – is there a daily limit on how many items to bill? Would four health assessments a day attract an investigation or penalty?***

In general, patients can receive any health assessment for which they are eligible at a point in time. Where the patient is eligible for more than one health assessment, there is no prescribed minimum interval of time between the provision of the different health assessments. Where patients are eligible for more than one health assessment, the practitioner should ensure they identify which target group the health assessment relates to when submitting claims to Services Australia. Additional information on claiming limits is available at Services Australia – Health assessments and your record keeping responsibilities.

Note however that time-dependent claiming restrictions apply to heart health assessment item 699 and health assessments under items 701–707 and 695.

As set out in explanatory note AN.14.2, item 699 can be claimed once per patient in a 12-month period. The heart health assessment items cannot be claimed if a patient has had a health assessment service, excluding an Aboriginal and Torres Strait Islander peoples' health assessment (item 715, 228, 92004, 92011), in the previous 12 months. However, it is possible to claim a subsequent standard health assessment item, including item 695, if the patient has had a service under items 699/177 in the previous 12 months.

The co-claiming of item 699 on the same day as a standard health assessment is only strictly permissible if the standard health assessment is provided following the heart health assessment.

Guidance on time-tiered health assessments (items 701–707, 715) is available in explanatory notes AN.0.36–AN.0.46. Guidance on heart health assessments and menopause and perimenopause health assessments can be found in notes AN.14.2 and AN.14.3 respectively.

### Pathology

***Could you clarify how the coding rules apply in everyday general practice? For example, when multiple tests are clinically indicated but only three are rebated, is there a risk that the GP appears to be over-ordering if those extra tests are billed to the patient or pathology? And how are GPs supposed to prioritise tests in that case – especially if unaware of which three will be rebated?***

'Episode coning' is a Medicare payment rule which means that when more than three pathology tests are requested for a single patient on the same day, by one or more medical practitioners (who are not a specialist or consultant physician), Medicare benefits are paid for only the three most expensive pathology items.

A number of exemptions apply to episode coning and these can be found in Rule 4 and Rule 18 of MBS explanatory note PN.0.33 – *Pathology Services Table*.

### Women's health

***Is it illegal if a patient is charged for example $50 for an Implanon insertion procedure, and the GP bulk bills a Level B consultation at the same time?***

When a practitioner bulk bills a service, they accept the patient's Medicare benefit for the service as full payment. An additional charge cannot be raised for any reason. In this scenario, if the consultation was solely in relation to the Implanon insertion, an additional fee could not be charged. Conversely, if the $50 fee in this case included the consultative elements of the Implanon insertion, it would not be appropriate to also claim an MBS attendance for that purpose.

Note also that this scenario is not split billing as that term is conventionally used. Split billing is where multiple MBS items are claimed on the same occasion, and the practitioner bulk bills one or more of those items and privately (patient) bills one or more others – that is, levies a fee that is higher than the Medicare benefit for those services. Split billing involves the claiming of MBS items for all services concerned and does not involve an MBS item for one or more services while one or more others are billed 'off-MBS', with no item being claimed.

## Policy/operational issues, including RACGP advocacy

### Activities that count towards the consultation time

***One problem is that Medicare says you should have complete notes but cannot consider times that the patient is not with you. This means when you see the patient you should complete your notes, so the patient has to wait for us to finish our notes which is not feasible, and they get annoyed when we look at our computer the whole time instead of focusing on them.***

The RACGP appreciates this feedback. We are advocating for GPs to be better remunerated for activities performed in between consultations, including clinical notes and other paperwork. Current legislation prevents MBS items from being billed when the patient is not present due to the enhanced risk of non-compliance and potential fraud.

When calculating the duration of an attendance for the purpose of item selection, only the time spent in active attention on the patient can be counted. Time spent updating clinical notes or discussing the patient's care with, for example, a parent or carer, in the patient's absence, cannot be counted.

We believe MyMedicare provides an opportunity to address the lack of proper remuneration for administrative tasks in general practice. Under a properly funded voluntary patient enrolment model, GPs and practices would receive additional payments to support the delivery of comprehensive services, including care coordination activities between consultations, beyond the relevant fee-for-service MBS items. This would improve timeliness of care, reduce the patient's financial and access burden, and improve capacity for GPs and practices to undertake population and preventive health activities.

Other potential solutions to reduce the administrative burden facing GPs are outlined in the RACGP's 2024 submission to the Department of the Prime Minister and Cabinet on the future of government service delivery.

### Assignment of benefit

***With telephone consultations, please explain how to obtain consent.***

If you bulk bill an MBS telehealth service, you need your patient's agreement to bulk bill the item/s before the Medicare benefit can be paid, or the agreement of a responsible person on behalf of the patient. For example, a responsible person could be a child's parent. This is called the assignment of benefit process.

If you can't get patient agreement in writing or by email for telehealth services, you can get verbal agreement from your patient during the telehealth consultation. More information about this is available on the Services Australia website.

The RACGP has received feedback that many GPs find the assignment of benefit process incredibly convoluted and onerous. As reforms to the process will be implemented in due course, we encourage GPs to continue with their usual process for the time being. Minister Butler has advised that there are currently no plans to pursue any broad punitive actions on this issue unless it relates to fraudulent claims against Medicare.

To stay up to date with changes to assignment of benefit rules, please keep an eye on the DoHDA website. Updated advice will be issued pending the commencement of legislative amendments to the assignment of Medicare benefits.

### Billing multiple MBS items

- ***My impression is Medicare does not like providers billing multiple items for one consult. If multiple services are billed for the same patient on the same day, eg item 23 and 2713, and both are clinically relevant and required, will it be more likely for the provider to be audited just because of this billing behaviour?***
- ***Why is billing multiple items if suggested by software a problem, especially if the service is provided appropriately?***

Multiple items can be claimed on the same day for the same patient if each service is clinically necessary, distinct, and meets all item descriptor requirements.

DoHDA reviews claiming data to identify patterns that may suggest routine incorrect claiming. For example, providers with a high proportion of co-claiming at high volumes, especially when this differs significantly from their peers, may be subject to further analysis.

Enforcement action is not taken based on claiming patterns alone, with factors such as patient demographics, clinical context, location and other environmental influences considered before any decision to act is made. Providers are also given the opportunity to self-reflect and provide further information to substantiate their claiming.

Finally, health providers are responsible for claims made under their provider number, regardless of who submits claims or receives associated payments. Even if software suggests items can be claimed together, you are responsible for ensuring the accuracy of your claims.

### Billing processes

***As a locum, I do not control billings to a great extent and do not always check. Managing new patients and practices is enough, and we are dependent on staff accuracy. Do you have any comment?***

If you have delegated your billing to a practice staff member, you should still double check all claims made. You are personally responsible for any MBS service billed using your provider number.

***Are there any plans for the Department to provide a practitioner portal where billing practices and benchmarks with like cohorts may be reviewed in real time?***

The Department has no such plan at this time. Variations in patient demographics, regional health needs, service delivery models, and operational contexts mean that billing data can differ significantly for valid reasons, which poses a challenge to establishing a meaningful benchmark that accounts for the diversity among practices. Presenting such comparisons without appropriate context can be misleading, potentially resulting in misinterpretation or unintended conclusions.

***Can you hold billings until a new provider number comes in?***

Yes, you can hold billings and lodge later once your new location provider number is active, provided you do not use anyone else's provider number.

### Compliance processes

***Is it correct that compliance reviews are generally for GPs that primarily do bulk billing?***

No. All providers that claim or request any type of Medicare service and/or prescribe or supply Pharmaceutical Benefits Scheme (PBS) medicines may be subject to compliance review and action.

***After an audit is triggered, and if the provider's post-audit billing behaviour is appropriate and not fraudulent, will the provider continue to trigger audits?***

The end of an audit does not prevent future audits. Providers must ensure their Medicare claiming remains compliant, as all claiming is subject to ongoing monitoring and review. Future audits will only occur if DoHDA has a reasonable concern that benefits have been paid for services that did not meet legislative requirements.

Audits are undertaken in circumstances where a provider appears to be routinely claiming in a manner that does not meet legislative requirements. They account for a small percentage of all Medicare compliance interventions.

***I am a GPT1 registrar who billed mainly items 36 and 44 during the first four months, trying my best to be safe, double-checking guidelines and taking time to explain concepts to patients. The time was spent with the patient. Am I at risk of an audit?***

DoHDA monitors claiming data, collects intelligence and carries out a range of targeted data analysis to identify potential non-compliance. Audits are undertaken in circumstances where a provider appears to be routinely claiming in a manner that does not meet legislative requirements.

Enforcement action is not taken based on the items claimed alone, with factors such as patient demographics, clinical context, location and other environmental influences considered before any decision to act is made. Providers are also given the opportunity to self-reflect and provide further information to substantiate their claiming.

As a health practitioner, you are responsible for keeping accurate records and being able to produce them to substantiate your Medicare claims if DoHDA requests them as part of a review or audit. Records should:

- clearly identify the name of the patient
- contain a separate entry for each attendance by the patient
- include the date when the service took place
- contain adequate and clear clinical information
- be completed at the time of the service or as soon as possible after.

***How are audit repayments calculated?***

The *Health Insurance Act 1973* enables the recovery of amounts paid in respect of professional services in certain circumstances. For example, a Medicare benefit may be recoverable if a professional service was not rendered in accordance with relevant item requirements.

Once the Chief Executive Medicare or a delegate has assessed the available evidence in an audit, they may decide to claim an amount as a debt due to the Commonwealth. If an amount is claimed, the health provider will be advised in writing, given reasons for the decision, and information about how to apply for a review of the decision.

The Act sets out circumstances in which administrative penalties apply in respect of amounts recoverable as debts due to the Commonwealth. Administrative penalties may be reduced, in part or in full, in certain circumstances. Penalties may be reduced in full where a health provider voluntarily informs the Department, before compliance activity has commenced, that an amount paid exceeds that which should have been paid. Other opportunities for full or partial

reduction of penalties are available after compliance activities have commenced and are made clear in relevant communications.

***What is the period of review? Will the PSR investigate something from five years ago?***

The PSR process begins when the Chief Executive Medicare requests that the PSR Director undertake a review of your provision of services during a specified period (the review period). The review period must be within the two years prior to the request.

***How extensive and frequent are any random spot checks and audits for MBS billing?***

DoHDA does not undertake random spot checks or audits. The Department monitors claiming data, collects intelligence and carries out a range of targeted data analysis to identify potential non-compliance. Audits are undertaken in circumstances where a provider appears to be routinely claiming in a manner that does not meet legislative requirements.

***A lot of times patients come in with a list of tests that are advised by a naturopath etc, which are not required. If you don't cooperate, there is a risk of personal injury. What do you suggest in those instances? Take the patients first or comply with Medicare?***

You should not be performing any unnecessary test to satisfy another practitioner. If you have concerns about the actions of another health practitioner, you can report these to the Australian Health Practitioner Regulation Agency (Ahpra) (if the profession in question is regulated), or the relevant professional association.

***If a GP at my clinic bills care plan items for normal consults, do I report them?***

The Department is responsible for ensuring the integrity of payments made through Medicare and the PBS. Allegations of incorrect claiming are taken seriously and any concerns raised are assessed in accordance with the Department's compliance procedures. Please see the DoHDA website for information about reporting incorrect billing, claiming, or suspected fraud.

*What you can report*

You can report suspected incorrect claims, including:

- services that were not provided but claimed
- claims that do not meet eligibility or legislative requirements.

Reports may relate to:

- health professionals: doctors, pharmacists, dentists and allied health professionals such as physiotherapists
- health organisations: pharmacies, medical practices, hospitals and administrative staff.

*Information to include*

To assist with the assessment of an allegation, please provide as much detail as possible, including:

- names of individuals or organisations involved
- dates and locations of the alleged activity
- any relevant documentation or evidence relating to the concern/s.

*How to submit a tip-off*

You can report concerns confidentially through any of the following channels:

- online via this link – Health Provider Tip-Off web form
- phone via the Department's Tip-Off line – 1800 314 808
- email to provider.benefits.integrity@health.gov.au (note: emails over 20MB will be blocked)
- by mail:
  Tip-Offs
  MDP 659
  PO Box 9848
  Canberra ACT 2601

*What process does the Department follow with allegations?*

The department may respond in various ways, including:

- education and guidance material
- review or audit
- investigation under relevant legislation and any breaches of Australian laws.

Please note that not all information provided results in further action being taken (such as where an assessment of the information does not indicate a breach of legislation administered by the Department).

*Will you be informed about how the Department has dealt with the concerns raised?*

Due to privacy and secrecy provisions set out in legislation, the Department cannot provide updates on the progress or outcome of the concerns raised. This should not be interpreted as inactivity – all allegations and concerns are reviewed thoroughly.

***How are PSR repayment amounts calculated? Some of these seem very high.***

In arriving at proposed terms for an agreement, the PSR Director will have regard to the likely outcome if your matter were to proceed onto a Committee and the Determining Authority.

The Director may consider:

- the amount expended by the Commonwealth for MBS or Child Dental Benefits Schedule (CDBS) services you provided where the Director considers there to be a possibility of inappropriate practice
- the proportion of possible inappropriate practice in the Director's review
- the seriousness of the conduct considered to constitute possible inappropriate practice
- any mitigating factors, including your willingness to acknowledge inappropriate practice, and steps taken by you to mitigate the risk of repeating the conduct (for example, undertaking training courses and changes made to your practice since you received notice of the review)
- your circumstances, and whether the totality of the proposed agreement (for example, a combination of a repayment and disqualification) might suit those circumstances
- whether you have any relevant previous PSR history, if applicable
- your submissions as to the appropriate way forward.

The most you could be asked to repay is the amount expended for MBS or CDBS services you provided during the review period for which the Director considers there to be a possibility of inappropriate practice. The Director cannot ask for an additional 'penalty' amount.

***Given that Medicare rebates have consistently lagged behind inflation for over a decade, and that GPs are expected to deliver increasingly complex care within time-constrained consults, how does the government reconcile this with its concern about 'gaming the system' when providers use legitimate item combinations to reflect the breadth of work done? Isn't there a risk that underfunding and scrutiny together create a perception that GPs themselves are being structurally disadvantaged by the system? For example, co-billing item 23 + 2713, the latter number being removed in November.***

The RACGP has longstanding concerns about the lack of any meaningful increase to Medicare patient rebates over the years. Rebates have not kept pace with inflation, and general practice is chronically underfunded in comparison to other parts of the healthcare system.

Our 2025-26 pre-budget submission outlined several proposals to improve the affordability and accessibility of general practice care, including:

- increasing MBS rebates by 40% for all standard general practice consultations longer than 20 minutes
- applying a 25% increase to Medicare rebates for GP mental health items.

We appreciate the concern around the changes to MBS mental health items from 1 November 2025, including the removal of items 2712 and 2713. The RACGP has highlighted to the Minister for Health that there are instances where these items can be co-claimed legitimately, and in fact the MBS explanatory note for GP mental health care expressly permits co-claiming when two distinct services are provided.

In the RACGP's submission to the independent review of Medicare integrity and compliance, led by Dr Pradeep Philip, we noted that GPs may underbill due to a fear of compliance activities, or avoid billing more complex item numbers due to confusion around claiming rules. In the RACGP's 2022 Health of the Nation survey, 16% of GPs said they limit the services they provide to avoid the consequences of non-compliance. Forty-two per cent of GPs reported having not claimed certain Medicare items, despite legitimately providing services, due to fear of being targeted in a compliance campaign.

The RACGP supports measures aimed at preserving the integrity of Medicare and use of health resources by preventing wrongful and fraudulent claiming. Compliance processes can be stressful for providers and affect the quality and timeliness of patient care. We maintain educational activities should be prioritised before compliance actions. Where reasonable, health professionals must be given an opportunity to adapt or rectify their billing practices prior to being subject to compliance activities. The RACGP is not in favour of measures that would increase the administrative burden for GPs in the event of any compliance activity. For example, requesting that providers review an extensive list of historical Medicare claims by consulting their records would detract from patient care.

***If you are referred to the PSR, do you have the opportunity to self-audit for voluntary errors? Or will you automatically be penalised and requested to pay a certain amount back?***

Once referred to the PSR, voluntary repayments will not simply result in the investigation being cancelled, but they can contribute to negotiating a resolution with the PSR Director. The Director must go through the proper processes once a practitioner is referred to them. On the other hand, referral to the PSR will not necessarily result in you being penalised and required to repay funds.

Following completion of their review, the PSR Director may seek to enter into an agreement with you. In these circumstances, the Director will contact you or your legal representative to negotiate the terms of the agreement, including any proposed action requiring you to repay MBS or CDBS benefits.

During the negotiation of the agreement the Director may raise issues that persist after their review of any submissions you have made, such as:

- your compliance with regulatory requirements and professional expectations
- the quality and adequacy of your records and other documentation
- the clinical relevance of your service provision
- your clinical input and decision making.

Negotiation of an agreement requires you to acknowledge you engaged in inappropriate practice in connection with providing specified services during the review period, and accept the terms imposed.

If the PSR Director provides you with terms of a draft agreement for your consideration, you are under no obligation to accept the terms of the proposed agreement or come to any agreement. Your response options may include:

- choosing to agree with the proposed terms
- proposing alternative terms which better suit your circumstances
- rejecting the terms of the draft agreement.

If you choose to propose alternative agreement terms, the Director will consider whether your proposal is reasonable and appropriate to your circumstances, having regard to the likely outcome if your matter were to proceed to a Committee and the Determining Authority.

Negotiating an agreement is the most common way matters involving inappropriate practice are resolved. This is primarily because the time taken to reach an agreement is shorter than a Committee process. The terms of any agreement must include an acknowledgement of inappropriate practice from you. The agreement can include the following actions:

- repayment of Medicare or dental benefits
- disqualification from using the MBS (in whole or in part), CDBS (in whole or in part) or PBS for a set period with a maximum of three years (or five years if you have been referred to the PSR before)
- a reprimand by the Director
- counselling from the Director.

***What would be the period for reviews or audits – one or two years?***

Please see this page for information on DoHDA's compliance approach, which can include audits and other types of reviews.

### Department of Veterans' Affairs (DVA)

***Are billing rules the same for DVA patients and non-DVA patients?***

GPs must bill DVA directly for services provided to eligible veterans and their dependants, ensuring no out-of-pocket expenses for the veteran. DVA payments to GPs are typically 115% of the MBS benefit, plus a Veterans' Access Payment (VAP) and potentially a Rural Enhancement Initiative (REI) loading.

The way to bill MBS and DVA item numbers is the same for all claiming channels.

### Eligible MBS item numbers

***Is there any specific list of item numbers that GPs have access to? Especially those that we can claim as well as non-GP specialists.***

There is no exhaustive list of all MBS item numbers that GPs are eligible to claim, as this depends on the specific skills and expertise of the individual doctor. Many MBS procedural items do not specify which practitioner is eligible to bill the item, and the GP must determine if they meet the requirements of the descriptor.

You may wish to consult the RACGP's MBS online tool (member login required), which includes a Full MBS list containing all the items listed in our various MBS guides. This includes a comprehensive list of GP attendance items (face-to-face and telehealth), as well as the most commonly used procedural items by GPs. Given the size of the MBS there may be other items used by GPs not included in this list.

### Gap fees

- ***Why can't GPs just charge patients the gap amount when they privately bill, especially during this time of high living costs?***
- ***Why doesn't Medicare allow patients to only pay the gap and the GP then gets the Medicare rebate, especially in low socioeconomic regions? It will make a huge difference for the patient since many patients cannot afford to pay the whole cost but can pay the gap. The current system prevents them from coming to GPs and compromises their health.***

Unlike other forms of health insurance, current legislation prevents patients from paying the difference between their benefit (patient rebate) and the total fee for the service. Instead, privately billed patients are required to pay the whole fee and subsequently obtain reimbursement for their benefit from Medicare. The *Health Insurance Act 1973* provides the legislative framework for the payment of Medicare benefits.

The RACGP recognises that only being required to pay the gap amount would make it easier for patients to afford fees. On a related note, we have continually expressed concern about the continued operation of the 90 day pay doctor cheque scheme. Despite reports the cheque system would be phased out, it remains operational. This archaic system is an added administrative and financial burden that GPs and patients simply do not need.

There are no plans currently to remove the 90-day timeframe, as it is seen as supporting bulk billing. This is because if a patient is unable to pay the full amount on the day of the consultation (rebate + gap fee), the GP could be left waiting up to 90 days to be paid. In that case the GP may choose to bulk bill the patient as a one-off. The RACGP will continue to advocate where possible for this scheme to be reviewed.

To avoid situations where patients are unable to afford your full practice fee, it is important to clearly advertise your fee policy, so patients understand the need to pay in full on the day of the consultation.

The quickest way for a patient to claim their Medicare benefit is at the clinic straight after they pay. With Medicare Easyclaim, patients can claim their Medicare benefit and have it paid into their bank account instantly through your practice's EFTPOS terminal.

### MBS complexity

***Why doesn't DoHDA simplify Medicare?***

The RACGP has long maintained that the MBS is unnecessarily complex and does not reflect the way GPs deliver person-centred, comprehensive, and holistic healthcare. This complexity is contributing to inadvertent billing errors and technical non-compliance, rather than deliberate non-compliance. It is a daily challenge for GPs to keep up with regular changes to item numbers and claiming rules.

Dr Pradeep Philip's review of Medicare integrity and compliance, undertaken in 2022-23, highlighted the complexity of the Medicare system. In response to the review, the Medicare Integrity Reform Branch of DoHDA was established to action Dr Philip's recommendations.

The RACGP seeks to work collaboratively with DoHDA to develop, improve or promote education and resources for providers in regard to Medicare compliance. We assist the Department in communicating Medicare changes to GPs and, where appropriate, reviewing fact sheets and other resources to ensure clarity and relevance to GPs. One example of this is the Understanding Medicare: Provider Handbook, which is an invaluable resource for providers new to the

Medicare system. It aims to articulate key MBS concepts in an easy-to-read guide, and we recommend all providers have this resource bookmarked for reference when needed.

The RACGP works closely with DoHDA's Medicare Education Section, part of the Medicare Integrity Reform Branch, to deliver education such as webinars to our members. DoHDA also presents regularly at RACGP conferences and events on the topic of Medicare compliance.

The RACGP has compiled links to information about the MBS and Medicare compliance on our website so you can easily access these from one central location. This page includes DoHDA, Services Australia and RACGP resources. Links are grouped under key themes, which are in alphabetical order. We've also included short descriptions of each resource to help you find what you need.

The MBS Review Advisory Committee (MRAC) has commenced a review of time-tiered MBS items to which the RACGP will be contributing. The review will consider issues such as item consistency, opportunities to streamline, and whether the current time-tiers appropriately support contemporary clinical practice. A working group has been established to lead this review and will report back to the full committee on its findings. Recommendations or advice from this review will be finalised and provided to government at the end of 2025.

### MyMedicare

***How do I check if a patient is already registered with another practice?***

If you believe a patient is registered with another practice, the easiest way to check is in the patient's My Health Record.

***What is the easiest way to check if a medical clinic is enrolled in MyMedicare?***

You can check if your practice is registered for MyMedicare by logging into your Provider Digital Access (PRODA)/Health Professional Online Services (HPOS) account. If you are registered, a MyMedicare tile should be visible when you click the My Programs tile on the HPOS homepage.

***Is MyMedicare registration tied to an individual practitioner or to all doctors in the clinic?***

Generally, MyMedicare occurs at the practice level. In most cases a practice rather than an individual provider will register for MyMedicare, however sole providers can register. When patients register for MyMedicare they will pick a practice to register with (and a single location if the practice has multiple sites) and select a preferred provider within that practice. Any provider registered to the patient's MyMedicare practice can provide care and receive MyMedicare benefits, not just their preferred provider.

A GP who is seeking to register as a sole provider should complete the registration process using their sole provider organisation information (i.e. business name as registered with the Australian Business Register [ABR]) in response to the fields relating to General Practice registration in the Organisation Register. The independent GP or sole practitioner can link themselves in the Organisation Register if they are:

- a vocationally registered GP
- a non-vocationally registered GP
- a GP registrar.

***With MyMedicare registration, has anyone looked into how a person over 50 will process all the information?***

The DoHDA website includes comprehensive information for patients about enrolling in MyMedicare. A suite of resources is available, including videos, fact sheets and frequently asked questions, as well as an easy read guide. Paper registration forms are also available for patients who would prefer to sign up without using digital services.

***What can we do about practices that are registering patients to their practice with MyMedicare without the patient's consent?***

A registration in MyMedicare is only confirmed when both the patient and practice have provided consent to formalise their relationship. Unauthorised patient registration will cause a practice to be non-compliant with the MyMedicare Guidelines.

If you are concerned that a practice is registering patients without their consent, you should contact DoHDA so they can take appropriate action. DoHDA investigates all complaints it receives and may take action where it finds non-compliance with MyMedicare requirements.

***Patients not registered with a practice via MyMedicare seem to have more freedom in getting their care plan, wherever and by whoever. Shouldn't there be a restriction on care plans being done only if you are registered with a regular practice? Otherwise, what's the incentive for registering?***

While MyMedicare registration supports continuity of care and is encouraged by the RACGP, it is recognised that access to chronic condition management services must still be provided for non-enrolled patients. There are several reasons why patients may not yet have registered for MyMedicare or may face barriers to registering, particularly as the scheme is still relatively new. Patients who are not registered with MyMedicare must still access GPCCMP items through their usual GP.

MyMedicare encourages participation in the program through access to longer MBS telephone items, improved continuity of care and future incentives to be added to the MyMedicare program.

### Opportunistic billing

- ***There are a lot of times where opportunistic health assessments have led me to diagnose chronic undiagnosed asymptomatic conditions, which no one else investigated because the patient presented for one problem and only that was dealt with. Isn't opportunistic assessment then a good thing?***
- ***Opportunistic screening and billing Medicare – is it not part of holistic patient care?***

Opportunistic assessments are appropriate if clinically relevant. A clinically relevant service is one that is generally accepted by the relevant profession as necessary for the appropriate treatment of the patient.

A provider is responsible for determining what services are relevant for their patients. When claiming Medicare benefits for those services, the provider must ensure that all elements of the MBS item descriptor are met.

The Department reviews and monitors claiming data to identify patterns that may indicate incorrect, inappropriate, or fraudulent claiming. This includes claiming higher benefit items than the services rendered, adding services to claims that were not required or never performed, or routinely performing services without considering the needs of each patient. Factors such as provider specialty, patient demographics, location, peer comparisons, expert stakeholder insights and broader environmental influences are considered to assess whether there is a reasonable concern.

Medicare benefits are generally not payable for health screening services. A health screening service is defined as a medical examination or test that is not reasonably required for the management of the medical condition of the patient.

***Can we get more clarification on what 'unbundling' services means?***

Unbundling refers to billing separate aspects of a service under multiple MBS items when those aspects are already included in a single, comprehensive item. Each MBS item is considered a complete medical service, and claiming individual components separately to maximise benefits is not permitted.

### Overseas claiming

***If a doctor is overseas and a patient has tests like a pathology holter done during that time (with the referral done prior to travel), how does that work?***

If you travel overseas, no MBS services can be provided or supervised using your provider number. If you have referred a patient for tests and these are performed by another practitioner in Australia while you are overseas, under that practitioner's provider number, you have not breached any rules.

- ***If I work a half day and then fly overseas at 8pm, will I get flagged for being overseas?***
- ***I have heard of GPs who were found non-compliant because an item number was billed to Medicare after they left the country. If I am catching an overseas flight at 10pm after working until 5pm that day, will I be found non-compliant and the item number/s rejected?***

Services performed on the date of exit/entry to Australia are not considered a compliance concern. The Department's data matching focuses on items claimed with a date of service where Home Affairs records indicate the provider was out of the country for the full day.

The Department does not make compliance decisions based on data matching alone. While unlikely to occur, if a provider was contacted about services performed on the date of exit/entry to Australia, they will be given the opportunity to provide additional information to substantiate their claiming.

***If we deactivate our provider number because we are going overseas, what happens when another specialist or radiology or pathology provider tries to provide the service?***

The other provider should be using their own provider number for any service they perform. It shouldn't matter that you have temporarily deactivated your own provider number.

***Regarding the overseas claiming, a colleague received one of the 'education' letters. They put through a claim for a skin procedure that was performed by them while in Australia. Because of the delay in billing that occurs when the clinician waits for histology to come back, the billing was processed by the clinic while the doctor was overseas. It's important to process the payments so the patient receives their Medicare rebate on a service they've received and to support business viability when the doctor is overseas for a prolonged period. Are reasons like billing processing being deferred while awaiting histology taken into account?***

Where a service is rendered by a provider on a date they are in Australia but claimed on a later date (when the provider is overseas), that would not be a compliance concern. The Department's data matching focuses on items claimed with a date of service where Home Affairs records indicate the provider was out of the country for the full day.

Where delayed billing/claiming occurs, it is important to ensure that the date of service is accurate and reflects the actual date the service was rendered. In the example provided, the date of service is the date the skin procedure was performed.

The date of service for skin excision items is the day that the excision is performed. The claim for the service should not be made until histopathology results are available – so a claim for the service may not be made until a later date, but the date of service remains the date that the excision was provided. Claims can be submitted to Medicare when the provider is overseas.

***Are interstate telehealth consults covered by Medicare?***

Medical practitioners working in general practice can only provide an MBS telehealth service where they have an established clinical relationship (ECR) with the patient unless exemptions apply. An ECR means the medical practitioner performing the service:

- has provided at least one face-to-face service to the patient in the 12 months preceding the telehealth attendance; or
- is located at a medical practice where the patient has had at least one face-to-face service arranged by that practice in the 12 months preceding the telehealth attendance (including services performed by another doctor located at the practice, or a service performed by another health professional located at the practice, such as a practice nurse or Aboriginal and Torres Strait Islander health worker); or
- is a participant in the Approved Medical Deputising Service (AMDS) program, and the AMDS provider employing the medical practitioner has a formal agreement with a medical practice that has provided at least one face-to-face service to the patient in the 12 months preceding the telehealth attendance.

The full range of exemptions is set out in explanatory note AN.1.1.

Additionally, from 1 November 2025, patients are able to access Medicare rebates for telehealth if they receive the service from their MyMedicare registered practice, regardless of whether they have been seen in-person in the last 12 months.

Where the requirements for ECR have been met, telehealth services can be provided to the patient from any location. However, Medicare benefits are only payable for professional services rendered in Australia to an eligible person. That is, both the patient and the health professional must be physically present within Australia, as defined in the *Health Insurance Act 1973*, when the service is provided.

### Prescribed pattern of services (80/20 and 30/20 rules)

***Are items 23 and 10990 considered two separate services under the 80/20 rule?***

Bulk billing incentive items, including item 10990, are not included in the 80/20 rule.

***Can you please explain a little bit more about the 80/20 and 30/20 rules? Can you also summarise what you said about bulk billing? Our clinic is bulk billed but still charges for certain items such as procedures etc.***

Information on the 80/20 and 30/20 rules is available on the Department's website.

There is no legislative barrier to a practitioner providing more than 80 services in a day, provided each service is clinically relevant and provided in an appropriate manner. Where a practitioner provides services at or near this level for a longer period, the practitioner's billing may be drawn to the attention of DoHDA's Practitioner Review Program (PRP).

If, however, a practitioner provides 80 or more professional attendance services on each of 20 or more days in a 12-month period, the *Health Insurance Act 1973* requires that the practitioner be referred to the Director of the PSR for a review of their provision of services. This pattern of service (known as a 'prescribed pattern of services' and commonly referred to as the '80/20 rule') is deemed to constitute inappropriate practice, except in exceptional circumstances. The Health Insurance (Professional Services Review Scheme) Regulations 2019 allow the PSR Director to consider exceptional circumstances when reviewing a practitioner's profile. Exceptional circumstances might, for example, include an unusual occurrence causing an unusual level of need for services on a particular day.

Relevant professional attendance services items covered under the 80/20 rule are listed in the Health Insurance (Professional Services Review Scheme) Regulations 2019.

In response to the second part of your question – if you bulk bill most patients/services but privately bill some services such as procedures, this is an acceptable billing model to use in your practice. A mixed billing approach is considered a viable option by many GPs.

***Re 80/20 – if 80 is not the number of patients, would it be clearer to state the maximum number of patients to be seen? The current 80/20 rule has created confusion.***

Both the 80/20 and 30/20 rules refer to the number of individual MBS services provided by a doctor during a single day – not the number of patients seen per day. You might bill multiple item numbers for the same patient on the same day, and these individual items (services) are counted separately towards the total.

***Can you explain the 30/20 rule simply?***

Any GP, prescribed medical practitioner or consultant physician who claims 30 or more relevant telephone attendance services on each of 20 or more (cumulative and/or consecutive) days in a rolling 12-month period will be in breach of the 30/20 telephone rule. All breaches of the 30/20 rule will be referred to the Director of the PSR.

A full list of MBS items subject to the 30/20 rule is provided in this fact sheet.

### Provider resources

***The Understanding Medicare: Provider Handbook appears to be the 2024 version. When will the 2025 book be released?***

The Handbook was released in 2024 and covers fundamental principles. The Department has commenced scoping content for a second edition. It is intended that this second edition will be predominately focused on the specifics of compliance and will cover topics aligned with the Department's 2025 health provider compliance priorities. Work on this is progressing and updates will be provided as the development of this product evolves – including any collaboration opportunities offered with key stakeholders including the RACGP.

### Record keeping

***Can you provide sample notes for item 36 and item 44?***

DoHDA does not provide sample clinical notes for services provided under items 36 and 44, but you may find the following resources helpful:

Administrative record keeping guidelines for health professionals
Medicare billing assurance toolkit – record keeping tips

We also suggest contacting your medical indemnity insurer to see what resources they have available to support you.

***Do your notes have to include all the discussion about confirming patient identity/limitations (i.e. telehealth etc)?***

Please refer to MBS Note GN.15.39 for guidance on maintaining adequate and contemporaneous records.

To be ***adequate***, the patient or clinical record needs to:

- clearly identify the name of the patient
- contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated
- provide clinical information adequate to explain the type of service rendered or initiated
- be sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the patient's ongoing care.

To be ***contemporaneous***, the patient or clinical record should be completed at the time that the service was rendered or initiated or as soon as practicable afterwards. Records for hospital patients are usually kept by the hospital and the practitioner could rely on these records to document inpatient care.

### Referrals

***How long do indefinite referrals last for?***

An indefinite referral does not expire. An indefinite referral is intended to cover the continuing care and management of the original medical condition for which it is written. If a GP agrees to write an indefinite referral, it must be clear to all relevant parties, including the patient's non-GP specialist or consultant physician, that the referral is for an indefinite period.

An indefinite referral is not intended to cover new medical conditions which arise after the referral has been issued. If the patient develops a condition clinically distinct from the condition for which the patient was originally referred to the non-GP specialist, the patient's GP can issue a new referral, and a new course of treatment will commence once that referral has been accepted.

Once an indefinite referral has been accepted by a non-GP specialist or consultant physician, that referral cannot be replaced with a referral for a shorter period for the same condition.

***Specialists are asking to have their names on referrals, rather than accepting open general referrals. This causes delays and further costs for patients to go back to their GP to amend the referral.***

An open referral contains the minimum requirements and can be presented to any specialist practising in the relevant specialty. In some instances, a patient presenting to a public hospital may elect to be treated as private patient. Where this occurs, the specialist must be named on the referral consistent with clause G19 of the National Health Reform Agreement.

A named referral is only required for private services in an outpatient setting. Public hospitals mandating named referrals as a way of claiming MBS items is illegal and should be flagged with DoHDA via the Report suspected fraud online form.

Even where a referral is named, the patient has the right to choose to see a different specialist, provided this decision is made prior to the commencement of treatment under the referral.

### Semaglutide

***I have a patient who comes to see me for a semaglutide injection every week. The patient is intellectually impaired, and their carers don't like giving it. Can I be reprimanded?***

It is unclear if the practitioner in this scenario is concerned about being reprimanded for prescribing semaglutide, or claiming a Medicare service for the administration of the injection.

Below is DoHDA's general advice based on each of these potential situations:

1. There is no specific item number for the administration of this medication to the patient. As per GN.14.35, some services are not listed on the MBS as they are regarded as forming part of a consultation or attract benefits on an attendance basis (for example time-based attendance items). To claim any MBS service, it must be considered clinically relevant by peers and meet all the specific and general item requirements set out in the MBS.
2. Prescribing under the PBS requires all criteria to be met. For semaglutide to be prescribed under the PBS specific criteria must be met and authority is required. Specific PBS criteria can be accessed here.

For specific circumstances, such as this question, it may also be appropriate to seek guidance from AskMBS.

### Split billing

- ***If I charge a gap for a consult, can I bulk bill an electrocardiogram (ECG) for example?***
- ***Can you bulk bill a GPCCMP and privately bill an unrelated service (eg 23)?***

- ***I would like a comment on bulk billing a consultation and charging the patient a fee for treatment such as cryotherapy or ear syringing which is not part of the consultation.***

Where a number of services are claimed under multiple MBS items on the one occasion (with the exception of diagnostic imaging and surgical operation items which will be discussed below), a GP can choose to bulk bill some services and privately bill others, charging an amount for the latter set at the provider's discretion. This amount may be higher than the MBS fee. See MBS Note GN.7.17 and the Services Australia website for more information.

This is called split billing and is permissible unless the fee for one item being claimed would be reduced or amended as a result of it being claimed with another item, as happens with diagnostic imaging and procedural (operations) items. For example, where the Multiple Operation Rule or the Multiple Services Rule applies to two services, billing cannot be split to bulk bill one item and privately bill the other. Where the Multiple Operation Rule or the Multiple Services Rule applies, the patient receives the maximum benefit payable when the billing is not split.

Under this rule, and for the purposes of Medicare claiming, a provider can privately bill a patient for a biopsy on a suspicious skin lesion (item **30071**) inclusive of costs for consumables, as well as bulk billing a timed attendance item (such as **23**) for a second issue, as the Multiple Operation Rule is not impacted by the claiming of an attendance item with a single procedural item.

However, it would not be permissible to bulk bill a melanoma excision item (such as item **31375**) while privately billing a biopsy item (item **30071**). In this scenario, as both items are MBS Group T8 – Surgical Operations items to which the Multiple Operation Rule applies, both services must either be bulk billed or privately billed.

Please note there are a number of co-claiming restrictions that apply to GPCCMP items. Planning and review items for GPCCMPs cannot be co-claimed with general attendance items for the same patient on the same day. See MBS Note AN.0.47 for details.

### Telehealth

***Reception booked a patient for telehealth who had not been seen in the clinic for just over 12 months. I did not realise it was over 12 months since their last face-to-face consult. Do I charge the patient privately or will I get into trouble for billing item 91891?***

If you are billing MBS telehealth items, you must ensure the patient has been seen face-to-face at least once in the previous 12 months. The face-to-face visit can either be with yourself or another GP/health professional at the same practice.

Additionally, from 1 November 2025, patients can access Medicare rebates for telehealth if they receive the service from their MyMedicare registered practice, regardless of whether they have been seen in-person in the last 12 months.

If the patient doesn't meet the 12-month requirement and they don't qualify for an exemption, or they are not enrolled in MyMedicare, they will not be eligible for a Medicare rebate and you cannot bill the relevant item. Instead, you will need to charge the patient a private fee if they are willing to forgo their rebate.

If you have incorrectly claimed an MBS telehealth item, you can submit a voluntary acknowledgement of incorrect payments to DoHDA.

### Women's health

***Will there be tripled bulk billing incentives for antenatal consults from 1 November 2025?***

No. From 1 November, GPs will be able to claim bulk billing incentive items when they bulk bill any Medicare-eligible patient. However, there are no changes to the items that the tripled bulk billing incentives apply to. Bulk billing incentives (both the single and tripled incentives) will apply to the same items they apply to now.

Guidance on bulk billing incentive arrangements is available in a factsheet and reference tables here. The reference tables show the specific items that can be claimed with each incentive item, for services provided by practices in different Modified Monash (MM) locations. The MM area categorisation of a practice or organisation can be checked by using the Health Workforce Locator Map.

Additional guidance can be found in explanatory notes MN.1.1–MN.1.8, which can be viewed by searching for the note number at www.mbsonline.gov.au.

For the purposes of bulk billing incentives, antenatal attendances would be considered ‘other unreferred services’.