

Understanding Medicare: Fundamentals and Compliance Essentials for GPs

Webinar Q&A – responses current as of 27 August 2026

After-hours services

What telehealth items can I use for after-hours attendances?

The only face-to-face after-hours attendance items that have been replicated in telehealth items are the ‘unsociable’ after-hours face-to-face items 599 (for vocationally registered [VR] general practitioners [GPs]) and 600 (for other medical practitioners [eg prescribed medical practitioners]), replicated in video items 92210 and 92211 respectively. The ‘unsociable’ after-hours period means the period between 11pm and 7am on any day.

For after-hours telehealth services generally, standard telehealth attendance items can be used. However, these will be subject to the eligible telehealth practitioner (ETP) / MyMedicare registration eligibility requirements, unless an ETP exemption applies. Information on these requirements and exemptions is available in [Medicare Benefits Schedule \(MBS\) Note AN.1.1](#).

The unsociable after-hours telehealth items are exempt from the ETP requirement. Note however that urgent after-hours items (in both sociable and unsociable hours) have specific requirements and can only be billed if the following conditions are met.

The attendance for these items must be requested by the patient or a responsible person during the same unbroken urgent after-hours period in which the medical service is provided. The medical practitioner must first determine that the patient requires urgent medical assessment.

In considering the need for an urgent assessment of a patient’s condition, the practitioner may rely on information conveyed by the patient or patient’s carer, other health professionals or emergency services personnel. A record of the assessment must be completed and included in the patient’s medical record.

The MBS urgent after-hours items may be used when, on the information available to the medical practitioner, the patient’s condition requires urgent medical assessment during the after-hours period to prevent deterioration or potential deterioration in their health. Specifically, the patient’s assessment cannot be delayed until the next in-hours period.

Guidance on after-hours items generally and residential aged care facility (RACF) after-hours services specifically is available in MBS Notes [AN.0.19](#) and [AN.0.15](#) respectively. Information on GP telehealth services can be found in a [fact sheet on MBS Online](#).

Ahpra / complaints handling

What do we do with patients who engage in threats and intimidation, including reporting to the Australian Health Practitioner Regulation Agency (Ahpra), because I am trying to explain the rules of Medicare in a polite way?

Providers should continue to explain Medicare requirements clearly, calmly and professionally, and ensure the discussion is documented in the patient record where relevant. Medicare compliance obligations remain the responsibility of the provider, including billing only where the service is clinically relevant, the full item requirements are met, and adequate records are kept. If a patient threatens a complaint or attempts to pressure a provider into billing incorrectly, the provider should not claim an item unless they are satisfied the MBS requirements have been met.

Assignment of benefit

The public guardian in NSW will usually not be available to sign but will indicate consent in advance for appropriate services. Does this meet the MBS requirements for bulk billing?

There are ways for consent from an appointed public guardian to meet MBS bulk billing requirements, and to minimise the time needed to seek their consent.

The 1 July 2026 updates to assignment of benefits (AoB) mean that a public guardian can provide consent before a service if needed. This could be per-service for scheduled services with an episodic agreement, or it could be for future unscheduled services with an enduring agreement for eligible patients.

Episodic pre-service assignment

An episodic pre-service assignment may cover multiple known services for up to six months, provided all relevant details are known in advance. This includes:

- the health practitioner who will provide the services
- the dates the services will be delivered
- the services to be provided.

Episodic pre-service assignment is intended for patients receiving ongoing scheduled care, such as dialysis, cancer treatment or palliative care, allowing a single agreement to cover all known appointments within that period.

If the service provided differs from the service described in the agreement, a new or updated AoB must be obtained. Pre-service assignments must accurately describe the anticipated service using the relevant basic service description published on the [MBS Online download page](#).

Enduring assignment arrangements

Enduring agreements allow eligible patients to assign their Medicare benefits for agreed ongoing bulk billed GP services without needing to complete a new AoB agreement for each visit. Enduring assignment arrangements are available for:

- patients registered with MyMedicare
- residents of aged care homes
- patients of Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Medical Services (AMSs).

When a Medicare claim is made using an enduring agreement for a MyMedicare registered patient, the provider must notify the assignor in writing within 24 hours of making the claim. Providers must also retain records of notifications as part of their enduring agreement record-keeping obligations.

Additional advice: Assignment of benefit by someone other than the patient

Where a patient cannot personally assign their benefit, an assignment may be provided by the person who would otherwise be responsible for the cost of the service.

A responsible person may include, but is not limited to:

- a parent or guardian
- a person holding power of attorney
- a person holding a guardianship order
- next of kin.

A responsible person should not include:

- the health professional who provided the service
- the health professional's staff
- a hospital proprietor or staff member
- an aged care home proprietor or staff member.

Health practitioners should ensure that any person acting for a patient has appropriate authority to do so. Further information about who can act for a patient is available from Services Australia at [Acting for someone with Medicare](#).

More information on the revised arrangements for AoB introduced on 1 July 2026 is available in the Department of Health, Disability and Ageing's (DoHDA) [frequently asked questions](#).

After 1 July, how can written consent be obtained to bulk bill phone consults for elderly patients who can't sign online forms?

If a patient's agreement to AoB can't be obtained physically or electronically, verbal agreement may be used until 30 June 2027 as part of transitional arrangements.

In obtaining a verbal agreement, the practitioner must outline to the patient information required for the relevant AoB agreement and confirm the patient agrees. If the patient agrees, 'assignor verbally agreed' should be entered in the assignor signature field.

Verbal agreements have the same record keeping requirements as signed agreements, including for episodic and enduring agreements.

Note that these requirements are not applicable to patients accessing healthcare funded by the Department of Veterans' Affairs (DVA).

Is pressing 'yes' on a Tyro terminal that is integrated with Pracsoft a compliant form of consent for in-house consultations?

Yes, if the assignor has been presented with the necessary information.

A terminal-based confirmation can be an electronic signature. To meet AoB requirements, the assignor should be confirming that the service details required for the claim are correct. The final agreement record is retained by the practice to substantiate the claim.

Providers are encouraged to consult their software vendor to determine whether AoB agreements can be created, recorded and retained through their practice management software. Many software vendors have completed a conformance process undertaken with Services Australia in preparation for incoming AoB requirements.

Billing multiple MBS items

Can you bill a telehealth item in the morning and a face-to-face item for review in the afternoon for the same issue?

In general, Medicare benefits may be paid for more than one service for a patient on the same day, provided that:

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

A service is clinically relevant if it is generally accepted in the profession as necessary for the appropriate treatment of the patient. MBS items are complete medical services. Tasks that are integral to one service should not be claimed separately under another item. A second item on the same day may only be appropriate if it represents a separate and distinct clinically relevant service and all requirements for that item are met.

Practical principle for same-day services

When considering whether two services can be billed on the same day, ask:

- Is the second service genuinely separate?
- Is it clinically relevant?
- Does it meet the full item descriptor in its own right?
- Is it supported by adequate records?

If the answer to all these questions is yes, a separate claim may be appropriate.

If a patient has seen two GPs around the same time, can Medicare be billed twice? For example, the patient sees GP 1 first for a few issues, then sees GP 2 for one of the issues (eg skin issue where GP 1 required the expertise of GP 2)?

Medicare may only be billed where each service is clinically relevant and meets the relevant item descriptor. If the second GP provides a separate and distinct service that is not simply duplicating or completing the first service, a separate claim may be appropriate. Records should clearly explain the clinical reason for the second attendance, the service provided and why it was necessary. Note that Medicare benefits are not payable where more than one medical practitioner attends the patient simultaneously.

What if the patient makes a telehealth appointment in the morning and then comes later in person for the same problem? Can I bill for total time spent with the patient, or should I bill both a telehealth and face-to-face item (e.g. 91900 and 36)?

The provider should consider whether the services are genuinely separate and whether each item descriptor is met. If the later face-to-face attendance is part of completing the same service, it should not be separately claimed simply because it occurred in two parts. If there are separate clinically relevant services, each claim must be supported by adequate records showing what was provided, when, and why each service was required. Where a single attendance comprises both face-to-face and telehealth elements, the appropriate item to claim (face-to-face or telehealth) for the total duration is determined by the modality by which the greater part of the attendance was provided.

If a care plan is prepared in the morning and there is a follow up of results via telehealth in the afternoon, can we bill separate items?

Planning and review items for GP chronic condition management plans (GPCCMPs) cannot be co-claimed by the same practitioner for the same patient as an attendance item on the same day. This applies to all general attendance items, including face-to-face, telehealth, after-hours and out of consulting rooms items.

For other types of plans, such as mental health treatment plans (MHTPs), separate items may only be billed if each service is clinically relevant, separate and distinct, and the full requirements of each item are met. If the follow-up is integral to the care plan service or part of completing that service, it should not be claimed separately. Also, it would not be appropriate to use MBS telehealth services for the simple communication of test results, as a standalone service where no other clinical interactions have been undertaken. The records should clearly support the clinical need and item requirements for each claim. Note that MBS telehealth items are considered to be direct substitutes for face-to-face attendances and are governed by the same principles and requirements. Telehealth items should not be billed for purposes that would not normally be billed to Medicare.

If a patient has a phone consult in the morning and the doctor notes another issue which requires face-to-face care on the same day, can I bill two separate items?

A second item may be appropriate where the face-to-face service addresses a separate and distinct clinical issue, and all MBS requirements are met. The record should clearly identify the separate issue, the clinical reason for the additional attendance, and the service provided. Providers should avoid claiming separately for tasks that are integral to the earlier service. Time requirements for one service cannot contribute to the time requirements of a second service if rendered.

When doing a MHTP under item 2715 and we need to manage a new result with high HbA1c, can we co-claim a 23?

Co-claiming may only be appropriate where the additional attendance is clinically relevant, separate and distinct from the MHTP, and the requirements of the attendance item are met in full. The record should clearly show that management of the new HbA1c result was not merely incidental to the MHTP and required a separate service.

Can you complete a health assessment and GPCCMP on the same day?

A health assessment and care plan should only be claimed on the same day if both services are clinically relevant, separate and distinct, and each item's requirements (as specified in the item descriptor and explanatory notes) are met. Providers should ensure the records clearly support the need for both services and demonstrate that one service was not simply an integral component of the other. However, it is not expected that the co-claiming of a chronic condition management (CCM) item with a health assessment would routinely occur. The expectation would be that a GPCCMP would be prepared following a health assessment as a result of a risk being identified, including confirmation of a chronic condition/s.

See [MBS Note AN.0.47](#) for information about GPCCMPs and AN.15.3–AN.15.6 for other CCM items.

Care and management plans

Does my patient need to spend 45 minutes with me for a service under 139? Can they see the nurse instead?

To complete the item requirements of item 139 the GP must spend at least 45 minutes in attendance with the patient. Practice nurses may assist with administrative or clinical support activities consistent with their scope of practice. However, any time spent with a practice nurse cannot contribute to the minimum 45-minute attendance requirement for item 139.

The 45-minute minimum duration for MBS item 139 is intentional and reflects the nature and purpose of the service, rather than the complexity of any single presenting issue.

The item is designed to support the development of a diagnosis and comprehensive, structured management plan for patients with severe and pervasive disabilities, not to fund brief or targeted assessments for isolated conditions. The time requirement signals that the service involves more than diagnosis and referral alone, with the expectation that the service includes all the activities listed in [MBS Note AN.0.73](#).

For complex neurodevelopmental disorder and eligible disability services, is a speech delay an eligible disability?

From 1 March 2026, stuttering, speech sound disorders (SSD), and cleft lip and/or palate (cleft conditions) were added to the list of eligible disabilities. Patients who are suspected of having, or are diagnosed with, these conditions will be able to access MBS items under the M10 item group, including allied health assessment, diagnosis and treatment services. Detailed guidance on the 1 March 2026 changes is available in an [MBS Online fact sheet](#).

Speech sound delays cannot be considered a speech sound disorder for the purposes of eligibility to referred allied health services. Speech sound delay and speech sound disorders are distinct conditions. Speech sound delay involves typical speech development that occurs later than expected, characterised by developmentally normal error patterns persisting beyond age norms. In contrast, speech sound disorders involve atypical speech development, with abnormal phonological processes and reduced system organisation that generally do not resolve without intervention.

While these conditions may be difficult to differentiate in infants, the MBS relies on the clinical definition of speech sound disorders, not speech sound delay, when determining eligibility. This is consistent with the [MBS Review Taskforce Report on Primary Care](#) (recommendation 10 for allied health), which recommended that 'severe speech and language disorders', including stuttering and speech sound disorders, be made eligible for M10 item services due to the severity and long-term impact of those conditions on patients. As speech sound delay is still a typical pattern of speech development (albeit delayed), it does not fit within the scope of the recommendation and its emphasis on including conditions with comparable severity to those already listed on the M10 eligible disabilities list.

Can my patient have a MHTP and a GPCCMP?

There is nothing precluding a patient from having both a GPCCMP and a MHTP, provided they meet the relevant eligibility requirements for each plan. Patient eligibility for each plan remains at the clinical discretion of the relevant GP or prescribed medical practitioner.

Where a GP determines that a patient is eligible for both a MHTP for the treatment of their mental health disorder, and a GPCCMP for the treatment of their chronic condition, it is permissible for both plans to be put in place.

Further, it must be noted that eligibility requirements differ between both plans. To be eligible for CCM services, the patient must have at least one medical condition that has been (or is likely to be) present for at least six months or is terminal. There is no prescribed list of chronic conditions. Whether a patient's condition, including their mental health disorder, qualifies as a chronic condition is a matter for the clinical judgement of the referring GP.

To be eligible to receive services under Better Access, patients must have a clinically diagnosed mental disorder as defined by the World Health Organisation ICD-10 classification (not including dementia, delirium, tobacco use disorder or mental retardation). To access allied health treatment under an MHTP, the patient must have a valid referral from a GP or prescribed medical practitioner who is managing the patient under a MHTP who is from the general practice they are enrolled in for MyMedicare, or their usual medical practitioner. Patients may also be referred directly by a psychiatrist or a paediatrician.

Where both plans are in place, the patient would be eligible for the full allocation of referred allied health services under both plans, as determined by their GP or prescribed medical practitioner. Currently, these allocations are:

For CCM, up to:

- five individual allied health CCM services in a calendar year (or 10 for First Nations patients)
- five services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner
- if the patient has type 2 diabetes, one assessment of their suitability for group allied health services and, if they are suitable, up to eight group allied health sessions

For MHTPs:

- 10 individual and 10 group therapy mental health treatment (Better Access) services in a calendar year.

A separate referral is required for each plan that details the treatment specific to that plan. The treatment provided by the allied health practitioner must be consistent with the plans, referrals, and requirements of the relevant MBS item/s.

Additional resources are [available here](#) and in MBS explanatory notes [AN.0.47](#) and [AN.0.78](#).

Can my patient have a MHTP and an eating disorder treatment and management plan (EDTMP)?

There is nothing precluding a patient from having both an MHTP and an EDTMP where they meet the clinical criteria for both. Each plan is assessed separately, therefore having a MHTP does not prevent a patient from accessing an EDTMP.

How service allocations interact

There is an interaction between the service allocations available under an EDTMP and an MHTP, depending on the order in which services are provided and claimed.

- Better Access services provided before an EDTMP is developed do not count towards the patient's EDTMP allocation.
- Better Access services provided after an EDTMP is developed will count towards the patient's allocation of 40 EDTMP services.

Better Access service limits apply on a calendar year basis (1 January to 31 December), while EDTMP service limits apply over a 12-month period from the commencement of the plan.

Under an EDTMP

Eligible patients may access:

- up to 40 eating disorder psychological treatment services
- up to 20 eating disorder dietetic services.

These services are available over a 12-month period from the date of the EDTMP and are subject to review requirements.

Review requirements

Patients must progress through the required review stages before accessing the full allocation of services. The review process determines whether further treatment remains clinically appropriate and whether additional services can be accessed. To access more than 20 psychological treatment services under their EDTMP, a patient will require a specialist review and recommendation from a consultant psychiatrist or consultant paediatrician in addition to a review conducted by a GP or medical practitioner.

Case conferencing items

Can I claim an item both for organising and participating in a case conference?

No. The item for organising and coordinating a case conference includes participating in the conference. As set out in [MBS Note AN.0.49](#), to organise and coordinate a conference means undertaking all the following activities:

- explaining to the patient the nature of the conference
- asking the patient whether the patient agrees to the conference taking place
- recording the patient's agreement to the conference
- recording the day the conference was held and the times the conference started and ended
- recording the names of the participants
- recording the activities mentioned in the definition of multidisciplinary case conference in clause 1.1.4 of the Health Insurance (General Medical Services Table) Regulations 2021 (the Regulations) and putting a copy of that record in the patient's medical records
- offering the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees), and giving each other member of the team, a summary of the conference
- discussing the outcomes of the conference with the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees).

To participate in a case conference the medical practitioner must meet the requirements of clause 2.16.16 of the Regulations which states that to participate:

- does not include organising and coordinating the conference
- involves undertaking all of the following activities in relation to the conference:
 - a) explaining to the patient the nature of the conference
 - b) asking the patient whether the patient agrees to the practitioner's participation in the conference
 - c) recording the patient's agreement to the practitioner's participation in the conference
 - d) recording the day the conference was held and the times the conference started and ended
 - e) recording the names of the participants
 - f) recording the matters mentioned in the definition of multidisciplinary case conference in clause 1.1.4 of the Regulations and putting a copy of that record in the patient's medical records.

Can I participate in a case conference by telehealth?

Yes. Case conference items can be used for face-to-face, phone and video attendances. Some participants may be present in the room and others may attend via video or phone – however, there must be continuous communication throughout the whole case conference by all participants.

Items billed by Urgent Care Clinics

What items can be billed by GPs in an Urgent Care Clinic (UCC)?

Medicare UCCs have been issued an exemption under subsection 19(2) of the *Health Insurance Act 1973*, which allows the payment of Medicare benefits for certain services provided by GPs, prescribed medical practitioners, and nurse practitioners working at these facilities while receiving a public salary. The MBS items which can be billed under these arrangements are set out in the relevant subsection 19(2) [direction](#) (latest version at the time of writing). This direction applies to UCCs in all jurisdictions.

Additional information on UCCs can be found [here](#).

If I work at a UCC, can I provide telehealth services after-hours?

As outlined in Section 7(6A)(b)(ii) of the [Health Insurance \(Section 3C General Medical Services – Telehealth Attendances\) Determination 2021](#) (the Determination), telehealth services must be provided during the hours of operation of the eligible UCC under the Commonwealth Urgent Care Clinic Program.

These items are 91790, 91800, 91801, 91802, 91920, 91853 for GPs. The items have no specified requirements in terms of business hours versus after-hours, and in general can be used at any time of day. However, the Determination restricts their use in eligible UCCs (noting not all UCCs are eligible).

LARC services

Why does my long-acting reversible contraceptive (LARC) loading fee keep being rejected?

On 1 November 2025, items 35503, 35506, 14206 and 30062 for the insertion or removal of LARCs had their MBS fees increased, and item 35501 was introduced to provide a 'loading' of 40% of the fee for the relevant LARC insertion or removal item(s). Thus, a patient's LARC insertion or removal service, and any consultation or other MBS items associated with providing the insertion or removal of the LARC service during the same appointment, must be bulk billed. The loading fee applies only to the relevant LARC procedural items – it does not apply to the consultation items.

In order to bill item 35501 to receive the 40% loading, the medical practitioner must bulk bill (accept the Medicare benefit as full payment) for the LARC item(s) (35503, 35506, 14206 and 30062), loading item 35501, and any consultation or other MBS items associated with providing the service to an individual patient.

When claiming item 35501 for a LARC service, the order in which items are listed in the claim is important. Services Australia have advised that each fee loading item (item 35501) must be listed directly underneath the corresponding eligible LARC items in the claim to ensure the correct loading amount is applied and the correct benefit is paid. For example, where both an insertion and removal service is provided, the order on the claim should be:

- 14206
- 35501
- 30062
- 35501

No other item number, including any other applicable bulk billing incentive items should be submitted between the LARC item and item 35501. Please contact Services Australia on the Medicare Provider Enquiry Line (132 150) for specific assistance with these claims.

Further information on LARC items, including guidance on the correct order in which to claim, is available in [MBS Note TN.0.1](#).

Prescribed pattern of services

Can you explain what 80/20 means in plain English?

The [80/20 rule](#) is a prescribed pattern of services rule. In plain English, it is designed to identify very high daily claiming patterns by medical practitioners. If a provider renders or initiates 80 or more professional attendance services on each of 20 or more days (cumulative, not consequently) within a rolling 12-month period, this may trigger referral to the Professional Services Review (PSR) process. Providers should monitor their claiming patterns and ensure all services are clinically relevant, properly documented and meet MBS requirements. Note that the rule is not activated by a single day's claiming activity. The threshold is reached cumulatively.

Record keeping

I want to keep my notes as brief yet adequate as possible to allow me to refer to them as needed. My colleagues tell me that a longer consultation requires a lot more writing, which seems subjective to me.

Records do not need to be lengthy, but they must be adequate and contemporaneous. To be *adequate*, they should clearly identify the patient, include a separate entry for each attendance, record the date of service, contain enough clinical information to explain the service provided, and be clear enough for another practitioner to understand and rely on for the patient's ongoing care. To be *contemporaneous*, the patient or clinical record should be completed at the time the service was rendered or initiated or as soon as practicable afterwards. Longer consultations do not automatically require lengthy notes, but the record must be sufficient to substantiate the item claimed and the clinical relevance of the service.

Services Australia, in consultation with DoHDA, has developed a [health practitioner guideline to substantiate that a specific treatment was performed](#). Information is also provided in [MBS Note GN.15.39](#).

Services that cannot be billed to Medicare

There is no item for the service I provided. What can I claim?

General attendance items are claimed for a professional attendance when no other MBS item applies. It is a general principle of the MBS that the item that best describes the service is the item that should be claimed. This means that where a more specific MBS item exists (for example a skin biopsy under MBS item 30071), the more specific item should be claimed. If no other MBS item accurately reflects the service provided, and the requirements of a general attendance item are met, the general attendance item is claimed.

For example, iron infusions may be claimed under a general attendance item that reflects the time spent by the GP in active attention on the patient.

What services do not attract a Medicare benefit?

Medicare generally won't pay for services that are not part of clinical patient care, are funded by another source, or are specifically excluded. Common GP examples include issuing repeat prescriptions without seeing the patient, insurance and pre-employment medicals, employer-requested assessments, health screening services (commercial driver's licence, aviation medicals), mass immunisation programs, non-therapeutic cosmetic procedures, and treatment where a public hospital, workers' compensation insurer, Transport Accident Commission (TAC), or another compensation body is responsible for the cost. It also excludes several specific treatments listed in [MBS Note GN.13.33](#).

Providers may elect to charge a private (non-MBS) fee for such services, where informed financial consent is obtained from the patient, including that no Medicare benefit is payable.

Split billing

Can you split billings, where you privately charge for a procedure with the applicable item number and bulk bill an attendance item number if clinically relevant?

Yes, split billing is generally permissible.

Where multiple services are claimed on the same occasion (excluding diagnostic imaging and surgical operation items subject to specific fee reduction rules), a practitioner may bulk bill some services and privately bill others. This is known as split billing, provided the fee for one item is not reduced or otherwise affected by the claiming of another item.

This type of billing arrangement is distinct from split billing practices that raise transparency concerns, such as separate booking or administration fees that obscure the true cost of care or issuing of two bills (one eligible for MBS rebate and one entirely private) for the same healthcare service (MBS item).

When split billing should not be used

Split billing should not be used where fee reduction rules apply, such as under:

- the Multiple Operation Rule (MOR)
- the diagnostic imaging Multiple Services Rule (DMSR).

In these cases, all affected services should be either bulk billed or privately billed to ensure the patient receives the maximum Medicare benefit payable.

Important reminder

A procedure item generally includes the routine clinical interactions reasonably required to perform that procedure, including:

- consent
- routine pre-operative assessment
- post-operative discussion
- routine aftercare.

An attendance item may only be claimed on the same day if there is a separate and distinct clinically relevant service beyond what is integral to the procedure, or a separate clinical issue is addressed. The requirements of each item must be met in full and supported by clear records.

Telehealth

How can I safely bill telehealth for a patient with a landline?

Telehealth services should only be billed where the relevant telehealth item requirements are met, including mode, patient eligibility and clinical relevance. For bulk billed patients, a valid [AoB](#) must be in place prior to the service being billed.

For a patient using a landline, the provider should ensure the service is an eligible telephone attendance, the full item descriptor is met, and the record clearly documents the service provided, the date, the clinical issue and any consent or assignment of benefit requirements relevant to the claim.

Note that from 1 March 2025, the term 'telehealth attendance' collectively refers to both video and phone attendances. Where an MBS item can only be claimed using a particular telehealth modality, the descriptor will specifically state phone attendance or video attendance. Where no telehealth modality is specified, the service must be provided in-person (face-to-face). Where an item descriptor specifies that the service is to be delivered by video, the provider must maintain a visual and audio link with the patient. Where an item descriptor specifies that the service is to be delivered by phone, then only an audio link is required.

Further information on MBS telehealth services, including relevant fact sheets, is available on [MBS Online](#).

How are the many exclusive telehealth services across the country making sure their billings are compliant with Medicare?

All providers, including services operating primarily or exclusively through telehealth, are responsible for ensuring each Medicare claim is compliant. This includes billing only where the service is clinically relevant, meeting the full item descriptor and MBS rules, maintaining adequate and contemporaneous records, and ensuring the provider can substantiate claims if reviewed. Payment of a claim does not confirm compliance, as claims may be subject to post-payment compliance review.

Time that counts toward the consultation

Of late we have had a lot of issues with Best Practice, with crashes happening at the end of the day. Hence, I had to append notes the next day. In such case, time spent with a patient shown on the computer doesn't reflect my actual time. Is this an issue?

In general, 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 before or after the attendance, for example in reviewing or updating clinical notes in the patient's absence, cannot be counted.

In this specific scenario, the relevant consideration is whether the item requirements were met and whether the records are adequate and contemporaneous. Records should be completed at the time of service or as soon as practicable afterwards. If system issues mean notes are appended later, the record should make clear what occurred, when the service was provided, and why the record was completed or amended later. Computer timestamps alone may not reflect the actual clinical time, so the clinical record should support the service and item claimed.

Information on how to calculate the duration of an attendance is provided in [MBS Note AN.0.9](#).

Workers' compensation

If a patient's work claim is not approved and the patient is unable or refuses to pay out of pocket, are GPs allowed to claim through Medicare to cover time spent and services already provided?

Medicare benefits are not payable for medical services related to a compensable injury or illness for which an insurer/compensation agency has accepted liability. However, Medicare benefits may be payable for treatment until the liability is accepted or rejected, as in this case (i.e. during the dispute process). Once liability has been accepted, invoices for treatment should be directed to the insurer under the process determined or agreed with the relevant insurer.

Once the insurer accepts liability, any Medicare benefits paid during the dispute period may be recoverable by the Commonwealth. Such Medicare compensation recovery arrangements are administered by Services Australia.

That said, Medicare benefits should only be claimed where the service is eligible for a Medicare benefit, and all MBS requirements are met. A claim should not be made simply to recover payment where another funding arrangement has not been approved, or the patient does not pay. Providers should consider whether the service is excluded from Medicare or subject to another compensation arrangement before claiming, and should keep records that support the basis for any Medicare claim.