Improving your understanding of the MBS

Responses to questions/comments from attendees

Webinar details

Date:	Thursday 29 September 2022
Time:	7.00 pm – 8.00 pm AEST
Facilitator:	Dr Rachael Sutherland
Presenters:	Dr Robert Menz Brett McPherson
Recording:	Click here to view.

General comments

Many of the questions received during the webinar on 29 September related to Medicare Benefits Schedule (MBS) interpretation. As with all specialist medical colleges, the RACGP has no legal authority to interpret MBS rules and regulations. There is no guarantee that Medicare will consider the use of an MBS item number appropriate, even if the RACGP does. It is the responsibility of the treating practitioner to ensure that any service billed to Medicare meets the item descriptor in the MBS and any eligibility requirements in full. You should maintain appropriate patient notes to demonstrate how you meet the descriptor of any Medicare service billed. For further information, see the RACGP's statement on Medicare interpretation and compliance.

Medicare education

The RACGP supports members to gain a better understanding of the complex system in which they practice. As such, the RACGP is supportive of Medicare compliance educative processes focusing on prevention of incorrect claiming, rather than punitive measures and blunt instruments which can distract providers from delivering appropriate and high-quality care to patients.

We are committed to furthering our working relationship with the Department of Health and Aged Care in order to benefit members by:

- working collaboratively to develop educational materials and provide advice on approaches to prevent incorrect billing
- improving providers' understanding of the legislative requirements around claiming Medicare items
- providing feedback to the Department on the impact of compliance activities.

AskMBS email service

We understand that there may have been some confusion around the advice given during the webinar in relation to relying on AskMBS responses as a legal defence. The RACGP has sought advice from the Department of Health and

Aged Care and can confirm that responses from AskMBS do not constitute legal advice. AskMBS emails include the following disclaimer:

This response is general in nature and only applies to your specific enquiry. Whilst the Department has taken care in preparing this response, it may not be complete or accurate. To the extent permitted by law, the Commonwealth of Australia accepts no liability arising from you or your organisation using the information, and you must always seek your own legal and financial advice before relying on it.

AskMBS remains a useful tool to help you better understand Medicare billing rules and whether it is appropriate to claim certain items. Enquiries relating exclusively to interpretation of the MBS are best directed to AskMBS via askmbs@health.gov.au. If you have concerns about relying on the advice or compliance processes, you should contact your medical defence organisation (MDO).

Responses to questions/comments

The responses below have been grouped together under common themes for ease of reading. We have also provided responses to some of the comments and observations made by webinar attendees on the night where we felt that additional information or clarification would be helpful.

Medicare compliance

- *Does AskMBS open a window for audit of your billing?*

No. We have not received any advice to suggest that emailing AskMBS increases your likelihood of being subject to compliance action.

- *Can a practitioner be audited without their knowledge?*

No, the RACGP is not aware of any situations where this has occurred. Practitioners who are subject to compliance action, whether it be a targeted letter, audit, or referral to the Professional Services Review (PSR), are made fully aware of the concerns identified with their billing and are given the opportunity to explain their actions.

- *Do private billing GPs get audited?*

Yes, if by private billing you mean the GP raised an account for a Medicare rebateable service. Any service for which a Medicare rebate is claimed may be scrutinised by the Department of Health and Aged Care if the GP has billed incorrectly or it is deemed not to be clinically relevant. Therefore, if you have billed Medicare for a service and charged the patient a gap fee, you may still be subject to compliance action.

If you provide a service that is completely private (i.e., the patient pays out-of-pocket for the full service cost and no Medicare item is billed and reimbursed to the patient), you would not be required to repay money to Medicare. However, you are still bound by regulations around the safe practice of medicine. You should also note that any care with an insurance component (eg workers compensation, Department of Veterans' Affairs [DVA]) is subject to the regulations of that insurer. Medicare is not the only funding source for GPs, and you should be aware of the rules in place for other schemes if your practice extends beyond Medicare.

- *A GP has claimed for my child when no consult has taken place. Do I need to report it?*

Without knowing the full context to this case, we cannot definitively say why this occurred. There are several reasons why the GP may have billed Medicare for a service provided to the child:

- The child saw the GP without their parent's knowledge and the consultation was processed using the parent's Medicare card.

- The parent had a consultation with the GP about their child, but the child was not present. In this case the GP should have explained that the consult would not attract a Medicare rebate.
- The GP inadvertently billed incorrectly for a consultation that never took place.
- The GP deliberately billed incorrectly for a consultation that never took place.

If you notice something unusual on your Medicare online account such as an erroneous claim, we recommend speaking to the practice in the first instance as this may have been an administrative error. You can also ring Medicare on 132 150 to check if any inaccurate or unexplained claims were the result of an issue with Medicare's online systems.

If you continue to experience concerns around item numbers being billed incorrectly, you can complete the Department of Health and Aged Care's health provider tip-off form. You can choose to remain anonymous when submitting a tip-off.

GPs should note that the rules around billing for time-based consultations are outlined in MBS Note AN.0.1. This note states that 'in itemising a consultation covered by an item which refers to a period of time, only that time during which a patient is receiving active attention should be counted'.

- *I have heard that billing longer item numbers (eg 36) too often increases the chance of audit. Is this true?*

Not necessarily. The RACGP understands that many GPs are reluctant to bill item numbers for longer consultations due to the possibility of being identified as an outlier among their peers. There is a perception amongst GPs that compliance activities are designed to monitor and target statistical outliers, as opposed to targeting fraudulent activity. Providers are concerned about being identified as an outlier due to their patient population/practice context and subsequently involved in stressful and often lengthy processes when defending their billing patterns and billing frequency.

You must ensure that all services, including any longer consultation items with more complex claiming requirements, are clinically relevant and are documented appropriately. If you are concerned about being identified as an outlier, your notes should explain how you met the requirements of each MBS item billed.

See question 26 on page 16 of this AskMBS Advisory for more information.

80/20 and 30/20 rules

- *How many long consultations can be done safely (item 36) out of 30 patients?*

It is unclear if this question is referring to the new 30/20 rule for phone consultations, which was introduced on 1 October 2022.

MBS items for longer phone consultations (>20 minutes) are no longer available, with the exception of the item for COVID-19 antiviral prescribing by phone (item 93716). Therefore the 30/20 rule is not relevant to longer phone consultations, as these cannot be billed to Medicare.

It also depends on what is meant by 'safely'. This could be referring to the patient receiving high-quality care, or from the GP's personal perspective, not attracting attention from compliance authorities.

Determining the number of longer consults that can be performed safely is a matter for individual GPs. As per advice provided by AskMBS, practitioners must use the most appropriate MBS item for the service provided to the patient. It is the treating practitioner's responsibility to consider the clinical relevance of any services rendered and to determine the appropriate item(s) to claim, if any. Practitioners are required to satisfy themselves that each professional service they provide meets the MBS item descriptor. They also need to exercise care to ensure that their conduct in relation to rendering services cannot be characterised as inappropriate practice (i.e. practice that a practitioner's peers could reasonably conclude was unacceptable to the general body of their profession). You should maintain appropriate patient notes to demonstrate how you meet the descriptor of any Medicare service billed.

If the services are clinically indicated, all requirements of the item descriptor/s are met, and appropriate notes are recorded, theoretically item 36 could be billed for all 30 patients in this scenario. However, if there is regular claiming of

item 36 30 times a day, this could attract compliance interest because it entails an absolute minimum of 10 hours of consulting time. Additionally, a GP who only claims item 36, and no other item numbers, would be more likely to come to the attention of compliance authorities.

See question 26 on page 16 of this AskMBS Advisory for more information.

- *Does the 12-month period referred to under the 80/20 rule mean a calendar year?*

No. A 12-month period under the 80/20 rule refers to a rolling 12-month period and the 20 days may be cumulative or consecutive. See the Department of Health and Aged Care website for more information.

Under the 80/20 rule, a medical practitioner is deemed to have engaged in inappropriate practice if they have rendered or initiated 80 or more relevant professional attendance services on each of 20 or more days in a 12-month period. From 1 July 2022, telehealth services including phone and video consultations are included in the 80/20 rule along with face-to-face services.

It is important to note that the rule refers to 80 services rather than patients, so if you bill multiple items for a patient on a single day, each of these items is counted separately.

- *I work in a practice that bulk bills. One GP sees 60 patients, the second sees 55, two other doctors see around 40 patients and I see only 30. Most of my patients have multiple issues and I bill item 36. Will it become an issue for me because my practice is different than my peers?*

Statistical methods used by the Department of Health and Aged Care compare individual GPs with the wider GP community; not only with other GPs working in the same practice.

Compliance activities have historically been focused on identifying providers whose billing deviates from average billing trends across the general practice workforce, and recuperating funds rather than the implementation of preventive and educative measures. Our view is that the Department should adopt a more considered method of identification that takes into account clinical factors and the characteristics of patient cohorts. Pleasingly, we are seeing some positive developments, such as the introduction of targeted awareness raising letters which are more educative and do not require providers to review a list of claims. The RACGP will continue to advocate for a fairer compliance process in our regular conversations with the Department.

The new 30/20 compliance rule only applies to phone consultations. If you are providing face-to-face or videoconferencing services, these are not covered under the 30/20 rule. As of 1 October 2022, GPs who provide 30 or more phone services on 20 or more days in a 12-month period will be referred to the PSR.

- *This is one thing RACGP really needs to work on. Everyone else wants to work from home but doctors aren't allowed to. To do one day a week of phone reviews, simple results etc would be a breach of the 30/20 rule even if it is highly appropriate medicine.*

The RACGP has long opposed the introduction of the 30/20 rule and has called for a review to ensure the rule is fit for purpose. Most recently, the RACGP co-signed a letter to the Minister for Health and Aged Care stating that COVID-19 is far from over, and phone consults remain a key pillar of Australia's pandemic response. You can read more about this in newsGP.

The importance of phone consultations for people who cannot, or prefer not to use videoconferencing is outlined in the RACGP's post-election advocacy priorities.

- *To clarify re: 30/20 rule – does that mean we should be advising elderly patients to avoid phone consults? It seems very easy to reach 30 phone consults in a one-year period, especially if patients are elderly and can't access video calls.*

To clarify, the 30/20 rule stipulates that if you claim more than 30 phone consults in one day, for more than 20 days in a 12-month period, you are deemed to have engaged in inappropriate practice and will be referred to the PSR.

The RACGP recognises that this rule will require many GPs to adjust their appointment schedules, and we are continuing to advocate for greater recognition of the benefits of phone consults for vulnerable patients.

Telehealth

- *If a patient of a residential aged care facility (RACF) is only ever seen at the facility, could a GP bill a telehealth consult if they have seen the patient face-to-face at the facility within the past 12 months?*

Yes. The Department of Health and Aged Care has confirmed that face-to-face visits with patients at locations other than the practice (such as at home or in a RACF) within the last 12 months will enable access to telehealth items.

The Department of Health and Aged Care has developed an AskMBS Advisory that provides information on the existing relationship requirement for telehealth services.

- *Telehealth stopped in aged care facilities. You can only use the telephone number and what about the administrative work, writing drug charts and new prescriptions etc?*

Providers can use general telehealth item numbers to provide care to patients in RACFs, however these items do not qualify for the Aged Care Access Incentive through the Practice Incentives Program (PIP). This omission also affects the ability to report on and analyse service use in RACFs.

Managing the complex needs of aged care residents will often require GPs to undertake unremunerated work, for instance by providing detailed notes and instructions to RACF staff, completing forms, and consulting or following up with other service providers, families and carers. The RACGP has publicly called for telehealth items to be introduced for professional attendances at a RACF, which would be equivalent to existing items 90020, 90035, 90043 and 90051.

The RACGP has also called for GPs to be able to discuss a patient's care with a nurse or other health practitioner, without the patient being present at the consultation. It is not uncommon for GPs to discuss a resident's condition with nursing staff at a RACF, however patient rebates are unavailable for this type of care. This issue is explored further in our submission to the Australian National Audit Office's audit of the expansion of telehealth services (see page 20).

The RACGP's MBS Aged Care guide provides a listing of MBS items for services provided by GPs to people in RACFs.

Chronic disease management

The following links provide information on MBS chronic disease management services.

MBS Note AN.0.47 – Chronic disease management items. This note lists MBS consultation items that cannot be co-claimed with chronic disease management services for the same patient on the same day.
Information on Department of Health and Aged Care website
Questions and answers on the chronic disease management items
Provider information
Patient information
Information on Services Australia website
Services Australia eLearning program – Chronic disease management
Services Australia eLearning program – Chronic disease management case studies

- *Can item 10997 be billed on the day of the initial care plan (721/723)? They do get paid but I thought it was only after the plan was in place.*

No. Item 10997 can only be claimed where a GP Management Plan (GPMP), Team Care Arrangements (TCAs) or Multidisciplinary Care Plan is in place and can be claimed for a maximum of five services per patient in a calendar year.

It would not be expected that item 10997 would be routinely claimed on the same day as items 721 or 723. See page 5 of this AskMBS Advisory for more information.

- *Could a chemist and dentist be part of a team care arrangement?*

Yes. It is important to document how you have consulted with at least two collaborating providers. TCA team members could include:

- the allied health professionals to whom a GP can refer patients for Medicare-rebateable CDM allied health services (i.e. Aboriginal health workers, Aboriginal and Torres Strait Islander health practitioners, audiologists, chiropractors, diabetes educators, dietitians, exercise physiologists, mental health workers, occupational therapists, osteopaths, physiotherapists, podiatrists, psychologists, and speech pathologists
- other allied health professionals such as asthma educators, orthoptists, orthotists, dentists, or prosthetists
- other health or care providers such as registered nurses, social workers, optometrists, and pharmacists.

A team might also include home and community service providers, or care organisers such as education providers, 'meals on wheels' providers, personal care workers (workers who are paid to provide care services), and probation officers where they are contributing to the plan and not simply providing a service identified in the plan. Similarly, persons such as a Workcover rehabilitation case manager, fitness instructor and personal trainer could be members of a TCA team if they are contributing to the plan.

See the Department of Health and Aged Care website for more information. Note while this page does not specifically refer to dentists, the Department has confirmed to the RACGP that dentists can be part of the care team.

- *Can you co-claim items 721 and 723?*

Yes, provided the requirements of both MBS items have been completed. The Department of Health and Aged Care advises that, provided the two services are delivered as per the Medicare requirements outlined in the item descriptors and explanatory notes, they can be claimed on the same day.

In many cases this would be unlikely, given that TCAs involve collaboration with the participating providers to discuss the following:

- potential treatment/services they agree to provide to achieve management goals
- documentation of the goals
- collaborating providers
- patient actions
- a review date.

Multidisciplinary case conferences

- *For the case conference item numbers such as 735, do you need to speak with all of the professionals in the case conference at the same time?*

Yes. The case conferencing team must include a GP and at least two other health or community care providers, one of whom can be another medical practitioner. The minimum three care providers (including the GP) **must be in communication with each other throughout the conference**. See the Department of Health and Aged Care website for more information on multidisciplinary case conferences.

Co-claiming

For general information on billing multiple MBS items, visit the Services Australia website.

- *You can't claim both items 23 and 2713 – it gets rejected all the time.*

As noted during the webinar, if a patient consults their GP for a mental health issue and other issues are subsequently raised, only the mental health item is billable. Alternatively, if the patient attends for a general issue and mental health concerns are discussed during the course of the consultation, both the general consult item and the mental health item can be billed. Supporting documentation must be retained in your clinical notes.

If you are co-claiming a general consultation item with item 2713, you will need to process these as separate invoices and note that the services are not related. Separate invoices reduce the likelihood of the claim being rejected; in which case you may need to provide further explanation.

Refer to 'Additional claiming information' in MBS Note AN.0.56 for more information.

- *Can a GP co-claim item 23 with a COVID vaccine item?*

As a general rule, you can only co-claim a general attendance item with a COVID-19 vaccine support item where this action is clinically indicated by the health needs of the patient. The rules around co-claiming are quite complex and the Department of Health and Aged Care has developed detailed information on this for providers. Please refer to pages 12–14 of the Department's frequently asked questions. The Department has also prepared scenarios which offer examples of how the MBS items can be billed, what to do when patients present with multiple clinical matters, and guidance on issues such as co-claiming.

- *If we cannot bill item 23 during the excision time (if we have consulted them earlier for the said lesion), how do others bill patients privately for performing skin excisions?*

You are able to privately bill patients for procedures (charge them the rebate + gap fee). The patient will then be reimbursed their rebate by Medicare. This is assuming by private you mean an MBS service which is not bulk billed, as opposed to a service which does not attract a Medicare benefit (eg excision for purely cosmetic purposes).

The RACGP does not provide advice on recommended fees, as this is a matter for individual GPs and practices to determine. Please note, however, that you are not required to bulk bill any procedure. Although you are unable to co-claim a general consultation item when performing a procedure such as a skin excision, you are free to charge an appropriate fee for the procedure.

Nurse time

- *If combined GP and nurse time for a health assessment goes over an hour and half, can you bill item 707?*

Yes. You can bill the relevant time-based number for a health assessment that a nurse has assisted you with, including item 707 if the combined time is at least 60 minutes. See pages 9–10 of this AskMBS Advisory for more information.

As per MBS Note AN.0.36, suitably qualified health professionals, such as practice nurses or Aboriginal and Torres Strait Islander health practitioners, employed and/or otherwise engaged by a general practice or health service, may assist GPs in performing health assessments. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the GP. This may include activities associated with:

- information collection
- providing patients with information about recommended interventions at the direction of the GP.

There is no requirement that all elements of a health assessment be provided on a single occasion, however, the service cannot be billed until all item requirements as set out in the item descriptor and associated explanatory notes have been met. There is also no prescribed maximum interval between the performance of the two components of the service. It would be a matter for the GP's professional judgement as to whether the service should be recommenced if a clinically significant period of time has elapsed.

Where the provider determines that it is clinically appropriate to provide a health assessment across multiple occasions, no item should be claimed on the first occasion, and the health assessment item should only be claimed on the occasion

the service is completed. Time spent by practice nurses or Aboriginal and Torres Strait Islander health practitioners in assisting medical practitioners in performing a health assessment goes only to the health assessment item and cannot be itemised separately, such as under item 10997. This applies even if the nurse sees the patient on a different day.

Importantly, providers should not use the delegation of tasks to practice nurses to extend the time that could reasonably be claimed given the patient's presentation and the type of assessment undertaken.

- *Can we include nurse time when billing?*

Not usually. See the response to the previous question and below for further details.

The Services Australia website contains information on how to claim services provided by a practice nurse on behalf of a medical practitioner. GPs are able to bill items on behalf of other health practitioners for:

- follow-up services provided to Aboriginal and Torres Strait Islander people who have received a health assessment (items 10987, 93200, 93202)
- services provided to patients with chronic disease (items 10997, 93201, 93203)
- haemodialysis for a patient with end-stage renal disease in a Modified Monash Model (MMM) 7 area (item 13105)
- antenatal services provided in a Rural, Remote and Metropolitan (RRMA) 3–7 area (items 16400, 91850, 91855)
- telehealth patient-end clinical support (item 10983)
- COVID-19 vaccine suitability assessment services (items 93660, 93661).

In some instances, both the medical practitioner and the nurse may need to see the patient. If this is the case, you can claim both a practice nurse item and an attendance item. The duration of an attendance item doesn't include the time a patient spends with the nurse.

Nurses can also assist medical practitioners to perform services such as health assessments and chronic disease management. See MBS Notes AN.0.36 and AN.0.47 for more information. You should note that time spent by nurses contributing to a health assessment can be counted as part of the total time (the GP would then bill the relevant time-based assessment item), however chronic disease management items are not time-based.

Seeking a second opinion

- *Can another GP bill item 23 for a consultation with a patient who is seeking a second opinion on the same day that he/she discussed with another GP from the same clinic?*

Yes, however it is important to ensure that this is reflected both in the appointment schedule and the clinical records by both GPs. Often what happens is a GP might call a colleague into a consultation with a patient to give a second opinion (eg about a skin rash). In this case the second GP would not be able to claim a consultation item.

Frequency of consultations

- *Is there any limitation on how often patients can be seen? Working in nursing homes makes me see most patients every week and I also do phone consults for some patients in between for additional issues. Being a new GP registrar, I'm worried about billing patients too often.*

There is no limit on how often you can see patients, however you must make sure that any service you provide is clinically relevant.

The *Health Insurance Act 1973* stipulates that Medicare benefits are payable for professional services. A professional service is a clinically relevant service which is listed in the MBS. A medical service is clinically relevant if it is generally accepted in the medical profession as necessary for the appropriate treatment of the patient. Further information is outlined in MBS Note GN.1.3.

MBS education

- *I am an international graduate who moved to Australia late in my career. I have been a GP in the UK for over 15 years. When I moved to Australia I had no MBS education apart from the practice manager telling me to decide between item 23 and 36. I have since taken a lot of interest in this, especially after the recent practice accreditation visit. Can the RACGP be more vigilant in ensuring that overseas doctors are appropriately educated by a source other than the practice we are contracted to, which has a vested financial interest in higher billing items? I am increasingly concerned and stressed by this.*
- *I've just arrived from the UK. Where would be best to learn about the basics?*

The MBS can be daunting for GPs new to the system, but ultimately it is the responsibility of the GP who is claiming Medicare items to be aware of the item requirements. In addition to the many resources listed below, it is strongly recommended that you also read the MBS item descriptor and any associated explanatory notes for items you bill. This are available on www.mbsonline.gov.au.

The Practice Experience Program (PEP) has a core module that links to the gplearning module 'GP Pathway to Australian General Practice'. This includes information about Medicare and billing, and this information is also included in Module 1 of the More doctors for Rural Australia program (MDRAP).

Information about the transition to RACGP-led general practice training from 2023 is available on the RACGP website.

In terms of the RACGP Curriculum, Domain 4 relates to ethical practice while Domain 5 is most related to billing.

The Department of Health and Aged Care has developed educational resources to help you meet your legal obligations and reduce the risk of incorrect billing under Medicare. Available resources include:

- eLearning programs
- Health professional guidelines
- Record keeping guidelines
- Medicare billing assurance toolkit
- A range of other fact sheets and infographics

The Services Australia website has a range of MBS education resources outlining claiming requirements for medical practitioners, allied health professionals and practice staff. Available resources include education guides, eLearning programs and infographics.

RACGP resources

- *Does the MBS online tool allow for multiple fee levels (eg private, discount, WorkCover etc)?*

The MBS online tool only contains MBS item numbers. It does not include other services such as DVA or workers compensation. The tool allows you to enter your own fee for MBS services that you provide. It will automatically calculate the patient out-of-pocket contribution based on the MBS rebate.

The rebate amounts listed in the tool reflect the rebate payable rather than the MBS fee. This will either be 100% or 85% of the fee. 75% rebates have not been included due to their relatively low application in general practice.