# Q&A – The role of the PSR

## Responses to webinar questions

### Webinar details

**Date:** 22 July 2025

**Time:** 7.00 pm – 8.00 pm AEST

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

**Presenter:** A/Prof Antonio Di Dio, PSR Director

**Recording:** Click here to view

### General comments

Many of the questions received during the webinar on 22 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 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 PSR has developed a comprehensive guide for health practitioners on the PSR process, which can be accessed here. This is designed to help those referred to the PSR to understand what to expect.

The PSR 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 PSR.**

### Responses to questions

We have grouped questions together under common themes in alphabetical order for ease of reading.

#### Aftercare

- ***If a patient has had an excision performed (and therefore billed) by a different practitioner, and then attends to see you on another occasion for wound review and suture removal, can this be billed as an attendance item? Or is it considered normal aftercare of the initial item and therefore you are not able to bill anything at all?***
- ***If post-operative wound infection is considered routine aftercare and does not attract a rebate, doesn't this go against the spirit of good clinical practice and discourage close review of potentially serious complications? This seems very odd.***

The rules around billing for aftercare are designed to prevent duplicate payments if a service has already been paid for through one funding stream.

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.

In the PSR's experience, most items used by general practitioners (GPs) include aftercare. An example of an item with aftercare excluded is 34524 (arterial cannulation for chemotherapy).

If your patient can't return to the same practitioner who performed the surgical item for aftercare, a different practitioner can bill attendance items for the normal aftercare they provide. Non-GP specialists and consultant physicians can't bill an attendance for normal aftercare services in this same situation.

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.

### Aged care

***Is there any advice in relation to residential aged care facility (RACF) item numbers?***

Please refer to the following MBS explanatory notes:

- AN.0.9 – Using time-tiered professional (general) attendance items
- AN.0.15 – After-hours RACF attendances
- AN.35.1 – Flag fall amount for RACGP attendance by a GP

### Billing multiple MBS items

***Is it appropriate to bill item 3 when you give a procedural explanation before you do a surgical excision?***

You can't claim a general attendance item to compensate you for time spent discussing or performing a procedure. If you are co-claiming an attendance item with a procedural item, the two items must be for separate clinically relevant services. If the two services are separate, you should bill the relevant time-based attendance item for the general consultation only – not for the combined time spent consulting with the patient and performing the procedure.

***Has co-billing item numbers – particularly the popular pairing of health assessment + preparation of a chronic disease management (CDM) plan – historically been an audit target?***

As the PSR cannot initiate own motion investigations and solely responds to referrals from Medicare, it cannot itself 'target' particular item number combinations. Should Medicare flag an issue related to co-billing, it is probable that PSR

will review this, although there is no PSR policy or approach regarding co-billing. Each matter that comes to PSR is reviewed on its own merits to determine if the billing that has occurred, including any co-billing, is of concern. When reviewing Medicare data and deciding which item numbers are relevant to review, if a practitioner has a pattern of co-billing various item combinations which is statistically higher than their peers, this may lead PSR to consider reviewing a sample of the co-billed services.

As with all co-billed services, each service billed needs to be distinct from the other and be clinically relevant. Additionally, the MBS requirements of each service rendered need to be satisfied including the respective time requirements. PSR have seen instances of co-billing of CDM and health assessment services which have raised concerns that the requirements for each MBS item were not met. More commonly PSR has seen instances of attendance items being co-billed with procedural items where it does not appear a consultation occurred separate to a procedure.

### Billing processes

***How do you check the duration of appointments? Sometimes multiple files are left open the whole day before billing.***

Many MBS items include a minimum time requirement. PSR considers a range of factors when determining if any service has met a minimum time requirement. While the duration recorded in the software is a useful and relevant piece of information, it is not determinative of whether a service met the minimum time requirements. PSR reviews focus on what is recorded as having occurred during the consultation, underscoring the importance of practitioners keeping adequate medical records.

### Chronic condition management

***With the reduced compliance/regulation of item 965 vs 721/723, where do you envisage PSR issues arising from the new item number?***

PSR is unable to make predictions about what issues may arise following the introduction of new item numbers, but at a high level it considers compliance issues under the new GP Chronic Condition Management Plan (GPCCMP) framework may not differ vastly from those seen under the succeeded system. Some common issues under the previous CDM framework which typically resulted in non-compliance included practitioners not tailoring a care plan to the patient's needs, listing generic goals, or providing these services when it was unclear that the patient had a chronic disease.

When referring patients to allied health, a failure to meaningfully consult with the other healthcare providers was often of concern. In reality, the core requirements of the items have persisted, which continue to require appropriate record keeping to demonstrate compliance with the MBS descriptors.

***Many patients request vaccines or want other health issues to be assessed when they come in for a GPCCMP. Can we co-bill?***

Planning and review items for GPCCMPs cannot be co-claimed for the same patient on the same day as general attendance items. A full list of restricted items is included in MBS Note AN.0.47 (see 'Co-claiming restrictions').

If you co-claim a GPCCMP item with an item not on the list of excluded items, the two services must be distinct and clinically relevant.

***Is it necessary for clinic staff (eg practice nurse) to enter a separate clinical note themselves to justify billing item 10997 for a task they perform under a GPCCMP?***

Whilst not mandatory, it is helpful from a compliance standpoint if the person who provided the service (i.e. the practice nurse) clearly records what they did. The PSR advises this is what most commonly occurs in practice – the nurse uses their own login to record their input.

It is theoretically possible for a GP to record what the nurse did, and this could also be sufficient.

### Completion of forms/paperwork

***When completing forms/paperwork for patients needing a driver's licence, can the GP do this as a private service, or does it need to be a Medicare item with or without a gap payment?***

Yes, you can provide a completely private service with no Medicare transaction if the patient is willing to forgo their right to a rebate. Alternatively, you can either bulk bill the applicable MBS item number, or privately bill the service, with the patient paying the full fee (rebate + gap) and then receiving their rebate back from Medicare.

### Compliance/PSR processes

***Are Medicare audits random or triggered by numbers/billing percentages etc?***

DoHDA and the PSR do not undertake random spot checks or audits. Compliance investigations are undertaken where there is a reasonable concern that benefits have been claimed incorrectly.

***Is there a recognised benchmark or utilisation rate you reference when evaluating whether a practice is appropriately claiming MBS items? And are there any indicators or red flags that might suggest under- or over-utilisation?***

As the PSR receives referrals from Medicare rather than initiating its own investigations, it is Medicare which reviews and can raise concerns with practices following the identification of atypical billing patterns. Medicare can then trigger a review by PSR if it retains concerns following its own process. Circumstances exist where Medicare is obliged to refer a matter to PSR such as where the 80/20 or 30/20 rules apply.

In deciding whether to conduct its process, Medicare may seek information from practices if their billing patterns are particularly different to other practices. Signs of over-utilisation may include, but are not limited to, extensive or uncommon billings for high rebate items such as Level C and D attendances, billing many services at the Extended Medicare Safety Net cap, excessively high claims for item numbers compared to similar practices as well as a notable shift in volume of claims relative to previous years. It is usually a case of Medicare reviewing and identifying outliers to investigate whether a variation from the practitioner's cohort could constitute inappropriate practice or not.

- ***On one of the slides, it mentioned that 91891 and 23 were the most reported item numbers. Are there any examples of what was wrong with those billings as they are very basic straightforward item numbers.***
- ***Do high ratios of item 36/44 compared to 23 get flagged for review?***

Where a practitioner is investigated by the PSR in relation to their use of MBS general attendance items, it could be that their billing deviates significantly from that of their peers (eg the practitioner is in the top percentile nationally for billing a particular item, or their overall provision of services is extremely high and these services make up most of the services provided during the review period). These items are the most reviewed by the PSR because they are the items most commonly billed in general practice. Where PSR has had concerns about these items, these primarily relate to medical records being inadequate. This is because they do not reflect the service provided and the records fail to demonstrate that the MBS requirements have been complied with.

Please note the PSR does take into account geographical location, workforce shortages and specialist expertise of practitioners when making determinations and imposing any directions on a practitioner.

***Is there an equivalent body to PSR for WorkCover and the Transport Accident Commission (TAC)?***

No – workers' compensation and transport accident authorities regulate payments for services provided to injured parties themselves.

***A tongue in cheek question – who regulates the regulators?***

The PSR is subject to a robust framework of public accountability and transparency. PSR's performance, and the exercise of its powers and functions, are subject to a range of public accountability measures.

PSR operates under Part VAA of the *Health Insurance Act 1973* and the *Public Governance, Performance and Accountability Act 2013*. It is an independent agency within the Australian Government Health, Disability and Ageing portfolio. The Director is the accountable authority for PSR and is appointed by the Minister for Health and Ageing for a term of up to three years. Together, the Director, Associate Directors and the Australian Public Service (APS) employees assisting them constitute a Statutory Agency under the *Public Service Act 1999*.

The Government periodically sets out its expectations as to how PSR fulfils its roles and responsibilities in a Statement of Expectations, to which PSR responds with a Statement of Intent. PSR appears before the Parliament's Community Affairs Legislation Committee during Senate Estimates hearings. PSR's accountability measures also include its Corporate Plan, Portfolio Budget Statements and annual reports. These documents are tabled in Parliament where relevant and available on the PSR's website. PSR's performance and financial statements are also auditable by the Auditor-General.

In addition to oversight by the Parliament and the relevant Minister, PSR's decisions can be subject to review by the courts, Commonwealth Ombudsman and Office of the Australian Information Commissioner. PSR is also subject to the jurisdiction of the National Anti-Corruption Commission.

The Director, Associate Directors, PSR Committees and the Determining Authority (DA) are the decision makers in the PSR Scheme. They are all appointed by the Minister following consultation with relevant professional bodies including the RACGP (except in the case of the non-practitioner member of the DA).

The PSR will generally publish details of the outcome of cases on its website on a monthly basis in accordance with this policy (updated August 2025).

***Do you offer training to avoid being referred to the PSR and receiving a penalty?***

Education and training on the correct use of MBS items is largely self-directed and undertaken at the practice level. This is not mandated in GP training to give doctors choice over how they undertake this learning.

The RACGP has published a webpage with links to Medicare and compliance education resources. We have modules on the MBS available through gplearning and routinely run webinars on this topic, so keep an eye on our events website. Medical defence organisations (MDOs) have also developed numerous resources to support correct MBS claiming.

A resource that is particularly valuable is DoHDA's Understanding Medicare: Provider Handbook. This handbook is a plain English guide that details the fundamental elements and principles of Medicare. It provides core guidance for healthcare professionals and others navigating the Medicare system. We encourage all GPs to bookmark the handbook for easy reference.

***Have you had to do PSR reviews for doctors in Aboriginal Medical Services (AMSs)?***

Yes. Inappropriate billing practices investigated by the PSR may include those potentially occurring in AMSs where Medicare items are billed for these services.

***Does Medicare only refer to PSR for malpractice or some other reason too?***

The PSR investigates Medicare-referred cases of possible inappropriate practice relating to Medicare, the CDBS and the PBS. Inappropriate practice is conduct that a practitioner's peers could reasonably conclude is unacceptable to the general body of their profession or specialty. It includes a practitioner's conduct related to:

- providing Medicare or CDBS service
- prescribing or supplying PBS medicines.

Cases of alleged practitioner misconduct unrelated to billing or prescribing would generally be dealt with by the Australian Health Practitioner Regulation Agency (Ahpra) or another healthcare complaints entity.

***Do you get flagged for voluntary declaration of incorrect payments which have been due to admin errors, eg a Residential Medication Management Review (RMMR) conducted by pharmacy and GP with discrepancy between actual dates performed?***

If you make a voluntary acknowledgement of incorrect payments to DoHDA, this in itself will not prompt a referral to the PSR. A referral will only be made where DoHDA suspects that inappropriate practice may have occurred, or where there is a clear breach such as exceeding service limits under the 80/20 and 30/20 rules.

***Why do MDOs always advise that it's better to accept the decision made by the PSR Director rather than going to a committee hearing where the outcome is always worse? And there are articles where an MP in Queensland is concerned that 100% of doctors who were referred to the PSR were found guilty and had to pay back money?***

The PSR is unable to comment on any advice provided by MDOs to their clients. Not all persons under review (PURs) referred to PSR are found to have engaged in inappropriate practice, with some matters resulting in no further action being taken. Examples of such cases can be found on the case outcomes section of the PSR website.

***If a practitioner is asked by PSR to pay back any amount, is the practice also responsible to pay back any admin charges received from the practitioner's billings?***

Where a practitioner is required to make a repayment to the Commonwealth because of inappropriate practice, it is the practitioner who is the responsible party. This is because it is the practitioner rather than the practice that Medicare refers to PSR. A practitioner and a practice can have their own contractual arrangements providing for a scenario where incorrect billing is largely a result of the practice's staff, although this is a matter for the PUR and practice.

### Dermatology

***Is a detailed consent and re-examination of the lesion (dermoscopy) counted as part of a procedure, or is it reasonable to bill a separate time-based item number along with the excision number?***

The PSR's view is that this is not a separate consultation – consent is part of the procedure.

### Health assessments

***A doctor auto-fills all 715s they do. It contains the same information in every case and the time taken is 30 minutes. Is this appropriate?***

Each MBS health assessment performed under item 715 requires you to keep a record of the health assessment and offer the patient and/or their carer a written report about the health assessment with recommendations about matters covered. This should be personalised for each individual patient and cannot necessarily be auto-filled.

### Pathology

- ***Frequently audited pathology are iron studies, B12, vitamin D. I see lot of women deficient in iron and order ferritin instead of full iron studies. Is that okay?***

- ***When patients come for a general check-up, can we order B12/iron/thyroid function tests (TFTs)?***

It is acceptable to order a high number of tests, provided these are clinically relevant and your rationale for ordering them is documented in the patient's notes. The PSR is generally concerned with high volumes of tests where no thought has been given to the patient's medical history, and a pattern emerges where tests are being routinely ordered for patients without proper consideration of their symptoms. For example, ordering a test every time a patient presents with fatigue would not be appropriate.

### Practice nurse services

***Some patients who may or may not be under a care plan need frequent nursing-only care and education without GP involvement on those visits (eg dressings/wound care in diabetic patients etc). If they are under a care plan, item 10997 can be billed. But 10997 can be billed five times only with a care plan per year. If they are not under a care plan or the five services have been used up, what item should be billed for that visit?***

Only a limited number of practice nurse MBS items are available, for services provided on behalf of and under the supervision of a medical practitioner. If a patient doesn't qualify for these services (eg because they don't have a GPCCMP), or they have expended the number of sessions allowed per year, they are not eligible for a Medicare rebate. In these cases, you will need to consider charging the patient privately for practice nurse services.

***Can you include nursing time when you bill an MBS item? For example, for a wound review even if you spent only a few minutes face-to-face with the patient.***

Generally, the time spent with a nurse is not included in the duration of a consultation item billed by the GP. There are specific MBS items for some services provided by practice nurses on behalf of and under the supervision of medical practitioners. See the Services Australia website for details.

DoHDA's AskMBS Advisory – General practice services #1 includes a question on the inclusion of nurse time when claiming a time-based MBS health assessment item (see page 7). This states that 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. The PSR has found that health assessments that involve nursing staff collecting information, but do not include a practitioner performing an appropriate patient examination, generating required investigation and referrals for identified abnormalities, and a preventive health plan for potential health risks, may be a clinical input and item descriptor concern.

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.

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

- ***Are the following items/services counted as part of the 80/20 and 30/20 rules: bulk billing incentives, practice nurse item 10997, electrocardiograms (ECGs), pregnancy tests?***
- ***Is an investigation item (ECG) a service item?***

None of these items are included in the 80/20 and 30/20 rules. See this fact sheet for a full list of MBS item groups the rules apply to.

***How are the 80 attendance items calculated? Is there a guide on this?***

A medical practitioner engages in inappropriate practice where some or all the services rendered or initiated constitute a prescribed pattern of services. This includes:

- if they have rendered or initiated 80 or more relevant services on each of 20 or more days in a 12-month period (known as the 80/20 rule)
- if they have rendered or initiated 30 or more relevant phone services on each of 20 or more days in a 12-month period (known as the 30/20 rule).

The 80/20 rule is based on the number of professional attendance services per day, which may not be the same as the number of patients seen in a day. See this fact sheet for a full list of MBS item groups subject to the 80/20 rule.

### Provider numbers

***To prevent someone else using your provider number, it was advised during the last webinar to suspend the number. But what if you have referred patients for pathology/imaging/to non-GP specialists – can these specialists still bill Medicare if our number is suspended?***

Yes – other providers should be using their own provider number to bill services that you have referred your patient for. Your provider number should only be used for services you personally provide or supervise.

### Telehealth

***I have a patient who has come in or booked a telephone consultation almost every day for the last few years. This is mostly mental health related. I take time to listen to him and record appropriate notes. Could I be at risk of a compliance investigation?***

There is no specific limit on the number of services you can provide to a specific patient, and no minimum number that will attract a compliance investigation. As with all MBS services, these phone consultations should only be performed if they are clinically relevant.

If a provider's claiming varies significantly from that of their peers without explanation, this could potentially trigger a compliance investigation. If documentation from a practitioner is requested to substantiate their claiming, it is critical that your clinical notes demonstrate how you met the requirements of any item number billed.