RACGP

Unpacking the Medicare compliance process

Responses to questions from attendees

Webinar details

Date: Monday 13 November 2023

Time: 7.00 pm – 8.00 pm AEDT

Facilitator: Dr Bruce Willett, RACGP

Presenters: Dr Sarah Mahoney, Department of Health and Aged Care
Dr Antonio Di Dio, Professional Services Review

Recording: Click here to view

General comments

Many of the questions received during the webinar on 13 November 2023 relate to Medicare Benefits Schedule (MBS) interpretation. As with all specialist medical colleges, the Royal Australian College of General Practitioners (RACGP) has no legal authority to interpret MBS rules and regulations. There is no guarantee that Medicare will consider the use of an MBS item number appropriate, even if the RACGP does.

It is the responsibility of the treating practitioner to ensure that any service billed to Medicare meets the item descriptor in the MBS and any eligibility requirements in full. You should maintain appropriate patient notes to demonstrate how you met the descriptor of any Medicare service billed. For further information, see the RACGP's statement on Medicare interpretation and compliance.

The RACGP has published a webpage with links to Medicare and compliance education resources. Collating resources in a central location means you don't have to search across multiple websites to find what you're looking for. We've grouped links under key themes listed in alphabetical order so you can easily locate the information you need. The resources come from the Department of Health and Aged Care (DoHAC), Services Australia, Professional Services Review (PSR) and RACGP and include MBS explanatory notes, fact sheets, education guides, eLearning programs, infographics and case studies.

The DoHAC and PSR have 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 DoHAC or PSR.**

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

MBS interpretation questions

Activities that count towards the consultation time

- *Is it correct to say that prior to 1 November 2023, tasks such as completing clinical notes after the consultation and preparing or updating a Shared Health Summary, while the patient is in the reception waiting area, could be counted towards the total consultation time? Is this still permitted? MBS Note AN.0.9 now states that 'only time spent with the patient (or on the telephone/video call with the patient in the case of telehealth) performing clinically relevant tasks can be included in the consultation time'.*

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.

The revised MBS Note AN.0.9, published on 1 November 2023, occurred as part of a broader review of MBS explanatory notes to provide clearer guidance on the operation of the MBS. There has been no change to the requirements of personal and professional attendance as set out in the *Health Insurance (General Medical Services Table) Regulations 2021*.

The activities that count towards consultation time in the revised note are consistent with the legislative requirements that 'the personal attendance of a medical practitioner upon a patient is necessary, before a "consultation" may be regarded as a professional attendance'.

The revision was managed through the DoHAC Explanatory Notes Advisory Group, which includes representatives from the RACGP, Australian Medical Association (AMA) and the Rural Doctors' Association of Australia (RDAA).

- *In the case of telephone consultations, doctors may need to call the PBS authority line or other services to complete necessary clinical tasks. Does the time spent on the call with the authority line or other services such as pharmacies (eg for urgent medications such as COVID antiviral availability) contribute towards the consultation time? Can MBS items be billed if these tasks are undertaken offline or when on mute/pause during the consultation?*

The calculation of consultation time for telehealth services should only include time where audio contact is maintained for attendances by phone and where audio and visual contact are maintained for attendances by video. If GPs contact the Pharmaceutical Benefits Scheme (PBS) authority line during a telehealth service, the time will only be counted toward the consultation time if audio and visual contact with the patient was maintained.

Aged care

- *Can we bill phone consults for speaking on the phone about the care of nursing home patients?*

People living in residential aged care facilities (RACFs) must be present when receiving an MBS service by video or telephone. Nurses or other health practitioners cannot represent a patient in a consultation with a doctor without the patient being present.

AskMBS

- *AskMBS seems to provide varied advice for the same question from different providers. What protection do we have regarding MBS claims if we follow AskMBS but may have been given an incorrect response?*

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

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

Please note that the AskMBS email advice service operated by the DoHAC (askmbs@health.gov.au) and the telephone enquiry line operated by Services Australia (132 150) are separate services with different functions. AskMBS provides

written responses to questions about the use of MBS items and the interpretation of explanatory notes and regulations. Services Australia provides advice on administrative issues and processes related to the Medicare system (eg claims processing, payments and rejections).

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

Billing without the patient present

- *If a parent comes to get advice or test results for very young children without the child present, how can we bill?*

If a parent attends a consultation with a GP about their child, but the child is not present, Medicare benefits are not payable for the service. The GP must explain to the parent that the service will attract a private fee.

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'.

Chronic disease management

- *When preparing a care plan (item 721 and 723), is 723 only claimable once at least one of the allied health professionals confirms verbal (documented) or written participation? Do we bill each item on a different day even though the patient is not present on the day when the allied health professional sends confirmation, or can we bill both on the same day pending allied health professional confirmation (especially for item 723)?*
- *If verbal consent has been obtained on the same day, can we then bill 723 on the same day as 721?*
- *If the service is provided on Monday, can the claim be submitted on Thursday (for example)?*
- *With the 723, when the TCA members send confirmation, does the patient need to be there to bill the item?*
- *Should we hold 723 on the day the service was provided and send the claim to Medicare once the criteria for collaborating with two other team members has been met?*
- *If we use one specialist as part of TCAs, do we accept their letters written to us as correspondence?*

When developing Team Care Arrangements (TCAs) under item 723, the GP must consult with at least two collaborating providers who will contribute to the development of TCAs and provide treatment and services to the patient under those arrangements.

Providers who will be part of a TCAs team must give consent to participating. However, there is no prescribed method by which consent can be obtained and it is not required that this be in the form of a written document. The method by which this agreement is given is a matter for the GP and collaborating provider to decide.

Note also that collaboration involves more than simply gaining the consent of the collaborating providers to participate in the TCAs. Communication with collaborating providers must be two-way, preferably oral or, if not practicable, in writing. Where oral communication is not practicable, collaboration should be documented by a written exchange detailing the treatment or services the collaborating practitioner will provide, based on their assessment of the patient's needs from information provided by the GP. Collaboration must occur as part of the development of the TCAs, not just when the TCAs are already in place.

Moreover, an MBS item cannot be claimed until all item requirements, as set out in the item descriptor and associated explanatory notes, have been met in full. MBS explanatory note AN.0.47 stipulates that when coordinating the development of TCAs, the GP must:

a. consult with at least two collaborating providers, each of whom will provide a different kind of treatment or service to the patient, and one of whom may be another medical practitioner, when making arrangements for the multidisciplinary care of the patient
b. prepare a document that describes:
    i. treatment and service goals for the patient

ii. treatment and services that collaborating providers will provide to the patient
iii. actions to be taken by the patient
iv. arrangements to review (i), (ii) and (iii) by a date specified in the document

c. explain the steps involved in the development of the arrangements to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees)
d. discuss with the patient the collaborating providers who will contribute to the development of the TCAs and provide treatment and services to the patient under those arrangements
e. record the patient's agreement to the development of TCAs
f. give copies of the relevant parts of the document to the collaborating providers
g. offer a copy of the document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees)
h. add a copy of the document to the patient's medical records.

TCAs can only be claimed when all components of the service have been performed. As outlined in AN.0.47, the final steps in the TCAs process are to offer a copy of the document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) and adding a copy of the document to the patient's medical records. It is only after these steps have been performed that item 723 can be claimed.

Fitness to work consultations

- *In instances when an imaging report may have originated from a work screening consult (eg fitness and capacity to work), but the patient ends up not getting the self-employment contract, can we direct the cost to Medicare?*

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

As set out in explanatory note GN.13.33 – *Services which do not attract Medicare benefits*, examples of services covered by the subsection 19(5) prohibition include the testing of fitness to undergo physical training programs, vocational activities or weight reduction programs, and compulsory examinations and tests to obtain a flying, commercial driving or other licence.

However, there are a number of exemptions from the prohibition, including for a medical or optometrical examination provided to a person who is an unemployed person (as defined by the *Social Security Act 1991*), at the request of a prospective employer. It is unclear whether the service mentioned in your enquiry meets these specific criteria but, if so, the service would be eligible for Medicare benefits. If not, benefits would not be payable as, even though the patient did not secure employment, the original intent of the service was as an employment-related screening examination, and so not a clinically relevant service.

Heart health assessments

- *Is claiming an MBS heart health assessment item (699) with a GP Management Plan item (721) on the same day considered inappropriate practice?*

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

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

A medical service is considered clinically relevant if it is generally accepted in the medical profession as necessary for the appropriate treatment of the patient. There is no restriction on co-claiming items 699 and 721 on the same day, provided both services are clinically relevant and your notes clearly explain the services provided. Please refer to Services Australia's education guide on billing multiple MBS items for more information.

Policy/operational issues, including RACGP advocacy

Aged care

A couple of regular logistical issues which we face in RACFs:

- *Performing ECGs on patients with limited mobility/disability who are on psychotropic medications*
- *Obtaining a second GP to review use of S8 medication if I am the only visiting GP looking after the RACF residents*

Thank you for providing this feedback. You may wish to share this with the RACGP's Aged Care Specific Interests Group, or become a member of the SIG if you haven't already.

Assignment of benefit for bulk billed services

- *With regard to the new rule that phone consults must have documented consent (in addition to the consent we obtain at the beginning of a phone consult) – what are the options for this that allow for smooth processes?*

While it has always been the requirement under the *Health Insurance Act 1973* that a patient must assign their Medicare benefit to the provider in exchange for not incurring any out-of-pocket costs and for bulk billing to occur, we know many members see assignment of benefit requirements as further red tape and a potential barrier to providing bulk billed care, and we are advocating for a better solution. The RACGP considers the need to manually document consent using a form to be an antiquated requirement that must be urgently reviewed. We have raised our concerns with the Health Minister and are calling for a solution that reflects current workflows in general practice.

Following the RACGP's representations to Minister Butler regarding changes to assignment of benefit rules for telehealth services, the Minister advised that he has asked his department to provide options to address our concerns, including legislative amendments. DoHAC has informed the Minister that until these changes are made, there are no plans to pursue any broad punitive actions on this issue unless it relates to fraudulent claims against Medicare.

After releasing an interim digital assignment of benefit form in December 2023, DoHAC, with Services Australia, is continuing engagement with software vendors to simplify the assignment of benefit process and lessen the administrative burden on GPs and practice staff as well as undertaking stakeholder engagement around potential legislative reform. A Bill to amend the assignment of benefit process was introduced to Parliament on 29 May 2024 and passed both houses on 2 July 2024. More information on the efforts to modernise the assignment of benefit process can be found on the DoHAC website.

- *We tend to see a number of residents who reside in RACFs who are diagnosed with dementia/cognitive impairment. It becomes difficult to expect them to sign assignment of benefit forms following consults. Do you have any solutions to this practical issue?*
- *Is 'patient unable to sign' sufficient for some telephone consults, eg an elderly patient who has no mobile and no computer and it is too hard for them to get to the post office for a stamp or walk to the letterbox to post consent to bulk bill?*

The use of verbal assignment by patients for telehealth services can be used where the patient's written or email agreement to assign their Medicare benefit cannot be obtained, but this process must still be supported by documentation of the patient's agreement in an approved form. In the event that a patient is unable to assign their benefit by any method, a 'responsible person' can consent on their behalf. Information published by Services Australia states that a responsible person refers to an adult person accompanying the patient or in whose care the patient has been placed. This includes a parent or guardian, someone who holds power of attorney or a guardianship order, or the next of kin. It does not include health professionals, practice staff and aged care staff.

Concerns have been raised by several GPs working in aged care who are unable to obtain consent from patients with conditions such as dementia. These patients may be supported during a consultation by a health professional such as a nurse or residential aged care staff, however consent must be obtained via a physical signature from a person who may not have been present at the consultation. The RACGP has therefore recommended to Minister Butler and DoHAC that the definition of a 'responsible person' who can provide consent on behalf of a patient be expanded.

The RACGP is continuing to seek clarity from DoHAC on the practical application of assignment of benefit rules in aged care settings for both face-to-face and telehealth services. Please refer to our website for the latest updates on the rules pertaining to telehealth consultations, which changed in September 2023.

Billing processes

- *I find myself speaking with practitioners about records and Medicare compliance when doing AGPAL accreditation visits (over 1,000 conducted so far). I must confess to being disappointed about the casual way this advice is often ignored. Please use the accreditation process and also advice/education from MDOs to reflect on your practice. Don't assume that because others in your practice do something (billing/records) it is acceptable.*

The RACGP echoes this statement. While it may be helpful to seek advice from your peers when billing, you are personally responsible for every service billed in your name or using your provider number. We encourage all GPs to seek advice from their MDO if they are concerned about possible incorrect billing or if they are the subject of a compliance review. MDOs have developed numerous resources to support correct MBS claiming, and you can also access resources compiled by the RACGP here.

- *With the introduction of new bulk billing incentive items on 1 November and the added complexity, Medicare are rejecting claims that are actually correct. Do we continue to resubmit them until they are approved?*

We would encourage you to contact Medicare on 132 150 if your claims are being rejected and you believe they are correct. The Services Australia website also provides an overview of Medicare reason codes used when claims are rejected.

Reference tables for bulk billing incentives in each Modified Monash area can be downloaded from MBS Online.

- *Is there any difference in billing in Aboriginal practices and non-Aboriginal practices?*

As a general rule, GPs are not required to bulk bill any service with the exception of COVID-19 vaccinations. The RACGP advises GPs and their teams to determine a fair and equitable fee for their services to ensure their practice's sustainability.

All Medicare services provided by Aboriginal Community Controlled Health Organisations (ACCHOs) are bulk billed.

Compliance data analysis

- *Do the data analysts make any allowance that your billings may reflect the local demographic makeup of your region? For example, more care plan billing in a deprived regional area with high numbers of chronic disease and concession card holders versus lower care plan billings in a well to do metro area full of private patients?*

The Benefits Integrity Division of DoHAC sorts through data and billing trends before deciding on compliance interventions. While DoHAC considers demographic information generally in its analysis, it cannot practically consider the demographics applying to every GP. Sometimes the RACGP is invited to meet with DoHAC to provide feedback on potential compliance risks and potential compliance activities.

In some cases, letters are sent to providers with high levels of billing for certain MBS items where it is not clear to DoHAC why this is occurring. DoHAC also receives tip-offs from members of the public who have concerns about the services their GP has billed. If following a tip-off, a review of a GP's MBS billing or PBS prescribing identifies concerns, a compliance activity may be initiated.

If you believe your billing meets the legislative requirements and is justified due to patient demographics, consider providing an explanation to DoHAC in consultation with your MDO. Neither DoHAC, nor the RACGP hold the view that merely being an outlier constitutes inappropriate billing, however it may prompt DoHAC to ask you to review your billing and consider your individual circumstances which are not likely to be visible in DoHAC's analysis of the entire provider population.

Both DoHAC and the PSR will take into account geographical location, workforce shortages and specialist expertise of practitioners when assessing whether or not a practitioner may have engaged in possible inappropriate practice.

Involvement of Ahpra in Medicare compliance

- *Do the Practitioner Review Program (PRP) and PSR cross refer cases to Ahpra and vice versa?*

DoHAC and the PSR will only refer practitioners to the Australian Health Practitioner Regulation Agency (Ahpra) where there are potential concerns regarding professional conduct or patient safety during their review.

Page 3 of the guide to the PSR process provides the following information about the involvement of other regulatory authorities:

> *At any time during the PSR process, a referral to a regulatory body can be made. This will occur if the Director, a Committee or the Determining Authority is concerned that a person has not complied with appropriate professional standards or has caused significant threat to somebody's life or health. Such a referral can be made to the Australian Health Practitioner Regulation Authority (Ahpra) or another regulatory authority.*

Practice software

- *What would you say about the use of software autofill in terms of integrity of medical records?*

The RACGP supports and promotes the uptake of digital solutions in general practice, especially where these solutions assist in the streamlining of typically onerous processes. Autofill software can negate the need for busy GPs to manually type out detailed information quickly and repeatedly by offering shortcuts to pre-written text.

However, as with a range of digital solutions, when used without care or when relied upon too heavily without supervision or some level of control by the user, information recorded may be misrepresented, not be specific enough or missed entirely. This risk was specifically highlighted by the Director of the PSR in his reflection on GP reviews in the PSR Annual Report 2022-23. It is the GP's duty to ensure that information is being recorded accurately. Autofill software should be used as a supplement to help improve workflows and efficiency. Using such technology does not remove the need for information to be checked. In most cases, a combination of manual typing and autofill would typically be used together to maintain the quality of patient records.

Prescribed pattern of services

- *Can you please revisit the 80/20 and 30/20 rules?*

The RACGP acknowledges GP concerns around the 80/20 and 30/20 rules, as perceived overservicing is not necessarily an indication of inappropriate practice. We called for a further deferral of the introduction of the 30/20 rule (which applies to telephone consultations only) due to the ongoing COVID-19 pandemic, however the rule came into effect on 1 October 2022. While referrals to the PSR under the 30/20 rule have commenced, we are yet to see significant numbers of practitioners referred for suspected breaches.

In regard to the 80/20 rule, the RACGP welcomed the decision to recommence targeted compliance letters to practitioners at risk of exceeding service limits under this rule. These letters give GPs an opportunity to review their billing before they are referred to the PSR.

As with all compliance interventions and tools, we will continue to monitor the impact of the 80/20 and 30/20 rules to inform any future advocacy response.

PSR referrals

- *Of the approx. 100 practitioners referred to the PSR each year, what is the percentage breakdown of GPs and other specialists?*

The Chief Executive Medicare sent 91 requests to review to the PSR Director in 2022–23, 70 of which were GPs. The average number of requests over the preceding five years was 103 cases.

In 2022–23 the PSR received requests to review cardiologists, dentists, endocrinologists, general physicians, general practitioners, general surgeons, neurologists, nuclear medicine physicians, nurse practitioners, other medical practitioners, paediatricians, pathologists, psychiatrists, rheumatologists, urologists and vascular surgeons. Of the persons under review referred to a PSR committee, 11 were GPs, four were other medical specialists, and one was a non-specialist medical practitioner.

- *I have seen many clinically inappropriate/not indicated CT imaging requests for patients often leading to incidental anxiety provoking findings referred by nurse practitioners. Does this mean if the practitioner is reviewed by PSR, it will be fellow nurse practitioners who determine 'clinical relevance'? Shouldn't this also be the case with other independent practitioners? This would also be the case for GPs/specialists. Just curious with the 'unleashing' health workforce scope by DoHAC in 23/24.*

The PSR Director may establish a Committee to decide whether a practitioner has engaged in inappropriate practice. Committee members are drawn from a panel of practising health or medical practitioners appointed by the Minister for Health and Aged Care.

Some panel members are appointed as Deputy Directors who Chair the Committee. A Committee includes a Deputy Director from your profession and two other panel members who are from your profession or, if applicable, medical specialty. One or two more panel members may also be appointed by the Director to give the Committee a wider range of expertise. A practitioner under review may challenge the appointment of a Committee member on the grounds of bias.

See the guide to the PSR process for more information.

Please note as set out in MBS Note IN.0.6, participating nurse practitioners can only request specific types of diagnostic imaging services for which a Medicare benefit can be paid. Participating nurse practitioners cannot request CT imaging for which a Medicare benefit would be payable.