Case study – Billing only for services provided

Case study

Mr A is suffering from cellulitis and is an admitted private patient at his local public hospital where he has stayed for 4 days.

Dr B 'the consultant physician' performed an initial consultation in the medical ward on day 1, with junior medical staff, employed by the hospital, reviewing and attending to Mr A during his stay on days 2 and 3.

Dr B attended, reviewed and discharged the patient sending him home on day 4.

Mr A receives a hospital bill for MBS item 110 (initial attendance) and three charges for MBS item 116 (subsequent attendance).

Mr A is unsure about the bill because he only saw Dr B on 2 occasions: on the day he was admitted and on the day he was discharged.

Mr A contacts Dr B's office to question the account. The practice manager tells him, that as an admitted private patient he must be charged for each day that he was in hospital.

Mr A is still unsure and contacts the department to see if the billing is correct.

Is this appropriate?

No.

It is not appropriate to bill Medicare daily simply because the patient remains admitted on that day.

As Dr B personally rendered the patient's initial consultation on the day of admission to hospital. He is entitled to bill item 110 to Medicare for this service.

Similarly, as Dr B personally rendered the service on the day of discharge from hospital, he can bill item 116 to Medicare.

On days 2 and 3 the patient was reviewed only by the hospital's junior medical staff.

Dr B cannot bill Medicare for services he did not actually render.

In addition, Medicare cannot be billed for services provided in a public hospital by doctors in receipt of a public salary at the time the services occurred. As is the case with the junior medical staff in this example.

Key points

- Referred consultation services will attract Medicare benefits, if the consultant physician or specialist who bills for the service is the person who renders the service.