Medicare billing in public hospitals – overview

20 March 2023

Patient election status and practitioner billing options

Patients are public patients unless they elect to be a private patient. This decision may be based on their health insurance cover and the type of hospital they attend.

A public patient in a public hospital

Public patients in a public hospital should be treated free of charge

If a patient is admitted to a public hospital they are treated as a public patient, unless they elect to be treated as a private patient. This decision needs to be based on informed financial consent.

Public services provided to public patients are funded under the National Health Reform Agreement (NHRA).

A public patient in a public hospital is treated free of charge, if:

- they have a current Medicare card
- the treatment is deemed clinically necessary.

When treating a public patient, no claims should be made against the Medicare Benefits Schedule (MBS). This is regardless of whether the service is bulk billed or not (a bulk billed service is not a public service).

All of a public patient's associated care is the responsibility of the hospital, including pathology and diagnostic tests.

Practitioners should not refer public patients for private MBS services. This includes tests done before patient admission and follow-up appointments related to the episode of care.

A private patient in a public hospital

Patients can receive private services in a public hospital

Patients can receive private (MBS and private health insurance-rebated) services in a public hospital where the hospital arrangements support this type of service. This helps to ensure the sustainability of the health system.

- A patient can choose to be treated as a private patient in a public hospital, after providing informed financial consent.
- The patient is entitled to MBS rebates for attendances.
- Practitioners with a right to private practice must ensure arrangements do not involve the practitioner or hospital being paid twice for a service.

A private patient in a private hospital

- A patient's visit will likely be funded through a mix of private health insurance and MBS arrangements.
- It is unlikely (noting that practitioners in private hospitals can see public patients) that MBS claiming for a private patient in a private hospital also involves a public hospital payment.

A public patient in a private hospital

- Private hospitals can contract out to provide services to public patients.
- Record keeping for these patients is carefully managed.
- A patient's election status is clearly tracked, including if they elect to change their status.
- MBS claims must not made for services funded as public services.

Patients should be given the choice to receive public or private services

Patients should be given the choice of whether they receive public or private services as part of informed financial consent. Patients should not receive preferential treatment – such as earlier access to the same health practitioner in the same hospital – based on this choice.

Commonwealth Health Insurance Act 1973

Eligibility for Medicare is governed by the *Health Insurance Act 1973*.

Section 19(2) of the *Health Insurance Act 1973* states that 'unless the Minister otherwise directs' a Medicare benefit is not payable in respect of a professional service that has been rendered by, or on behalf of, or under an arrangement with:

- the Commonwealth
- a state or territory
- a local governing body, or
- an authority established by a law of the Commonwealth, a law of a state or a law of an internal territory.

This means, unless the Minister provides an exemption, patients can't claim a Medicare benefit for a professional service if the service has already been paid for through another mechanism or arrangement with the Australian Government or a state or territory government.

Health practitioners should actively manage referrals, requests and claiming arrangements to ensure services are not paid for twice through public hospital and MBS funding.

The variety and complexity of working arrangements in a public hospital can lead to inadvertent inappropriate claiming.

Health practitioners should consider:

- the public or private election status of a patient (it is particularly important that this is established where referred or requested services, imaging or testing is provided)
- whether the practitioner has rights to private practice, or is receiving payment for the service from the public hospital
- whether the service could be part of pre-care (such as tests prior to admission) or aftercare (follow-up) relating to a public episode that should be funded as a public service.

National Health Reform Agreement (NHRA)

Clause G17 of the NHRA outlines that public patients should not generate charges against the Medicare Benefits Scheme (MBS).

To claim a professional service rendered to a patient in a public hospital as a Medicare benefit, all of the following criteria must be met:

- the patient has elected, in writing, to be treated as a private patient
- the patient is eligible for a Medicare benefit
- any referrals the patient has are valid for Medicare and NHRA purposes

- the MBS item number is billed correctly (and only for the services rendered by the individual provider)
- when the medical service (or MBS item) delivered is billed under Medicare. The service must not be partly or fully paid under an alternative arrangement (such as NHRA or WorkCover)
- as a healthcare provider, you must have rights through a hospital agreement to treat the patient under private practice. You can only bill Medicare if the patient has elected to be a private patient under admission
- the patient has been referred to a named specialist (if relevant) who is exercising their rights of private practice and the patient has chosen to be treated as a private patient.

Patient election – movement between public and private

Under the NHRA, if an eligible patient is admitted to a public hospital, they have the right to be treated as a public patient.

In writing, through informed financial consent, a public patient can elect to be treated as a private patient. Once the patient has chosen to be treated as a private patient, they cannot change back to a public patient unless unforeseen circumstances occur. Section G30 of the NHRA outlines unforeseen circumstances, such as:

- complications requiring extra procedures
- extensions in the patient's length of stay beyond what was originally planned by a health professional
- a change in the patient's social circumstances (such as the loss of a job).

If a patient changes their status, it is effective from the date of change. Once they have chosen to change from a public to a private patient, all services provided to them are claimable under Medicare. This is only in effect from the point of private election onward for the duration of their hospital episode.

Any services that have been rendered to the patient before becoming a private patient are not eligible for Medicare payments.

Public hospital in the home care

For public patients, hospital in the home (HITH) care is funded under the National Health Reform Agreement (NHRA) as if the patient was physically admitted to the hospital. All care that would have been provided if the patient was at the hospital is covered for patients receiving HITH care.

The responsibility for managing both the primary cause of the admission and unrelated but necessary or corollary care sits with the hospital. Services, consumables, and other costs for public patient hospital services are funded under the NHRA and provided to the patient free of charge; “free of charge” in this context means there is no charge to the patient or Medicare.

If a hospital delegates public services to a private provider, such as a private radiologist or general practitioner (GP), charges should not be generated against the MBS. The service remains part of the public service episode and the hospital is funded for the service under the NHRA. If delegation of care occurs, the private provider can be reimbursed for the services by the hospital through NHRA funding.

In rare circumstances, services can be compliantly billed to Medicare for a patient who is otherwise publicly admitted, including those in HITH. Generally, this would only occur where the patient seeks routine or pre-scheduled care unrelated to the hospital admission.

These circumstances depend on whether the patient chooses, independent of the hospital or other influences, to obtain a private service, for instance:

- a public patient could be admitted but ambulatory and, by choice, seeks a second medical opinion on their hospital treatment with their usual GP or private specialist
- an admitted, ambulatory public patient may seek private diagnostic imaging or pathology tests for ongoing care related to a chronic condition, and choose for the service to be billed privately
- a patient might obtain a private service that was not necessary care, such as proceeding with pre-planned plastic surgery for keloid (acne) scar revision by a practitioner that works privately at the hospital, while unexpectedly admitted for public mental health care.

Some Medicare services cannot be billed for admitted patients and, by extension, patients receiving HITH care; this includes telehealth services and allied mental health services.

Outpatient referral requirements under the NHRA

A referral to a named specialist (named referral) is required for a patient to access private services at a public hospital outpatient clinic (NHRA clause G19b). This applies regardless of whether the patient funds the service personally or receives a Medicare benefit or private health insurance rebate.

Importantly, patients have a right to be treated as a public outpatient regardless of whether they present to the clinic with a generic or named referral. Public hospitals must not control referral pathways so that a named referral is required for access to a public clinic (NHRA clause G17b).

It is acceptable for a hospital to request a named referral if the patient, patient's carer, or other authorised party has decided to be seen as a private outpatient and has provided informed financial consent. It should be made clear that the request is according to the patient's wishes, rather than to facilitate private billing as a matter of policy or a default approach to providing care.

Patients can make the decision to remain public or elect to be private when they meet with their GP, when they book the appointment, or when they attend the outpatient clinic. If the patient is unsure, it may be best for the GP to provide a named referral – this will ensure the patient does not have to seek an additional referral before being seen, if they subsequently decide to be private. Referrers should not be required to provide a named referral for patients that have elected to remain a public patient.

A valid referral must be in place prior to any referred service being billed to Medicare and cannot be backdated.

While it is not a requirement, general practitioners are encouraged to provide patient-centred advice on the consequences of either a public or private election, including that:

- **private care** may involve an out-of-pocket cost, Medicare benefits and private health insurance rebates may apply, and the patient will have the right to choose their treating practitioner
- **public care** is provided at no cost to the patient, and with no charges raised against Medicare or private health insurance. Waiting times to access services may apply and the patient is treated by the practitioner appointed by the public hospital.

It is recommended that practitioners record a patient's election to be public or private on the referral, if the decision is made at the time of referring.

The Health Provider Tip-off form

If you are concerned that a provider or hospital is billing Medicare for a public hospital patient, or mandating that a named referral is provided before allowing any access to outpatient services, please raise your concerns through the Health Provider Tip-off form.

Due to privacy and secrecy requirements, the Department may not be able to provide feedback on your tip-off but will follow up with the relevant hospital or health department as required.