



Australian Government

Department of Health, Disability and Ageing

Understanding Medicare

Provider Handbook



How to use this handbook

This 'Understanding Medicare: Provider Handbook' is designed to provide an overview of the Medicare system and how it works. In it, you will find a summary of the key terms, concepts and processes that make up this system.

This handbook provides a basic introduction to Medicare. However, it is not a complete guide to working within Medicare and should only be used as a starting point to understand the Medicare system. Throughout this handbook, you will be directed to where you can find more information about the topics introduced. Section 6.2 of this document – '[Where to get help and support](#)' – tells you how you can find further assistance.

While care has been taken to ensure that the information in this handbook is accurate, it is important to remember that the legislation is always the main point of reference when it comes to understanding Medicare. This handbook does not provide legal advice. The legislation that establishes the legal basis for Medicare can be found on the [Federal Register of Legislation](#).

Terminology

In this handbook, we refer to **practitioners** and **providers**. These are general terms for professionals who 'provide' services in the healthcare system. We use these terms instead of 'doctor' or 'medical professional' because not all providers who participate in Medicare fit within these categories. For example, allied health professionals such as psychologists and podiatrists may be providers or practitioners without being doctors.

If you are new to the Medicare system, you will probably find some unfamiliar language in this handbook. We have defined Medicare-specific terms throughout the text, and you can also find these definitions in the glossary at the end of the document.

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1 Introduction

The Medicare system aims to provide eligible Australian residents affordable, accessible and high-quality health care.

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1.1 What is Medicare?

Medicare is Australia's universal health benefits system. It is funded by the Australian Government and provides free or subsidised healthcare services to Australians (and eligible overseas visitors). It was introduced in 1984 with the aim of providing eligible Australian residents affordable, accessible and high-quality health care.

When someone is enrolled in Medicare, the Government pays some of their health care costs. This includes costs for non-hospital services (such as general practitioner [GP] visits), hospital services (such as surgical procedures), medicines, diagnostic services (such as diagnostic imaging and pathology services), and other non-GP specialist services.

1.2 Medicare programs

Different types of health services are funded and paid for in different ways under the Medicare system. There are several different **programs** within the Medicare system that have their own specific purpose, structure and funding arrangements. These programs complement each other and work together to provide Australians with comprehensive access to affordable health care.

Some of the main programs within Medicare are the Medicare Benefits Schedule (MBS) and the Child Dental Benefits Schedule (CDBS). The [Pharmaceutical Benefits Scheme \(PBS\)](#) subsidises [medicines](#) for people with a Medicare card.

Medicare programs:
a broad term for the different schemes that sit within the Medicare system



Medicare

Medicare is Australia's universal health scheme and provides a 'benefit', known as a **Medicare benefit**, for eligible health services. This usually involves a patient going to a health provider of their choice, paying a price set by the provider for a health service, and receiving a rebate into their bank account that covers some of the price that they paid.

The **Medicare Benefits Schedule (MBS)** lists the services that can be subsidised under Medicare. This includes:

- consultations with health practitioners, such as GPs and non-GP specialists – these can be in person or **telehealth** services
- mental health services, including psychological therapy, mental health assessments and treatment plans
- some health assessments
- surgical services
- diagnostic imaging services, such as ultrasounds
- radiation oncology and chemotherapy treatment
- pathology tests
- eye tests done by an optometrist
- hospital services for private patients.

We explore more about the MBS and how to navigate it in the next chapter.

Medicare benefit:

the amount available from Medicare to help patients pay for health services

Telehealth:

health services delivered over the phone or via video call

Child Dental Benefits Schedule

The Child Dental Benefits Schedule (CDBS) is a national, means-tested program that provides eligible children aged 0–17 years with a benefit for basic dental services. There is a cap on the total value of dental services that a child can receive under the CDBS in a 2-year period. You can find more information on the [CDBS webpage](#).

Pharmaceutical Benefits Scheme

The Pharmaceutical Benefits Scheme (PBS) is a program that provides subsidised medicines to Australians. Similar to the MBS, the **Pharmaceutical Benefits Schedule** lists the medicines that Australians can access through the [PBS](#). [More information on PBS eligibility](#) can be found on the Services Australia website.

PBS co-payment:

the amount that a patient pays for a medicine that is covered under the PBS

Patients make a **PBS co-payment** towards the cost of a PBS medicine and the Government generally covers the remaining cost. This process usually involves a person going to a pharmacy with a prescription.



There may be instances where people pay more than the co-payment. For example, if they choose a particular brand of medicine, they may pay a brand premium.

Some cheaper medicines are priced lower than the general patient co-payment; for these medicines, patients pay the full price.

The co-payment amounts are indexed each year and can be found on the [PBS.gov.au website](https://www.pbs.gov.au).



Example

In 2024, Sarah is a general (non-concessional) patient with a prescription from her GP for antibiotics listed on the Pharmaceutical Benefits Schedule. The general patient co-payment is \$31.60. Although the actual market cost of the antibiotics is \$200, Sarah pays only \$31.60 when she collects her prescription from the pharmacy. The pharmacist will claim the remaining \$168.40 from the Government through the PBS.

PBS Safety Net

For patients who need a lot of medicines, the PBS Safety Net can help to keep costs down. Patients can apply for a PBS Safety Net card which entitles them to PBS medicines at no or lower cost once their costs reach a threshold amount for the calendar year.

The Services Australia website provides additional information about the [PBS Safety Net](#) and the [PBS Safety Net thresholds](#).

1.3 Medicare and hospitals

National Health Reform Agreement

The National Health Reform Agreement (NHRA) is an agreement between the Australian Government and all state and territory governments. It guides how Medicare funding is used to fund services delivered to public and private patients in **public hospitals**.

Under the NHRA, the Australian Government contributes funds to states and territories for public hospital services. This includes services delivered through emergency departments, hospitals and community health settings. The agreement recognises states and territories as system managers of public hospitals.

Services delivered in private hospitals are paid for by a combination of the Medicare benefits, the patient and the patient's **private health insurance**, where applicable.

Public hospital:

a hospital recognised and approved to operate as a public hospital by a state or territory government

Private health insurance: insurance that Australians pay for through private health insurers. Private health insurance helps cover medical services that may not be covered by Medicare. The Government offers a range of incentives that encourage Australians who can afford it to have private insurance.

Many services delivered to patients in public hospitals are funded through the NHRA. However, Medicare benefits are available for some services provided in public hospitals to **private patients**.

When a person is admitted to a public hospital, they can choose to be treated as either a public patient or a private patient.

Public patients: The Australian Government provides funding to the states and territories under the NHRA to support the provision of free hospital treatment to public patients.

Private patients: A private patient may be charged for the costs of the services that are provided to them in hospital, including for certain procedures and tests.

A Medicare benefit may be available to help them pay for some of these services.

The Medicare Benefits Schedule covers some of the cost of services provided to private patients in hospital. This is the case even if a private patient is receiving care in a public hospital. The hospital services that Medicare may cover are listed on the MBS.

1.4 Medicare Safety Nets

Australians with high **out of pocket** healthcare costs can access extra support from Medicare through the **Medicare Safety Net**. Once a patient's out of pocket costs for non-hospital health services reach a set amount they will receive a higher rebate from Medicare for their health services for the rest of the calendar year.

There are [two Medicare Safety Nets](#): the 'Original Medicare Safety Net' and the 'Extended Medicare Safety Net' (EMSN).

Out of pocket costs:

money that patients directly contribute to their medical costs. In practice, this is usually the difference between the amount a practitioner charges for a service and the amount of Medicare benefit the patient receives

Example



This example assumes that the patient is eligible to receive EMSN benefits.

In this scenario the MBS fee is \$100, there is an 85 per cent out of hospital rebate and a 300 per cent EMSN benefit cap of \$300.

If the doctor charges \$120 for the service of which the MBS fee is \$100, the patient will receive:

- 85 per cent out of hospital rebate of \$85; and
- 80 per cent of their remaining out of pocket amount or \$300, whichever is the lesser amount.

In this example, their initial out of pocket cost is \$35 (i.e. $\$120 - \$85 = \$35$).

Eighty per cent of that out of pocket cost is \$28 (i.e. $80\% \times \$35 = \28).

As such, they will receive an EMSN benefit of \$28.

This means that the patient will receive a total benefit of \$113 (i.e. $\$85 + \$28 = \$113$) from Medicare and will have a final out of pocket cost of \$7 (i.e. $\$120 - \$113 = \$7$).

This example is correct as at 1 September 2024.

In summary

Medicare is Australia's universal health benefits system. The Medicare system contains several programs. Each has their own functions and operates differently.

Some of the main programs within Medicare are the Medicare Benefits Schedule and the Child Dental Benefits Schedule (CDBS). The Pharmaceutical Benefits Scheme (PBS) subsidises medicines for people with a Medicare card.

The costs of health services provided to public patients in public hospitals are directly covered by the NHRA. Private patients are responsible for the costs of the hospital services they receive, either in a private or public hospital. However, Medicare benefits are available to help them pay for some of these services. They may also have private health insurance to help them cover the costs.



2 The Medicare Benefits Schedule

The MBS lists services that are covered by Medicare. Each MBS item has an item number, item descriptor, Schedule fee and benefit rate. The item number is used when claiming a benefit for a service.

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The MBS is the list of health services for which the Government may pay a Medicare benefit.

Each service on the list is referred to as an **MBS item** and has been assigned a unique **MBS item number**.

MBS item: a service that has been listed on the MBS and allocated an item number

MBS item number: the number allocated to a service that is on the MBS. In practice, this is a code used to claim a Medicare benefit for that service

The MBS is divided into 8 categories:

-  1. Professional attendances (for example, general face-to-face and telehealth)
-  2. Diagnostic procedures and investigations (for example, electrocardiograms [ECGs], sleep studies, lung function tests)
-  3. Therapeutic procedures (for example, IVF, radiation oncology, surgical procedures, anaesthesia)
-  4. Oral and maxillofacial services (for example, mouth, jaw, face and neck items)
-  5. Diagnostic imaging services (for example, ultrasound, X-ray, CT scan, MRI, diagnostic radiology)
-  6. Pathology services (for example, blood tests, tissue samples, genetic tests)
-  7. Cleft and craniofacial services (for example, treatment of cleft lip)
-  8. Miscellaneous services (for example, allied health services, bulk billing incentive items, nurse practitioner services).

Each category is divided into groups and then further into subgroups. This makes it easier for you to find the item that you are looking for.

In the list above, the colours reflect the colour coding used for the categories on MBS Online.

You can download a [digital copy of the MBS Book](#) and you can search the [MBS Online database](#).

How items are added to the MBS

MBS items are added to the MBS by a decision of the Australian Government through the budget process, based on advice, which can include the Medical Services Advisory Committee (MSAC) and the MBS Review Advisory Committee (MRAC).

All MBS items must be written into the legislation under the *Health Insurance Act 1973*.

2.1 Key components

Each item on the MBS includes a set of key components. These tell you what the service is, what it can be used for, and how much the Medicare benefit is. These components include the **MBS item number**, **item descriptor**, **Schedule fee** and **benefit rate**.

Item descriptor

An MBS item descriptor sets out an item's elements and requirements. These are often referred to as **item requirements**. A service provided must match the item descriptor and all item requirements as well as other relevant requirements. If a practitioner performs a service that does not meet all the requirements for an item on the MBS, a Medicare benefit is not available.

Item requirement:

an essential element of an MBS item. Medicare benefits are only available for services that meet all the item requirements for an item on the MBS

Some MBS items have **time requirements**. For some services, items may be available that differ only in terms of their time requirement. For example, the appropriate item for a GP consultation will depend on the length of the consultation. Items with longer time requirements generally have higher Schedule fees. A time requirement is one of the requirements to be met before a Medicare benefit is payable.

Schedule fee

The **Schedule fee** is a fee for service set by the Australian Government. It may differ from the actual fee charged by a practitioner. The Medicare benefit is a patient benefit and is the amount that the Government pays towards the MBS service and is calculated based on the Schedule fee.

Schedule fees are shown on the MBS as an Australian dollar amount.

Benefit rate

The **benefit rate** tells you the different benefit amounts for each MBS item. This is shown as both a percentage and an Australian dollar amount. The benefit amount is generally calculated by multiplying the Schedule fee by the benefit rate. For example, if the Schedule fee for an item is \$50 and the benefit rate is 85%, the maximum benefit available for that item is \$42.50.

More information about benefit rates and how Medicare benefits are calculated is included in chapter 5 – [How much is the benefit?](#)

2.2 Other components

Explanatory notes

MBS **explanatory notes** are instrumental to the appropriate use of MBS items. They provide information about Medicare rules as well as specific guidance relevant to MBS items. Explanatory notes can be accessed via MBS Online.

[More information on general explanatory notes](#) can be found on MBS Online.

Extended Medicare Safety Net cap

Some MBS items have an **Extended Medicare Safety Net cap**. This is a limit placed on how much safety net benefit a patient receives. It is shown as an amount in Australian dollars.

More information is available online about the [Extended Medicare Safety Net and Extended Medicare Safety Net cap](#).



Example – An MBS item

Category 1 - PROFESSIONAL ATTENDANCES

23 **MBS item number**

Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant:

- (a) taking a patient history;
- (b) performing a clinical examination;
- (c) arranging any necessary investigation;
- (d) implementing a management plan;
- (e) providing appropriate preventive health care;

for one or more health-related issues, with appropriate documentation

Fee: \$ **Benefit:** 100% = \$

(See para [AN.0.9](#), [AN.0.74](#), [MN.1.3](#), [MN.1.4](#), [MN.1.5](#), [MN.1.6](#), [MN.1.7](#), [MN.1.8](#) of explanatory notes to this Category)

Extended Medicare Safety Net Cap: \$

[← Previous - Item 4](#)

Group A1 - General Practitioner
Attendances To Which No Other
Item Applies

Subheading 2 - Level B

Item descriptor as found in legislation

Explanatory notes give further guidance to provider on whether the item is applicable for the service being provided

Schedule fee and benefits

Extended Medicare Safety Net helps patients with out of pocket costs for out-of-hospital services. Some MBS services have a cap on this benefit

This is an example of what an MBS item looks like on MBS Online. This is item number 23 in Category 1 – Professional Attendances. It describes a GP attendance lasting less than 20 minutes (time requirement) which might include a range of elements, such as taking a patient history.

In summary

The MBS lists services that are covered by Medicare. These services are called MBS items, and each has an allocated item number that is used when a benefit is being claimed for that service.

Each MBS item has set components, including an item descriptor, Schedule fee and benefit rate. The amount of the Medicare benefit available for an item is calculated based on its Schedule fee and benefit rate. For a Medicare benefit to be available, the service provided must match the item descriptor and all item requirements.



3 MBS rules and requirements

The *Health Insurance Act 1973* sets out requirements relating to Medicare. These include the types of services, who is eligible for services and how services are to be provided.

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There are various requirements and rules that apply to the Medicare process. If the requirements for an MBS service are not met, a Medicare benefit will not be **payable**.

These requirements are set out in the *Health Insurance Act 1973*. We have summarised them and what they mean below. However, the legislation is always the main point of reference for understanding Medicare and its requirements. You can read the *Health Insurance Act 1973* on the [Federal Register of Legislation](#).

Payable: refers to whether a Medicare benefit may be paid. A benefit is only 'payable' if all relevant requirements have been met

3.1 When is a Medicare benefit payable?

Medicare benefits are generally only payable for **professional services** that are **clinically relevant**, fulfil all **item requirements** for the relevant MBS item, are provided by a **practitioner permitted to participate in Medicare**, and are **provided in Australia**.

Professional services: A broad term for services covered by Medicare. These services are set out in the MBS.

Clinically relevant: Services that would be generally accepted by a relevant profession as necessary for the appropriate treatment of the patient. For example, an eye X-ray is unlikely to be clinically relevant for a patient complaining of chest pain.

Item requirements: Services must meet the item requirements set out in the relevant item descriptor.



Example

The item descriptor for a heart check (heart health assessment) includes a blood pressure test. A Medicare benefit is not payable unless the patient's blood pressure is tested, and all other relevant requirements are met.

Practitioner permitted to participate in Medicare: A medical or other practitioner (for example, an allied health professional) who is permitted to participate in Medicare.

To participate in Medicare a practitioner must hold a current registration with a relevant Australian registering body, such as the Australian Health Practitioner Regulation Agency (Ahpra). They must also meet other requirements such as maintaining their qualifications and obtaining a provider number.

Provided in Australia: Medicare benefits are generally only payable for services provided in Australia. This means that all components of the service must be performed in Australia, including any reviewing, reporting and supervisory elements. For telehealth services, both the patient and the practitioner must be located in Australia for a Medicare benefit to be payable.

3.2 Excluded services

Certain types of services are not able to be covered by Medicare. These include:

- X** medical examinations for the purposes of life insurance, superannuation, a provident account scheme or admission to membership of a friendly society
- X** professional services related to a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability
- X** services paid for by employers or under an industrial agreement
- X** services related to the administering of vaccines that are covered by a mass immunisation program
- X** specifically excluded services, such as tattoo removal and non-therapeutic cosmetic surgery
- X** health screening services (with some exceptions).

MBS Online provides a [full list of excluded services](#).

Services funded by other arrangements

Medicare benefits are not payable for medical services rendered under other arrangements. This could include an arrangement with the Australian Government, a state or territory government, a local governing body or an authority established under national, state or territory law.

3.3 Who is entitled to Medicare benefits?

Generally, to be eligible for Medicare a patient must permanently reside in Australia and be one of the following:

- ✓** an Australian citizen
- ✓** a permanent visa holder
- ✓** a New Zealand citizen
- ✓** in certain circumstances, an applicant for a permanent residence visa.

In some circumstances, persons who are not permanent Australian residents may be able to access some Medicare benefits. This may apply to:

- temporary residents covered by a relevant ministerial order
- temporary visitors whose home country has a reciprocal healthcare agreement with Australia.

The Services Australia website provides [more information on patient eligibility requirements](#).

Medicare cards

To receive Medicare benefits, eligible Australians must enrol in (join) Medicare. Once enrolled, a person will receive a **Medicare card** which displays their Medicare card number.

Families can choose to be included on the same Medicare card and have the same Medicare card number. Each person on a [Medicare card](#) will have an **Individual Reference Number (IRN)**.

Individual Reference

Number (IRN): a single-digit number assigned to each person on a Medicare card. This number is used to identify which person on the card is receiving a service or benefit

3.4 Other requirements

Practitioner proficiency

Practitioners must generally meet minimum proficiency requirements before they can provide MBS services.

These requirements are designed to ensure practitioners are appropriately trained and working within a recognised professional framework. For example, practitioners usually need to meet certain criteria for postgraduate qualifications and experience or be in an approved workforce training program.

Medicare also restricts the availability of Medicare benefits for services provided by some **international medical graduates (IMGs)** and former international medical students. These restrictions generally apply for 10 years from the time an IMG becomes registered as a practitioner with a state or territory medical board.

The Minister for Health and Aged Care may grant an exemption to these restrictions if a practitioner chooses to work in an area considered to have a workforce shortage. In practice, this enables Medicare benefits to be available for services provided by the practitioner at a particular location.

International medical

graduate (IMG): a practitioner who received their primary medical qualification from an institution outside of Australia or New Zealand. Otherwise known as an overseas trained doctor (OTD)

The Department of Health and Aged Care website provides [more information on these restrictions and when they apply](#).

Complete medical service

In general, each professional service listed on the MBS is considered a 'complete medical service'. This means that each service is an independent and complete service in itself.

A practitioner must perform all the necessary elements of a service before the MBS service is considered to have been provided. This means that all the tasks required to perform one MBS service are part of the same MBS item and should not be claimed separately. This includes procedural tasks such as routine preoperative and postoperative care.

Attendance requirements

Generally, professional attendance items, such as GP consultations, require a practitioner to actively attend to the patient. This means that the practitioner must be present while all elements of the service are being provided. Some MBS items require a practitioner to attend in person and some MBS items enable this attendance to be via telehealth.

If an MBS item contains a time requirement, generally only time that the practitioner spends actively attending to the patient can count towards this requirement. Time spent away from the patient, or time spent by other staff with the patient, is not usually considered to be time taken to deliver the service.

Referrals and requests

Some services require a **referral** from another provider if the service is to be claimed through Medicare. In pathology and diagnostic imaging, a referral for these services is usually called a **request**. These terms may be used to refer to written advice from one practitioner to another, asking for a service to be provided to a patient.

While the terms 'referral' and 'request' are often used interchangeably, a 'referral' is generally made to a non-GP specialist, consultant physician or allied health professional and may not constitute a request for diagnostic imaging or pathology.

Referral: a written request from one practitioner to another, asking for a service to be provided to a patient

Request: a request for a pathology or diagnostic imaging service

In summary

Medicare benefits are not payable unless all relevant requirements have been met. These requirements include both individual item requirements and general Medicare requirements, such as clinical relevance and practitioner proficiency requirements. Medicare benefits are payable subject to and in accordance with the *Health Insurance Act 1973*. The legislation is always the main point of reference for understanding Medicare and its requirements.



4 Medicare claiming

If requirements for a service are met, a claim may be submitted for a payment of Medicare benefit. Claims may be made through various claiming channels.

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For a Medicare benefit to be paid for a service, a valid **Medicare claim** must be made.

Who makes a claim and who receives the associated Medicare benefit depends on the circumstances in which a service is delivered and paid for. Generally, there are three main claiming scenarios:

Medicare claim: a request to Medicare for a benefit to be paid for a service delivered

1 A patient makes a Medicare claim directly

They can do so after receiving and paying an expense for an eligible health service. In this scenario, the patient submits the claim, and the Medicare benefit is paid into the patient's nominated bank account.

2 A provider makes a Medicare claim for their patient

This is usually done by the practitioner or a practice staff member after a service has been provided. In this scenario, the provider submits the claim, but the benefit is paid into the patient's nominated bank account.

3 A provider makes a Medicare claim directly

This can only occur if the patient has assigned their Medicare benefit to the provider as part of a process known as bulk billing. In this scenario, the provider submits the claim, and the benefit is paid into the provider's nominated bank account.



Example

Alex visits their GP for a consultation. They are charged \$80 for the visit. This price is higher than the Schedule fee. This means Alex will have out of pocket costs for the service. Alex pays the practice \$80 for the full cost of the service. When they get home, they go online and submit a Medicare claim for the service. A few days later, a Medicare benefit is paid into their nominated bank account. This benefit does not cover the full cost of the visit and Alex is out of pocket (has paid) for the difference between the fee charged by the GP and the Medicare benefit.



Example

Manik visits their GP for a consultation. The GP decides to bulk bill the service, meaning Manik will have no out of pocket costs. Manik agrees to assign their Medicare benefit for the service to the GP as full payment, and the GP receives that amount when the claim is paid.

4.1 Patient claiming

Patients can claim a Medicare benefit after receiving and paying for an eligible service. Medicare benefits operate as a rebate, so they can only be paid *after* a service has been delivered. There are a range of ways that patients can submit Medicare claims. The Services Australia website provides [more information about patient claiming options](#).

4.2 Bulk billing

In the Medicare system, providers set their own prices for the services that they provide. These prices can be more than the Schedule fee set for a particular service, and therefore more than the Medicare benefit available for that service. This billing option is often referred to as **private billing**.

Private billing: where a practitioner charges a private fee for a service. This fee can be greater than, equal to, or less than the Schedule fee for a service

However, providers can also choose to accept the Medicare benefit available for a service as full payment for that service. This is known as **bulk billing**.

Medicare is a system designed to provide patient benefits. This means that generally patients, not providers, are entitled to receive Medicare benefits. However, when a provider bulk bills a service they will receive the Medicare benefit for that service instead of the patient. This requires the patient to 'assign' their benefit to the provider.

If a provider chooses to [bulk bill](#) a service, they cannot charge the patient fees in respect of that service. This includes any practice fees, administration fees or costs for materials used during the service. There is an exception relating to the provision of vaccines to a patient.



Example

Sandeep visits his GP for a consultation. After his appointment, Sandeep goes to reception and is told that his GP offers bulk billing. Sandeep agrees to the consultation being bulk billed. He is not charged anything for his visit.

Sandeep's GP submits a claim to Medicare for a Medicare benefit for the service provided to Sandeep. If all relevant requirements are met, this benefit will be paid into the GP's nominated bank account.

Bulk billing incentives

Medicare offers **bulk billing incentives** to eligible providers to encourage them to bulk bill more of the services they provide. These incentives are designed to help make health services more affordable for some patients. This includes children, and people with a [Commonwealth Concession Card](#).

When a provider bulk bills an eligible service for one of these patients, they may [claim a bulk billing incentive item](#). These items are listed on the MBS and increase the value of the Medicare benefit that the provider receives for a bulk billed service.

Split billing

There may be instances when a practitioner provides several services to a patient on one occasion. They may choose to bulk bill some of these services and not others. This is known as **split billing**.

There are some circumstances where split billing is not available. This is usually the case when the items being claimed are subject to [‘multiple operation’ or ‘multiple services’ rules](#).



Example

Mary visits her GP for a check-up. During the consultation, Mary's GP notices a mole on her arm and performs a skin biopsy.

Mary's GP claims two MBS items for this visit: one for the consultation and one for the biopsy. The GP chooses to bulk bill the biopsy item but privately bill the consultation item. No multiple operation rules apply to this combination of items.

4.3 Administrative requirements

There are several requirements that providers need to be aware of before submitting Medicare claims.

Provider numbers

To submit a Medicare claim a provider must have a valid **provider number**. Provider numbers are issued to practitioners by **Services Australia**.

Provider numbers uniquely identify practitioners and the locations where they deliver services. Generally, a provider will have a different provider number for each location at which they practise.

Services Australia:

the executive agency that processes claims and payments in respect of health benefits schemes, including Medicare

Recordkeeping

Practitioners should always keep adequate records of the services they provide to patients. These records may include:

- clear identification of the name of the patient
- a separate entry for each attendance by the patient for a service and the date on which the service was provided or initiated
- clinical information adequate to explain the type of service provided or initiated
- enough detail for another practitioner to understand and rely on them to effectively undertake the patient's ongoing care.

Medical records should be kept securely as either physical or electronic files.

Keeping documents

There are rules about how long providers must keep documents that relate to MBS services, Medicare benefits and Medicare claims.

MBS Online provides [more information about documentation requirements](#).

4.4 How providers submit claims

Claiming channels

Providers can submit claims through a range of **claiming channels**. These channels are managed by Services Australia.

The Services Australia website provides a useful [guide to how the different claiming channels work](#).

Claiming channel:

a method, platform or software used to submit claims to Services Australia

Who can submit a Medicare claim?

In addition to practitioners, practice managers, receptionists, administrators and other practice staff may submit Medicare claims.

Often, practice staff will submit Medicare claims on behalf of practitioners, rather than practitioners doing so themselves.

4.5 Incorrect payments

If a person is paid a Medicare benefit based on an incorrect claim or for a service that did not meet all relevant Medicare requirements, the amount may be recovered.

The Department of Health and Aged Care undertakes a [range of compliance programs](#) designed to respond to incorrect payments.

In summary

Both providers and patients can submit claims to Medicare. Who makes a claim and who receives the associated Medicare benefit depends on the circumstances in which a service is provided and paid for. In particular, claims are made differently depending on whether a claim is privately billed or bulk billed.

Bulk billing involves a provider accepting the Medicare benefit for an MBS item as full payment for the relevant service. For a service to be bulk billed the patient must 'assign' their Medicare benefit to the provider. Providers cannot charge the patient any additional fees for a bulk billed service.

There are certain requirements that must be met when claiming Medicare benefits. Incorrect claims can result in payments being recovered.



5 How much is the benefit?

The Medicare benefit rate paid for a service depends on the type of service and the circumstances in which it is provided.

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The amount of the Medicare benefit available for an MBS item varies. Depending on the circumstances, an amount equal to 75%, 85% or 100% of the Schedule fee for an MBS item may be payable.

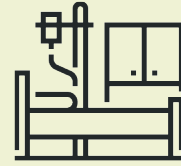
Generally, the benefit rate will be:



100%
for GP
attendances



85%
for all other out-of-
hospital services



75%
for private patient
hospital services



Regulations

Some MBS items always have a benefit equal to 100% of the Schedule fee. These items are set out in the [Health Insurance Regulations](#).

5.1 Other rules and conditions

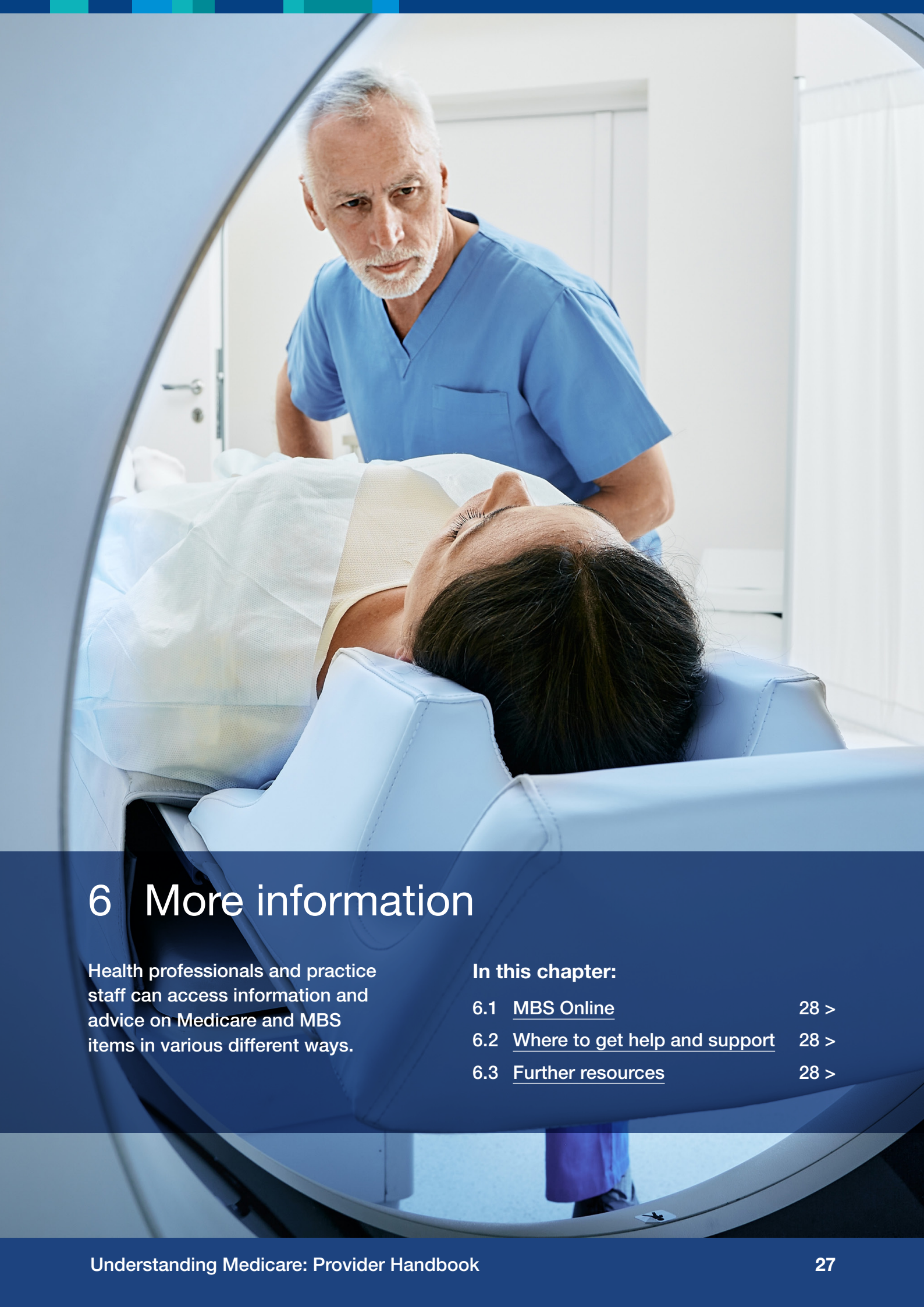
There are a range of other rules and conditions that may affect the amount of the Medicare benefit available in certain circumstances.

These include 'multiple operation' and 'multiple services' rules that apply when certain MBS items are claimed together and 'multiple attendance' rules about the number of MBS services that can be provided. The Services Australia website provides more information about [rules relating to billing multiple MBS items](#).

In summary

In general, the Medicare benefit paid for a service is equal to 100%, 85% or 75% of the Schedule fee. The benefit rate depends on the type of service and the circumstances in which it is provided.

There are a range of rules and conditions that may affect the amount of the Medicare benefit paid in certain circumstances.



6 More information

Health professionals and practice staff can access information and advice on Medicare and MBS items in various different ways.

In this chapter:

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6.1 MBS Online

[MBS Online](#) contains the latest information on the MBS, including updates on changes to the MBS as they occur. MBS Online publishes the MBS item descriptors and accompanying explanatory notes, which guide practitioners in correctly providing and claiming services. Any MBS item or explanatory note can be found by searching for the item or note number.

MBS Online also publishes point-in-time fact sheets with more information on MBS changes. The [Downloads](#) section includes complete MBS documents. Changes to MBS items are published in the 'News' section of the website. Providers can also [subscribe](#) to receive information about MBS updates.

6.2 Where to get help and support

Services Australia

Services Australia can provide advice on obtaining a provider number and assist with queries related to submission and payment of claims. More information is available on the [Services Australia website](#).

AskMBS

Providers can contact AskMBS by email at askMBS@health.gov.au for written advice about MBS items and rules. AskMBS has published several [AskMBS advisories](#) on the Department of Health and Aged Care website to help providers understand MBS billing requirements.

6.3 Further resources

Department of Health and Aged Care website
health.gov.au/topics/medicare/compliance/how-to-comply

Services Australia Health Professional Education resources
hpe.servicesaustralia.gov.au

Federal Register of Legislation
legislation.gov.au

Glossary

Benefit rate: the percentage of the Schedule fee that is equal to the Medicare benefit for an item

Bulk billing: a process where a patient assigns their Medicare benefit for a service to a provider and the provider accepts this benefit as full payment for the service

Bulk billing incentives: incentives designed to help make healthcare services more affordable for patients. These are listed on the MBS and can only be claimed when the relevant services are bulk billed

Child Dental Benefits Schedule: a national, means-tested program that provides eligible children aged 0–17 years with a benefit for basic dental services

Claiming channel: a method, platform or software used to submit claims to Medicare

Clinically relevant service: a service that would be generally accepted by a relevant profession as necessary for the appropriate treatment of a patient

Explanatory notes: notes which provide further guidance for providers on whether an MBS item is applicable for the service being provided

Extended Medicare Safety Net cap: a limit placed on how much a patient's out of pocket expenses for an item can contribute to their Extended Medicare Safety Net

Individual Reference Number (IRN): A single-digit number assigned to each person on a Medicare card. This number is used to identify which person on the card is receiving a service or benefit

International medical graduate (IMG): a practitioner who received their primary medical qualification from an institution outside of Australia or New Zealand. Otherwise known as an overseas trained doctor (OTD)

Item descriptor: a description of an MBS item's elements and item requirements

Item requirement: an essential element of an MBS item

MBS item: a service that has been listed on the MBS and allocated an item number

MBS item number: the number allocated to a service that is on the MBS. This code is used to claim a Medicare benefit for that service

Medicare: Australia's universal health benefits system. It is funded by the Australian Government and provides free or subsidised healthcare services to Australians (and eligible overseas visitors)

Medicare benefit: an amount available from Medicare to help patients pay for health services

Medicare Benefits Schedule (MBS): a list of services that are subsidised through Medicare

Medicare card: a card that signifies a patient's eligibility for Medicare and displays their Medicare card number

Medicare claim: a request to Medicare for a benefit to be paid for a service

Medicare Safety Net: extra support for Australians with high out of pocket healthcare costs. Once a patient's out of pocket costs for non-hospital health services reach a set threshold they will receive a higher rebate for their health services for the rest of the calendar year. There are two levels of Medicare Safety Net: the 'Original Medicare Safety Net' and the 'Extended Medicare Safety Net'

National Health Reform Agreement (NHRA): an agreement between the Australian Government and all state and territory governments. Under this agreement, states and territories fund and manage public hospitals, with financial assistance from the Australian Government

Out of pocket costs: money that patients directly contribute to their medical costs. In practice, this is usually the difference between the amount a practitioner charges for a service and the amount of Medicare benefit the patient receives

Payable: refers to whether a Medicare benefit may be paid. A benefit is only payable if all relevant requirements have been met

PBS co-payment: the maximum amount that a patient pays for a medicine listed on the PBS

Pharmaceutical Benefits Schedule: a list of the medicines that Australians can access through the PBS

Pharmaceutical Benefits Scheme (PBS): an Australian Government program that provides subsidised medicines for people with a Medicare card

Practitioner/provider: general terms for professionals who provide services in the healthcare system

Private billing: where a practitioner charges a private fee for a service. This fee can be greater than, equal to, or less than the Schedule fee for a service

Private health insurance: insurance that Australians pay for through private health insurers. Private health insurance helps cover medical services that may not be covered by Medicare

Professional service: a broad term for services covered by Medicare. These services are set out in the MBS

Provider number: a code that uniquely identifies a practitioner and the location at which they deliver services

Public hospital: a hospital recognised and approved to operate as a public hospital by a state or territory government. Public hospitals are funded by both the Australian Government and state and territory governments

Referral: a written request from one practitioner to another, asking for a service to be provided to a patient

Request: a request for a pathology or diagnostic imaging service

Schedule fee: a fee for service set by the Australian Government. It may differ from the actual fee charged by a practitioner

Services Australia: the executive agency that processes claims and payments in respect of health benefits schemes, including Medicare

Split billing: where a provider bulk bills some and privately bills some of a set of services delivered to a patient

Telehealth: health services delivered over the phone or via video call

Time requirement: an item requirement relating to the length of time to deliver a service to a patient

We value your feedback

Your insights and suggestions are important to us. Feedback on this handbook can be provided to the Department of Health and Aged Care by email to medicareeducation@health.gov.au