From: s22
To: JIN, Hongxia; s22
Subject: RE: AskMBS advisory--GP services #2 [SEC=OFFICIAL]
Date: Tuesday, 2 August 2022 9:38:00 AM
Attachments: AskMBS advisory_GP services 2_July 2022.pdf
image001.png
image002.jpg

Hi everyone,
This time with the attachment
s22

From: s22
Sent: Tuesday, 2 August 2022 9:24 AM
To: JIN, Hongxia ; s22

Subject: FW: AskMBS advisory--GP services #2 [SEC=OFFICIAL]
Dear CAEB Directors
Please see email below about the latest AskMBS advisory.
Regards
s22
Director – Case Flow Management Section

Benefits Integrity & Digital Health Division | Health Resourcing Group
Compliance Audit and Education Branch
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The Department of Health acknowledges the Traditional Custodians of Australia and their continued connection to land, sea and community. We pay our respects to all Elders past and present.

From: AskMBS Internal Queries s47E(d) @health.gov.au>
Sent: Monday, 1 August 2022 1:42 PM
To: MCCABE, Daniel <Daniel.McCabe@health.gov.au>; s22 @health.gov.au>; s22 @health.gov.au>; s22 @health.gov.au>; s22 @health.gov.au>; s22 @health.gov.au>; s22 @Health.gov.au>; s22 @health.gov.au>; s22 @health.gov.au>
Cc: s22 @health.gov.au>; s22 @health.gov.au>; s22 @health.gov.au>; s22 @health.gov.au>; DL AskMBS Section s47E(d) @health.gov.au>
Subject: AskMBS advisory--GP services #2 [SEC=OFFICIAL]
Hi everyone
This is to advise that AskMBS has published its second advisory on general practice services. The origins of this advisory differ slightly from the norm. While AskMBS advisories usually summarise

responses to questions received by AskMBS, this advisory originated as the Department's response to questions from the Royal Australian College of General Practitioners (RACGP), arising from a webinar it conducted in conjunction with Avant Mutual. As would be expected, the questions identified a range of issues of interest to GPs, so the Department obtained RACGP's agreement to publishing the document as an AskMBS advisory. It has been sent directly to relevant peak bodies as usual.

The topics covered fall into the following categories:

1. Telehealth
2. The 80/20 rule
3. Chronic disease management
4. Co-claiming
5. Standard attendances
6. Mental health
7. Skin lesions
8. Cervical screening

The advisory can be viewed on the AskMBS website at AskMBS Advisories | Australian Government Department of Health and Aged Care, and I have also attached a .pdf version. If you require any further information, please contact s22 at s22 @health.gov.au

s22

AskMBS

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Australian Government
Department of Health and Aged Care

ASKMBS ADVISORY

General Practice Services 2

Royal Australian College of General Practitioners—Medicare Compliance Webinar

Issues raised by attendees

July 2022

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Introduction

On 24 November 2021, the Royal Australian College of General Practitioners (RACGP) held a member webinar, 'Understanding Medicare compliance', presented by experts from the RACGP and Avant Mutual. The aim of the webinar was to improve understanding of compliant billing of Medicare Benefits Schedule (MBS) items among GPs in Training (GPiT).

Attendees asked a number of follow-up questions in relation to the webinar, generally seeking clarification on the correct billing procedures for specific MBS items. The RACGP referred these questions to the Department of Health and Aged Care (the Department). The Department's AskMBS advice service coordinated and largely authored a response, with contributions from other areas of the Department on matters of broader MBS policy.

These responses are given below, arranged in the subject and question format originally presented to the Department by the RACGP. This information is accurate as of July 2022. Medicare policy changes over time in response to a range of factors, and providers of MBS services should maintain their awareness of current policy settings and item requirements by monitoring advice issued by the Department through channels such as direct communications and MBS Online (www.mbsonline.gov.au), and by seeking clarification from AskMBS when necessary.

AskMBS is an email advice service (askmbs@health.gov.au) providing information and advice to health professionals and other users of the MBS on the interpretation and application of MBS items, explanatory notes and associated legislation, to assist them in billing Medicare correctly. AskMBS issues its own advisories, targeted at specific provider groups, addressing issues commonly raised in enquiries it receives. These advisories, along with this document, can be found online at www.health.gov.au/resources/collections/askmbs-advisories.

Disclaimer: The information in this advisory is current and accurate as of July 2022. Medicare policy changes over time in response to a range of factors, and providers of MBS services should maintain their awareness of current policy settings and item requirements by monitoring advice issued by the Department of Health and Aged Care through channels such as direct communications and MBS Online, and by seeking clarification from AskMBS when necessary.

Telehealth

1. Exceptions to the telehealth 12-month rule include patients who are in isolation. How do we know for sure if a patient is isolating while awaiting the result of a COVID-19 test?

The established clinical relationship requirement (12-month rule) is defined as one face-to-face consultation with a GP or another practitioner associated with the same practice in the 12 months preceding the telehealth service. Exemptions to this requirement include but are not limited to individuals required to self-isolate or quarantine based on State or Territory public health orders. For example, this may include self-isolation or quarantining following a positive COVID-19 test result or as a close contact awaiting a COVID-19 test result. Detailed information continues to be updated online, at MBS Online - MBS Telehealth Services from July 2022

As with all MBS services, supporting documentation must be adequate and contemporaneous as per *the Health Insurance (Professional Services Review) Regulations 1999.* For GP and OMP telehealth services where the patient does not meet eligibility requirements, information relevant to the patient's exemption must be documented. In the case of pending PCR results this could include a certificate of attendance from the COVID-19 pathology collection clinic, relevant Medicare claiming information related to COVID-19 pathology testing, or telecommunications evidence from state authorities.

In the context of people who are self-isolating following a positive test or close contact, the duration of the exemption period is determined by requirements in the patient's State or Territory. These are just some examples that could be used as evidence to support eligible telehealth services where a patient is impacted by COVID-19.

While it is expected that patients comply with all relevant State or Territory public health orders, the accurate billing of services under Medicare is the legal responsibility of the rendering practitioner. Information, including toolkits and guidance, on Medicare compliance is available on the Department of Health and Aged Care's website at Medicare compliance | Australian Government Department of Health

2. Are we allowed to do telehealth with patients who are abroad if seen in the last 12 months?

No. A fundamental Medicare principle applies here, prohibiting the payment of Medicare benefits for services provided outside Australia. Under section 10 of the *Health Insurance Act 1973* (the Act), Medicare benefits are only payable for professional services rendered in Australia to an eligible person. That is, both the patient and the health professional must be physically present within Australia, as defined in the Act, for a Medicare benefit to be payable. This legal requirement applies to all Medicare services including telehealth (video and telephone) services.

Where an MBS item cannot be claimed, the medical practitioner may choose to raise a private fee for the service. Under the principle of informed financial consent, patients should be made aware in advance of the costs of medical services prior to any service/s being provided. Patients are also required to be advised where Medicare benefits are not payable prior to providing the service.

Please note that new data matching laws allows the Department of Health and Aged Care to match Medicare records with immigration records to determine whether a doctor and/or patient were in Australia on the dates that services were provided.

Under the Act, health professionals are legally responsible for the services billed to Medicare under their provider number or in their name. This means, that where an incorrect claim is made and benefit paid, the practitioner whose provider number was used is responsible for the repayment of the full amount of any incorrect Medicare benefits that were paid.

Practitioners who believe that they have claimed MBS items inappropriately can contact the Department of Health and Aged Care to make a voluntary acknowledgment of incorrect payments at Voluntary.Compliance.Team@health.gov.au

Further information about Medicare compliance, including information on voluntary acknowledgements can be found here: www.health.gov.au/health-topics/medicare-compliance/about/what-medicare-compliance-is

3. With the existing relationship rule – what if the relationship exists only because the patient has been referred explicitly to you? A GP has referred a patient to me to see them for FPS counselling. It has suited her to attend via telehealth and getting her in now for a face-to-face is difficult.

A referral to a specific GP does not over-ride the existing relationship requirement for MBS telehealth services. As of 20 July 2020, GPs, as well as other medical practitioners (OMPs) working in general practice, must only perform an MBS COVID-19 telehealth service where they have an existing relationship with the patient. An 'existing relationship' is defined as:

- the medical practitioner who performs the service has provided a face-to-face service (that was billed to Medicare) to the patient in the last 12 months; or
- the medical practitioner who performs the service is located at a medical practice, and the patient has a face-to-face service arranged by that practice in the last 12 months. This can be a service performed by another doctor located at the practice, or a service performed by another health professional located at the practice (such as a practice nurse or Aboriginal and Torres Strait Islander health worker); or
- the medical practitioner who performs the service is a participant in the Approved Medical Deputising Service program, and the Approved Medical Deputising Service provider that employs the medical practitioner has a formal agreement with a medical practice that has provided at least one face-to-face service to the patient in the last 12 months.

There are a number of exemptions from the existing relationship requirement. AskMBS has published an advisory on the existing relationship requirement and exemptions from it, available here.

4. Can a phone consult be billed if the patient is in hospital at the time that they contact their GP?

No. MBS telehealth services provided by GPs are not available to admitted hospital patients, including hospital-in-the-home patients.

80/20 rule

5. Could someone please explain the 80/20 rule? If you “breach” the 80/20 rule, what do you pay back? Are there any mitigating factors considered, such as hours worked? Does the 80/20 rule include bulk billing incentives, nurse incentives etc?

There is no legislative barrier to a practitioner providing more than 80 services in a day, provided each service is relevant, medically necessary, and provided in an appropriate manner. Where a practitioner provides services at or near this level for a longer period, the practitioner’s billing may be drawn to the attention of the of the Department and Aged Care’s Practitioner Review Program (PRP).

If, however, a practitioner provides 80 or more professional attendance services on each of 20 or more days in a 12-month period, the *Health Insurance Act 1973* requires that the practitioner be referred to the Director of Professional Services Review (PSR) for a review of their provision of services. This pattern of service (known as a 'prescribed pattern of services', and commonly referred to as the ‘80/20 rule’) is deemed to constitute inappropriate practice, except in exceptional circumstances. The Health Insurance (Professional Services Review Scheme) Regulations 2019 (legislation.gov.au) allows the Director PSR to consider exceptional circumstances when reviewing a practitioner’s profile. Exceptional circumstances might, for example, include an unusual occurrence causing an unusual level of need for services on a particular day.

We note that providing services at this level would place considerable strain on a practitioner and might raise questions as to the quality of care the practitioner could provide, and the impact on the welfare of that practitioner. Relevant professional attendance services items covered under the 80/20 rule are listed in the Health Insurance (Professional Services Review Scheme) Amendment (2022 Measures No. 1) Regulations 2022 (legislation.gov.au).

The peer standard process applied under the PRP and PSR Scheme ensures that conduct is assessed against the standards of the general body of the relevant profession. This ensures factors such as workload or the complexity of patient care for that profession are considered. This safeguards against any unfair penalisation, while still protecting the investment in the costs of Medicare, as peers are best placed to make these profession specific assessments. Under the PSR Scheme, specialist advice can be sought, and a committee of peers can be accessed to ensure appropriate standards and considerations are applied.

If a request is made to the Director PSR to review a practitioner’s provision of services, and there is a finding of inappropriate practice, this may result in sanctions which could include an order for repayment of Medicare benefits for services provided in the review period that have been found as being provided inappropriately. Any sanctions, including repayments, are determined by the PSR.

Please refer to the following publication with further details about the 80/20 Rule: 'PSR to consider impact of COVID-19 on 80/20 Rule' at Other publications | Professional Services Review (psr.gov.au)

Chronic disease management

6. I have seen issues with care plans where clause 'a' of 721 states the focus is 'health' but the care plans are mainly 'chronic disease' focussed. Any comments on this?

Under the Medicare chronic disease management plan items, chronic disease refers to a patient who suffers from at least one medical condition that has been present (or is likely to be present) for at least six months or is terminal. Item 721 requires that, in addition to other requirements, a comprehensive written plan describing a patient's health care needs, health problems and relevant conditions is prepared (AN.0.47, Item 721 a.). The purpose of the plan is to provide a framework for achieving the best possible health outcomes for the patient with the chronic condition.

7. Do I have to pay back care plan fees if I have not reviewed them?

No. While it is not a legislative requirement of item 721 (and item 723 for the preparation of Team Care Arrangements (TCAs)) that a subsequent review occurs under item 732, it is expected and strongly encouraged that once a GPMP and TCAs are in place, they will be regularly reviewed. The recommended frequency is every six months.

A care plan is a useful mechanism for recording comprehensive, accurate and up-to-date information about the patient's condition and all of the treatment they are receiving. It is not designed to simply 'set and forget' without regular input from the patient, their usual practitioner and any other health professionals contributing to the planning process.

8. For claiming TCAs – we usually send a letter to the practitioner asking them to reply and agree to take part. Can I claim it on the day I receive their replies without necessarily seeing the patient?

All requirements for item 723 must be met prior to claiming the item, up to and including offering the patient a completed copy of the plan.

AskMBS highlights that the collaboration requirement for item 723 involves more than simply gaining the consent of the collaborating providers to participate in the team care arrangements. It is also a requirement of item 723 that the GP discusses 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. This requirement cannot be completed until after collaboration with the contributing providers has occurred.

In most circumstances this will necessitate an additional attendance with the patient, after all of the collaboration requirements of item 723 have been completed. It is at this point that item 723 can be claimed. Note that this means that, while items 721 and 723 can be co-claimed on the same day where the requirements of both items are met, in many cases this would not be feasible, and it would not be expected that items 721 and 723 would be routinely co-claimed on the same day.

In support of a clearer interpretation of item 723, the following points serve to highlight appropriate practice:

1. The general practitioner discusses the prospect of a TCA with the patient and during this initial attendance obtains the patient's agreement to proceed with the development of the TCAs.
2. After obtaining the patient's agreement, consultation occurs with the necessary practitioners associated with the TCAs.
3. After this consultation has been completed the patient is then invited back to the clinic where the general practitioner outlines the proposed care plan.
4. Only after the patient agrees to the prepared TCAs and is provided with a copy can item 723 be billed using the date of this final step.

9. Can a different GP bill a 5020 for a patient if they had a chronic disease plan with another GP earlier the same day?

Yes. There is no restriction on a GP billing item 5020 (or any other attendance item) for a patient on the same day that another GP has provided a chronic disease management service, such as the preparation of a GP Management Plan under item 721, to the same patient.

10. Can I have an example of what would constitute a reasonable relationship between providers for TCAs?

TCAs are for patients who have a chronic or terminal medical condition and complex needs requiring ongoing care from a multidisciplinary team. When coordinating the development of TCAs, the medical practitioner must consult with at least two other health or care providers to make arrangements for the multidisciplinary care of the patient. It is expected that members of a TCA work together in a professional manner to achieve the best possible health outcomes for the patient.

Underpinning Australian Health Practitioner Regulation Agency's (APHRA) Code of Conduct is the assumption that practitioners will exercise their professional judgement to deliver the best possible outcomes for their patients. Good relationships with colleagues and other practitioners strengthen the practitioner-patient/client relationship and enhance care. Practitioners have a responsibility to contribute to the effectiveness and efficacy of the health care system. Further information is available by searching for 'Code of conduct for registered health practitioners' at: www.ahpra.gov.au.

11. Do we have to do two separate forms for reviews of GPMPs and TCAs?

There is no requirement for GPs undertaking a review of a GPMP or TCAs to use a specific form for this purpose. In keeping with general Medicare principles, all practitioners who provide, or initiate, a service for which a Medicare benefit is payable, should ensure they maintain adequate and contemporaneous records. See explanatory note GN.15.39 for further guidance.

The Department of Health and Aged Care can conduct an audit of professional services, including requiring the production of documents to substantiate services rendered in the previous two years, and raise debts for any incorrect billing. An audit does not review a practitioner's clinical input or clinical judgement. Rather, an audit is concerned with whether the practitioner has adequate documents to substantiate that a professional service was, in fact, rendered and met all the elements of the MBS item descriptor.

12. For GPMP and TCA reviews, can you bill them both at the same time (i.e. 2 x item 732) or do they have to be at separate times?

Yes. Where item 732 for reviewing a GPMP and another for reviewing TCAs are both delivered on the same day, as per the MBS item descriptors and explanatory notes, they can both be claimed on the same day.

Clinical notes should reflect the start and end times of each review to support their provision as separate times and to assist with claims processing. Both electronic claims and manual claims need to indicate the services under 732 were rendered at different times. AskMBS suggests seeking further advice from Services Australia (13 21 50 or medicare.prov@servicesaustralia.gov.au) in relation to the appropriate submission of claims of this nature.

13. I do both reviews and charge only one item 732 – is that wrong?

As outlined in the response to question 12, a provider may claim item 732 for each review performed where the services meet the item requirements in full.

14. Can you provide more detail about what constitutes collaboration with an allied health professional?

Collaboration means communicating with the other providers involved in Team Care Arrangements (TCAs) to discuss potential treatments or services they will provide. Communication must be two-way, preferably oral or, if not practicable, in writing (including by exchange of faxes or email). It should relate to the specific needs and circumstances of the patient. The communication from the collaborating providers must include advice on treatment and management of the patient.

While it is not mandatory that an allied health provider must see the patient before contributing to the plan (unless they wish to), they do need to provide input to the TCAs on the treatment or services they will provide, based on their understanding of the patient's needs.

Note that, in many cases, it is expected that the allied health professional can provide advice about the treatment/services they will provide based on the information provided by the GP, including the patient's current GP Management Plan.

It would not be sufficient for a provider to simply say 'I will assess the patient and then I will advise you what treatment I will provide', as this would not constitute discussing or providing advice on potential treatment or services and would leave nothing to be documented in the TCAs. It is not necessary to 'case conference' with the collaborating providers (i.e. talk with all of the providers at the same time). The requirements for collaboration are set out in MBS explanatory note AN.0.47 *Chronic Disease Management Items (Items 721 to 732).*

15. Is there any specific time for 721/723 (e.g. 20 minutes)?

There is no minimum or maximum duration for items 721 and 723 specified in the item descriptors or explanatory notes. Services under these items should take as long as required to perform all the elements listed in explanatory note AN.0.47 to a clinically appropriate standard. The time taken will vary from patient to patient.

Please note that the chronic disease care planning process is not simply a mechanism to activate the patient's eligibility for Medicare rebates for allied health services. The CDM items were developed to provide GPs with a structured way of managing a wide range of chronic

medical conditions and to assist them to plan and coordinate the care of patients with multidisciplinary care needs. Care planning can be used as a tool for organising the care a patient needs and help reduce the need for *ad hoc*, episodic consultations.

Participation in the development of a care plan can also help encourage the patient to take some responsibility for their care, including the identification of any actions the patient might take to help achieve the goals of the treatment.

Health practitioners are encouraged to apply clinical judgement to determine if the service is appropriate, clinically relevant and meets all the elements of the MBS item descriptor. They should also ensure that their conduct in relation to rendering services cannot be characterised as inappropriate practice i.e. practice that a practitioner's peers could reasonably conclude was unacceptable to the general body of their profession.

16. How can I check a patient's eligibility for GPMP/TCA and remaining sessions available for allied health services?

A patient's eligibility is based on their Medicare claiming history, which is information held by Services Australia. Providers can contact Services Australia on 132 150 or medicare.prov@servicesaustralia.gov.au to determine a patient's eligibility for services.

It is also possible to use Services Australia's Health Professional Online Services (HPOS) for this purpose, noting that this system will only return advice that the item is payable or not payable on the date of the proposed service.

Services Australia has published a guide on how to use this service which can be found at the following link www.servicesaustralia.gov.au/organisations/health-professionals/services/medicare/hpos/services/using-mbs-items-online-checker-hpos

Please note that as the HPOS system is managed by Services Australia, AskMBS cannot comment on its content or management.

Co-claiming

The following case study was presented during the webinar: A mother who is having trouble breastfeeding presents to her GP. During the course of the consultation, the GP ascertains the patient is also suffering from postnatal depression. The consultation lasts a total of 40 minutes, with most of this time spent discussing the patient's mental health. What MBS items could the GP bill in this scenario?

17. I thought 23 could only be claimed with 2715 or 2712 if it is an acute and unavoidable problem?

AskMBS's standard advice on the co-claiming of a mental health service with a standard attendance is that a separate and additional attendance should not be undertaken in conjunction with the mental health consultation items, unless it is clinically indicated that a separate problem must be treated immediately. This is consistent with the broader principle that Medicare benefits may be paid for more than one attendance on a patient on the same day by the same practitioner, 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; and
- 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.

Note in particular that, in order to provide more than one service to a patient on the same day, each time requirement that an item may have must be separately met. That is, time spent with a patient cannot be counted more than once.

Claims with sufficient information provided to support the payment of two services on the same day may both be assigned a benefit by Services Australia. However, you will need to provide the times of each service on the claims and specify that these were distinct and separate services.

18. Is it true that the order of presentation/complaints matter? What is the rationale for claiming 23 then 2713, but not 2713 then 23?

The order in which multiple services are provided has no bearing on Medicare claiming, provided that there is no duplication of services and the claims note the times of each service and specify that they were distinct and separate.

19. What if the time spent discussing the mental health component is less than 20 minutes (i.e. not eligible for 2713)?

An MBS item can only be claimed when all item requirements, as set out in the item descriptor and associated explanatory notes, have been met in full. When an item specifies a particular time requirement, that requirement must be met. There is no GP mental health treatment item for a service less than 20 minutes in duration. In such cases, the appropriate standard attendance item should be claimed.

20. Do you combine the time spent discussing physical and mental health issues and claim a 36?

Where no separate mental health treatment item can be claimed, it would be appropriate to claim item 36, for an attendance of at least 20 minutes and **less than 40 minutes** in duration, during which mental health issues were discussed, provided that the requirements of item 36 are met in full and the service is clinically relevant.

21. Instead of 23 and 2713, can 44 be charged in the case about the breastfeeding woman?

It is a fundamental principle of Medicare that the item that best describes the service is the item that should be claimed for that service. This means, for example, that it would not be appropriate to claim a general attendance item for mental health treatment service if it were possible to claim a dedicated mental health treatment item.

The time requirement for item 23 is 'lasting less than 20 minutes' and, for item 2713, 'at least 20 minutes'. On that basis, depending on the actual composition of a 40-minute attendance, it would be theoretically possible to claim item 2713 for the mental health component and item 23 for the breast-feeding component. In this case, it would not be appropriate to claim item 44 for the attendance overall.

If, on the other hand, an attendance lasting at least 40 minutes included a mental health component of less than 20 minutes' duration, it would be appropriate to claim item 44 provided that all item requirements are met in full, and the service is clinically relevant.

22. Does it matter what the patient initially came in for when co-billing 23 and 2713? If the patient came in for postnatal depression and then found she had troubles with breastfeeding, can we still bill 2713 and 23?

The order in which issues are discussed has no bearing on the claiming of multiple items 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; and
- 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.

Standard attendances

23. Can I get really clear example of when an item 3 should be used?

To support GPs to provide services to patients, there are a number of service items and payments available under the MBS. These include time-tiered general attendance items, which are designed to allow doctors to use their clinical judgement to promote the flexibility and responsiveness that is essential to support the smooth operation of general practice in Australia.

Doctors use their clinical judgement and experience to provide quality services for very short, focused treatments for straight forward medical condition(s) through to long consultations that address the needs of patients with multiple or complex care needs. Consistent with the guidance provided in the MBS, a Level A (MBS item 3) is to be used for obvious and straightforward cases, which do not meet the requirements of a Level B or other general attendance items.

24. Is there more of an allowance for registrars to claim a high percentage of level C and D attendances because things take us longer?

The Department of Health and Aged Care recognises that the nature and billing profile of individual practitioners' practice will differ due to a range of legitimate factors. No compliance issues should arise provided that all requirements of an MBS item, as set out in the item descriptor and associated explanatory notes, are met in full before the item is claimed, and the relevant service is clinically relevant. 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.

Noting that AskMBS has no involvement in the Department's direct compliance function, we can advise that, in performing compliance activities, including monitoring of MBS claiming, the Department uses a range of available information and strategies (including other numerical parameters) to analyse patterns of claiming.

Analysis of MBS claiming patterns, which can involve flagging practitioners who have claimed certain items at a higher rate than their peers, does not necessarily lead to findings of inappropriate practice or trigger specific compliance action. In some cases, it may simply prompt the Department to request that the practitioner review their MBS claims.

If the practitioner believes that their pattern of claiming is justified, perhaps because of the nature of their practice, and has documentation to demonstrate their claim this explanation can be provided to the Department at that time. There is no 'allowance' as such for specific groups of health professionals.

25. I always feel bad when consults go just beyond 20 minutes. And sometimes even worse when they go 19 minutes 45 seconds. Any help? Also, how should we detail when we have four issues in a consult? Is this almost automatically a 36 minimum in most peer eyes?

Please see the response to question 23 for additional context.

The requirements for general attendance items are set out in the MBS. A Level C (MBS Item 36) is to be used for a consultation lasting at least 20 minutes for cases in relation to one or more health related issues, with the completion of appropriate documentation. The Department of Health and Aged Care has developed administrative record keeping

guidelines for health professionals to support good administrative record keeping: Administrative record keeping guidelines for health professionals | Australian Government Department of Health.

26. If many of my patients are elderly/present with multiple issues on a single consult and take longer than 20 minutes, is frequently billing item 36 an issue?

The Department of Health and Aged Care recognises that the nature and billing profile of individual practitioners' practice will differ due to a range of legitimate factors. No compliance issues should arise provided that all requirements of an MBS item, as set out in the item descriptor and associated explanatory notes, are met in full before the item is claimed, and the relevant service is clinically relevant. 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.

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If the practitioner believes that their pattern of claiming is justified, perhaps because of the nature of their practice, and has documentation to demonstrate their claim this explanation can be provided to the Department at that time. There is no 'allowance' as such for specific groups of health professionals.

27. Is there any such thing as the 4-hour rule in terms of being able to bill a second timed attendance item for the same patient on the same day? For example, sending the patient for imaging, then ringing them back later in the day with the results/follow-up?

There is no mandated (i.e. legislated) minimum time period between attendances on the same patient on the same day for Medicare billing purposes. There is guidance provided in MBS explanatory note AN.0.7 *Multiple Attendances on the Same Day* and within an education guide on the Services Australia website: www.servicesaustralia.gov.au/organisations/health-professionals/topics/education-guide-billing-multiple-mbs-items/33231. Both resources state that there should be a 'reasonable' lapse of time between services.

However, AskMBS considers the reference to a reasonable lapse of time to be redundant; the more important consideration is the purpose of the attendances. It is possible, especially in a face-to-face setting, to conceive of hypothetical scenarios in which two separate attendances could be provided with virtually no interval between them, and for both attendances to be correctly billed. These scenarios would generally involve the completion of one attendance, the patient leaving the consulting rooms, and then re-entering for treatment of an unforeseen condition.

However, this does not mean that all multiple patient interactions on the same day can be billed as separate attendances. In the scenario provided in this question, the phone call for the provision of results would be considered a continuation of the first attendance at which the investigations were requested, and no Medicare benefit would be separately payable (although the time taken for the phone call could be counted towards the duration of the initial attendance for billing purposes).

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) attendance/s 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; and
- there is no duplication of services.

In general, whether one attendance is a continuation of another is a matter for the judgement of the medical practitioner based on the clinical scenario and general guidance. For further details on claiming multiple attendances on the same day please refer to MBS explanatory note AN.0.7, which can be viewed by searching MBS Online for the note number at www.mbsonline.gov.au. Services Australia has also published a guide on billing multiple items on the same day that can be viewed here: www.servicesaustralia.gov.au/organisations/health-professionals/topics/education-guide-billing-multiple-mbs-items/33231

Mental health

28. Can you please clarify if only one mental health care plan is possible from 1 January to 31 December? What if the patient sees a psychologist on that mental health care plan on 10 January in the next year?

There is no fixed time limit on a GP Mental Health Treatment Plan (MHTP). A Medicare benefit will not be paid for preparation of an MHTP within 12 months of a previous claim for the patient for the same or another MHTP preparation item, or within three months following a claim for a MHTP review (i.e. item 2712). Many patients will not require a new plan after their initial plan has been prepared and it is not required that a new plan is prepared unless clinically required.

In general, a patient's MHTP is treated as a living document which can be updated at any time to incorporate relevant information, such as feedback or advice from other health professionals on the diagnosis or treatment of the patient. Ongoing management can be provided through the MHTP consultation and standard attendance items, as required, and reviews of progress through the MHTP review item, or through the MHTP or standard attendance items.

As MHTPs do not expire, patients may still be referred for further allied mental health services for as long as the referral is consistent with what is in the MHTP and the referring practitioner has determined that further services are required.

Skin lesions

29. When performing a skin lesion excision, can we bill an item number for consent and discussion about the procedure? Can we also bill for a consultation the following day when the patient comes in for review, as this does not correspond with procedure time?

Each professional service listed in the MBS is a complete medical service. For procedural services such as those listed in MBS Group T8–Surgical operations, an item is taken to include any 'consultative' activities associated with the procedure, including pre-procedure discussions and post-procedure review and care planning. It would not be appropriate to bill separate attendances for these purposes.

Additionally, section 3(5) of the *Health Insurance Act 1973* states that services included in the MBS (other than attendances) include all professional attendances necessary for the purposes of post-operative treatment of the patient. For the purposes of this book, post-operative treatment is generally referred to as 'aftercare'.

Aftercare is deemed to include all post-operative treatment rendered by medical practitioners, and includes all attendances until recovery from the operation. Medicare will not normally pay for any consultations during an aftercare period as the Schedule fee for most operations, procedures, fractures and dislocations listed in the MBS item includes a component of aftercare.

Cervical screening

30. If a patient comes in for a cervical screening test and a script, do you bill just for the screening or can you bill item 23 as well?

If a cervical specimen is personally collected by a medical practitioner or an eligible nurse practitioner or midwife, a professional attendance item can be claimed that covers the time of their personal attendance upon the patient. The relevant attendance item depends on the type of health professional performs who performs the service.

It would not be appropriate to bill another attendance item merely for the issuing of a prescription. The item descriptor for item 23, for example, includes 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. These components could reasonably be expected to cover a service involving the taking of a cervical specimen and the issuing of a prescription for a related or other condition.

If a cervical specimen is personally collected by a practice nurse or other allied health practitioner (who is accredited to do so) for which no attendance item is claimable, no Medicare benefit is claimable for the collection of the specimen. However, the laboratory testing will continue to attract Medicare benefits where it is appropriate, and all requirements of the item have been met.

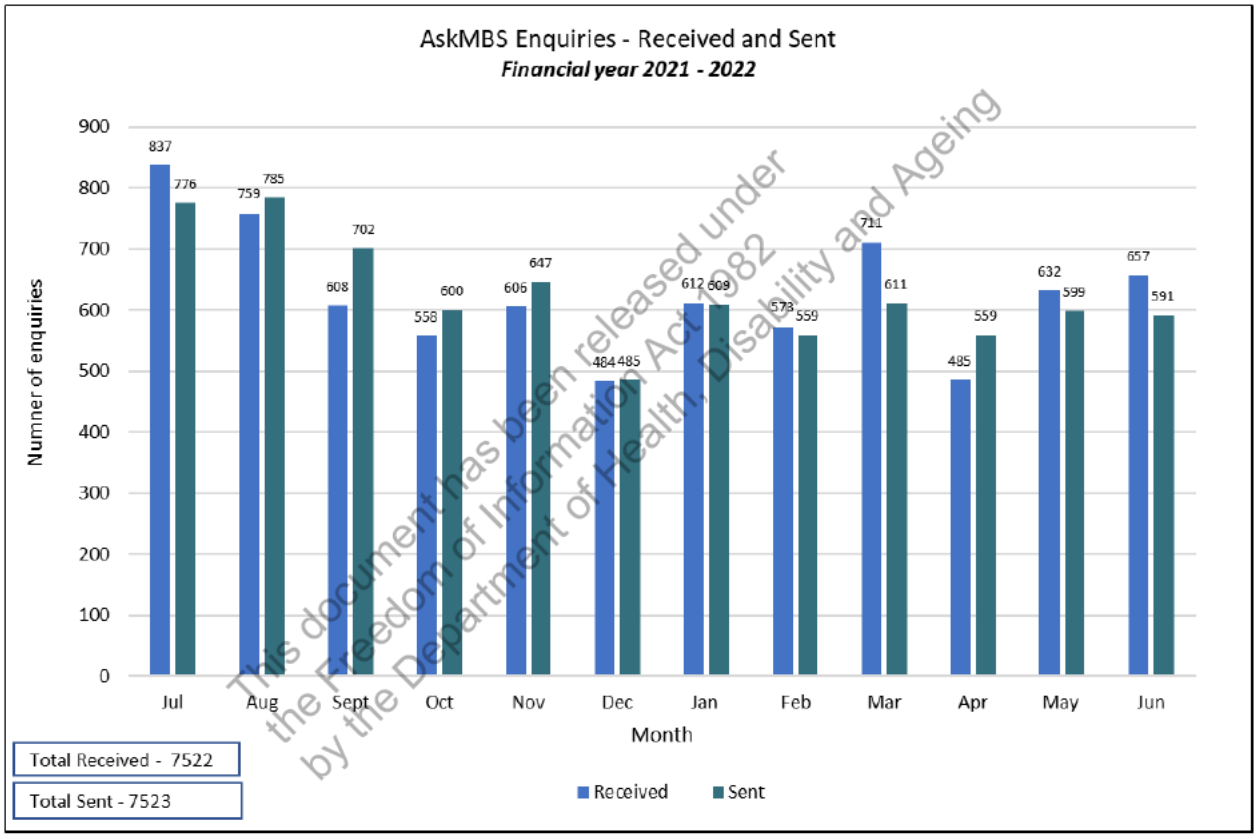
Note the items for taking a cervical screen from a person who is unscreened or significantly under-screened—items 2497–2509, 2598–2616 and 251–257—should be used in place of the usual attendance item.

AskMBS metrics 1 July 2021 – 30 June 2022

AskMBS receives enquiries from medical practitioners providing MBS services as well as practice managers, billing agents, professional organisations, and a range of other stakeholders. The service averages around 150 enquiries per week.

A key AskMBS metric is a response time of 15 working days. In some cases this is not achievable, such as when it is necessary for us to seek policy advice from the relevant area of the Department to inform our response. In the period from 1 July 2021 to 30 June 2022 AskMBS had an average response time across all enquiries of nine working days.

The chart below shows figures for monthly workflows from 1 July 2021 to 30 June 2022.



From: ASDWG Secretariat
To: DL DL ASDWG Members
Subject: Analytics and Strategy Development Working Group (ASDWG) [SEC=OFFICIAL]
Attachments: 20220901 - Agenda - Analytics and Strategy Development Working Group.docx
image001.png
ASDWG paper - RIN-525 - Inappropriate co-claiming of GP Management Plans (item 721) and Team Care Arrangements (item 723) on the same day - RTS Director Cleared .docx
RTS ASDWG paper - RIN-475 - RTS Director Cleared.docx
RIN463 - Inappropriate claiming of IDD items- ASDWG paper - Director cleared.docx
RIN-500 - potential inappropriate claiming of attendance items by multiple providers for the same patient - ASDWG paper - RTS Director Cleared.docx

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Good Morning/Afternoon Attendees,

Please find attached the papers for the Analytics and Strategy Development Working Group (ASDWG), to be held 9:30am-11:00am (AEDT) on Thursday 1 September 2022.

The papers will also be available on the ASDWG SharePoint site.
<http://sharepoint.central.health/divisions/PBID/SRC/SitePages/Analytics%20and%20Strategy%20Development%20Working%20Group%20(ASDWG).aspx?InitialTabId=Ribbon%2EDocument&VisibilityContext=WSSTabPersistence>

Regards
Secretariat

Analytics and Strategy Development Working Group (ASDWG)

s47E(d) @Health.gov.au <mailto s47E(d) @Health.gov.au>

Benefits Integrity & Digital Health Division | Health Resourcing Group
Compliance Assessment Branch

The Department of Health and Aged Care acknowledges the Traditional Custodians of Australia and their continued connection to land, sea and community. We pay our respects to all Elders past and present.

-- Do not delete or change any of the following text. --

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Australian Government
Department of Health and Aged Care

Benefits Integrity and Digital Health Division

RISK TREATMENT

RIN-475: Inappropriate co-claiming of chronic disease management services and practice nurse support services (item 10997) on the same day

Responsible officer: s22

Risk description

General Practitioners (GPs) may be inappropriately claiming a practice nurse/Aboriginal and Torres Strait Islander health practitioner[1] (ATSIHP) support service (item 10997) on the same day as Chronic Disease Management (CDM) item/s: GP Management Plan (GPMP – item 721), Team Care Arrangements (TCA – item 723), CDM review item 732 and the telehealth equivalents[2]. This claiming pattern may indicate that:

- the practice nurse is solely undertaking the development of the CDM plan items and the GP is not meeting item requirements in developing the plan; and/or
- the practice nurse item is being incorrectly claimed as an add on for the support the nurse provides to develop or review the CDM plan, as the nurse's services are already compensated under the CDM plan and review item.

Practice nurses can assist in the development of CDM plans; however, the claiming GP must meet all regulatory requirements, review, and confirm all assessments, and see the patient for the service. If a practice nurse solely undertakes the development of the plan without the GP involvement, the item requirements have not been met.

Medicare note MN.12.4 states the purpose of item 10997 is to assist patients who require access to ongoing care, routine treatment and ongoing monitoring and support between the more structured reviews of the care plan by the patient's usual GP.

In February 2020, AskMBS released an advisory message covering general practice services, including practice nurse involvement in CDM services[3]. The advisory states that time spent by practice nurses or Aboriginal and Torres Strait Islander health practitioners in assisting medical practitioners with the CDM items applies only to the CDM item and may not be itemised additionally, such as to item 10997.

Further, the advisory states that:

- item 10997 is for monitoring and support of patients with a chronic disease between normal GP visits and is not intended to be used for the creation of a care plan;
- item 10997 can only be claimed where a GP Management plan, Team Care Arrangement or Multidisciplinary Care Plan is in place;
- item 10997 is intended to be used for monitoring or support services for a person with a chronic condition between the more structured reviews of the care plan by the patient's usual GP; and
- it would not be expected that item 10997 would be routinely claimed on the same day as items 721 or 723.

Data refresh outcomes

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Targeting and thresholds

Risk Treatment sought advice from the AskMBS and Professional Review Sections regarding the co-claiming behaviour identified. AskMBS confirmed that the purpose of item 10997 is to assist patients who require access to ongoing care, routine treatment and ongoing monitoring and support between the more structured reviews of the CDM plan by the patient's usual GP. For this additional reason, it is not expected that item 10997 would be claimed

[1] In this paper, the term 'practice nurse' is inclusive of Aboriginal and Torres Strait Islander health practitioner as relevant MBS services/items are shared across both health professional groups.
[2] 721,723,732, 92068, 92069, 93203, 92072, 00229, 00230, 10997
[3] AskMBS Advisory - February 2020

s47E(a)

on the same day, and that while there may be circumstances in which this is clinically appropriate, these would be rare[5].

Senior Medical Adviser (SMA) s22 confirmed there would be few reasons to co-claim 10997 services with a CDM service, as that would not be in keeping with the intent of item 10997 as a review service between rendering CDM services. Rather, such a pattern may be more opportunistic in nature. In general, it would be the case that some period would need to elapse after the development of a GPMP and/or TCA before a service under item 10997 would be appropriate[6].

Risk Treatment consulted with the Provider Early Intervention Section (PEIS) regarding the project scope and potential for targeted letter treatment. PEIS raised concerns about the inclusion of the review items, noting that the AskMBS advisory states that a practice nurse can prepare the review for a patient ahead of seeing the GP. Risk Treatment acknowledged the query raised by PEIS and sought further advice from AskMBS and the Medical Benefits Division (MBD) specifically regarding the co-claiming of 10997 with review items.

AskMBS confirmed that it receives a large number of questions relating to the appropriate use of item 10997, including how this item can be used for practice nurse assistance during the provision of an item 732[7]. When AskMBS is asked more generally regarding the use of 10997 for CDM services 721/723, words as per the AskMBS General Practice Advisory are provided in response. On occasion, an enquirer will quote the activities outlined in MN.12.4 and query why 10997 cannot be used solely for the collection of information to inform a review under item 732. In such cases, the response provided is as follows:

"It is not expected that item 10997 would be routinely claimed on the same day as Chronic Disease Management (CDM) items 721, 723 or 732… a service under 10997 should be an independent service and not merely an adjunct to a GP review performed on the same day or occasion for the purposes of collecting information".

MBD advised that as per AN.0.47 (the note associated with item 732), a practice nurse, Aboriginal and Torres Strait Islander health practitioner, Aboriginal health worker or other health professional may assist a GP with items 721, 723, and 732 (e.g., in patient assessment, identification of patient needs and making arrangements for services). However, the GP must meet all regulatory requirements, review, and confirm all assessments and see the patient. This implies that any activities undertaken by the practice nurse as part of the review would be part of the 732 service[8].

Based on the above advice, Risk Treatment has determined that it is appropriate for the review items to remain in scope for the risk. In consideration of internal stakeholder advice including from SMAs, AskMBS and MBD, the risks and sensitivities detailed in this paper, and outcomes from external consultation, the following thresholds were used to identify providers suitable for Practitioner Review Program (PRP) and Targeted Letter treatment.

s47E(a)

[5] ASK MBS advice - D21-6200475
[6] SMA advice D22-2437741
[7] AskMBS Advice D22-2391931
[8] MBD Advice D22-2423143

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Triage

s47E(a)

Treatment summary and estimated savings

s47E(a)

Risks and sensitivities

s47E(a)

External consultation

Risk Treatment engaged with the Royal Australian College of General Practitioners (RACGP), the Australian Medical Association (AMA) and the Australian College of Rural and Remote Medicine (ACRRM) on the 27 July 2022[15]. The Rural Doctors Association of Australia (RDAA) were invited, however, did not attend. Stakeholders advised that there is confusion amongst the sector around co-claiming generally and that there is an opportunity to

[9] RIN-531 validated risk assessment D22-1249000. While a seasonal spike in some providers' use of 10997 was identified, data cannot provide insight as to why the spike may exist. In addition, SMA advice did not consider the data significant in its own right, however noted that providers identified in other potentially non-compliant CDM behaviours (such as those explored in RINs 525, 527, 475) may have their use of 10997 considered further. While this risk is recommended not to progress in its own right, some insight from this risk may be therefore considered for cross-concern providers.

[10] Two providers were triaged out due to open Investigation cases, 63 for open PRP cases, one for an open Audit case and 10 for open AAA/TC cases

[11] Acceptance of providers for PRP treatment – D22-2438290

[12] Acceptance of providers for Targeted Campaign treatment – TRIM LINK

[13] <insert behavioural savings estimation email from BIES via TRIM link>

[14] Estimated savings via debt raised is calculated using the updated formulation as per Risk Treatment *'Savings estimations for compliance treatment'* SOP V1.2 D21-5350726.

[15] Key points and actions D22-2408470

provide education in the first instance. With patients attending GP practices less frequently, GPs will attempt to provide a full service (particularly for vulnerable patients and in rural/remote locations) so there will be occasions where GPs are appropriately using these items, however, acknowledged there are irregular claiming patterns in the data.

Internal consultation

- Risk Identification Section, Compliance Assessment Branch
- Risk Analytics Section, Compliance Assessment Branch
- Professional Review Section, Compliance Enforcement and Professional Review Branch
- MBS MBSR General Practice Section, Medical Benefits Division
- AskMBS Section, Provider Support and Systems Branch
- Provider Early Intervention Section, Compliance Audit and Education Branch
- Behavioural Insights and Evaluation Section, Compliance Assessment Branch

Recommendation/s to ASDWG

s47E(a)

Governance

Governance forum	*Meeting date*	*Governance forum outcome*
RPG	22 February 2022	Endorsed
ASDWG (validation)	28 April 2022	Endorsed
ASDWG (treatment)	1 September 2022	Pending

Administration

Project TRIM container: E21-114513

Australian Government
Department of Health and Aged Care

<Date> Reference: **NCDM <Case Number>**

<Title> <Firstname> <Surname>
<Address Line 1>
<Address Line 2>
<SUBURB> <STATE> <Postcode>

Dear <Title> <Name>

The Department of Health and Aged Care (the department) is committed to supporting providers to meet Medicare Benefits Schedule (MBS) requirements, including when claiming items for monitoring and support for a patient with a chronic disease by a practice nurse or Aboriginal and Torres Strait Islander health practitioner (item 10997).

Between 01 March 2021 and 28 February 2022, on<XXX> occasions, you claimed a practice nurse item 10997 and Chronic Disease Management (CDM) item/s for the same patient on the same day.

MBS item 10997 should not be claimed in relation to assistance provided to a GP to prepare or review a GP Management Plan or Team Care Arrangements.

MBS item 10997 can only be claimed if the patient has an existing GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan in place. A patient is eligible for up to five 10997 services per calendar year. This item is intended to be used between the more structured reviews of the plan by the patient's usual GP.

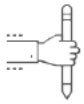
While claiming these items on the same day is not restricted, the department considers that item 10997 would not routinely be claimed at the same time as a CDM item. Medicare benefits are only payable where both services are clinically relevant, and the full item descriptor of each service have been met. If a patient does require separate consultations on the same day, each professional attendance item you are claiming should be recorded as a separate and distinct entry in the patient's notes.

Enclosed with this letter is a list of CDM item/s and MBS item 10997 co-claimed between 01 March 2021 and 28 February 2022. While there may be circumstances where these claims are appropriate, the department asks that you review your services to ensure your claiming meets MBS requirements.

What you need to do

Review your claiming using the attached schedule. Each claim needs to meet the MBS criteria.

- If you identify any incorrect payments you must repay these to the department along with any associated incentive payments.
- If you believe your claiming is correct, consider providing an explanation to the department at voluntary.compliance.team@health.gov.au.



Return the attached Voluntary Acknowledgement of Incorrect Payments form for any claims that do not meet the criteria along with your completed schedule of claims by **<DD MM YYYY>.**

GPO Box 9848 MDP 114 SYDNEY NSW 2001

What you need to know

While the vast majority of providers do the right thing, the department has a role in ensuring health professionals comply with MBS claiming requirements. The department will continue to monitor your MBS claims in the future. You are personally responsible for all claims made using your provider number.

This is an opportunity to check your services have been claimed correctly and to address any incorrect claims in a timely manner. The department may take compliance action, such as an audit, if concerns are identified that a provider has not met the MBS requirements and has been paid benefits they were not entitled to receive. If this occurs, administrative penalties may be applied.

If you have any questions relating to the information in this letter, please email voluntary.compliance.team@health.gov.au including your reference number **NCDM<Case Number>.**

Yours sincerely,

< >
Assistant Secretary
Compliance Audit and Education Branch
Benefits Integrity and Digital Health Division

Where do I go to get further information?

General information on MBS items and rules	Please visit MBSOnline.gov.au
Additional information on MBS items and requirements	Please email AskMBS@health.gov.au
Assistance with completing a Voluntary Acknowledgement form or further information regarding this letter	Please email voluntary.compliance.team@health.gov.au
AskMBS Advisory	In February 2020, AskMBS released an Advisory message covering general practice services, including practice nurse involvement in CDM services.

GPO Box 9848 MDP 114 SYDNEY NSW 2001

General Practitioners: Medicare Benefits Schedule (MBS) Provider Compliance

27 July 2022

This information is provided in-confidence and should not be distributed unless otherwise discussed with the Department of Health and Aged Care.

Australian Government
Department of Health and Aged Care

Concern identification

We view a compliance concern as a specific behaviour relating to a provider group's claiming, prescribing or supplying that is believed to be incorrect, inappropriate or fraudulent.

At times when looking at a provider group there may be a particular concern in focus already. This may be due to a tip-off or past compliance activity. Other sources for concern identification include:

- Analysis of Medicare data
- Intelligence from our operations areas or other areas of the Department
- Risk intelligence products
- Other government departments and industry

Potential compliance concerns within the GP sector

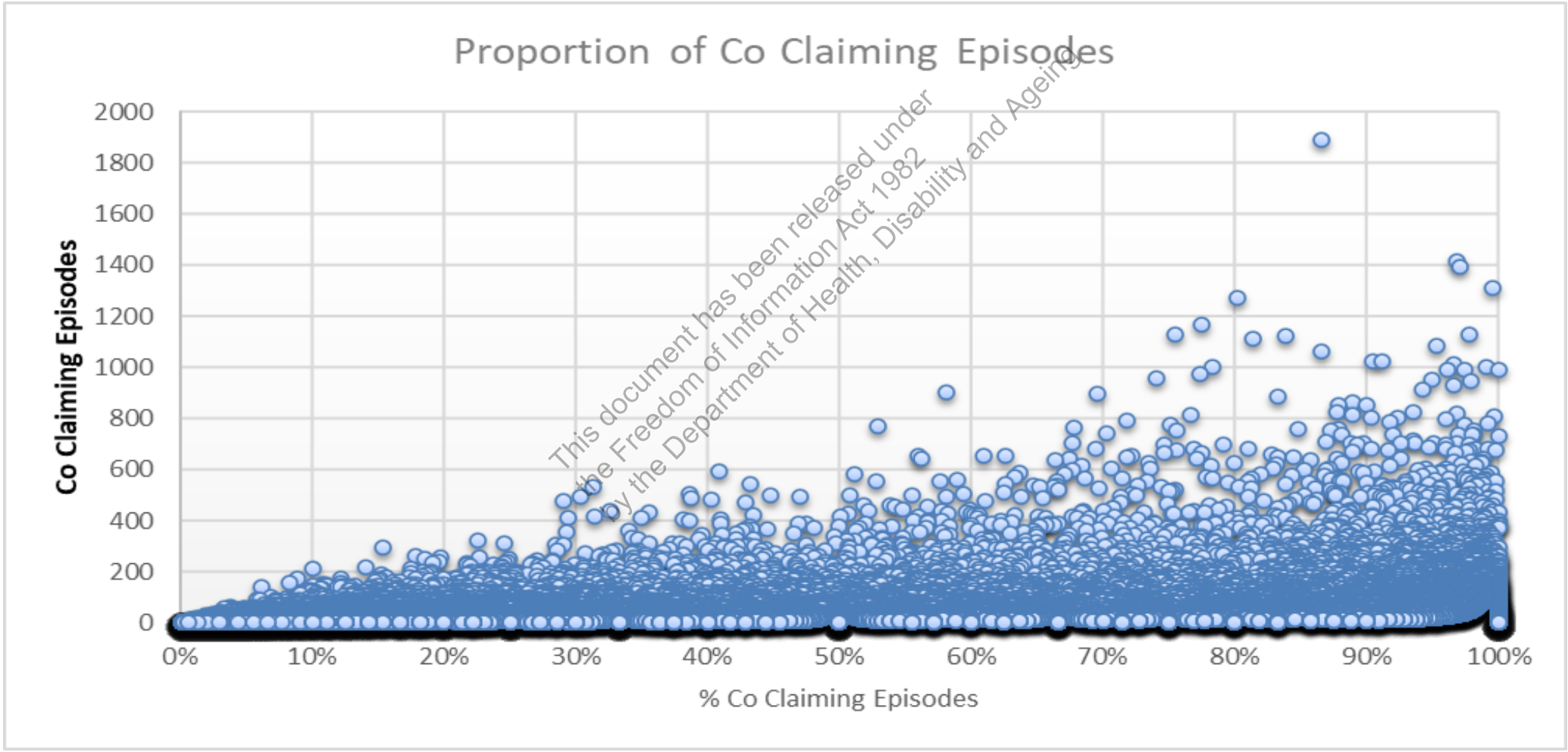
- **Routinely co-claiming CDM planning items and practice nurse support services (item 10997)**
  - Providers may be routinely claiming CDM planning items (GP Management Plan and/or Team Care Arrangements) on the same day as a practice nurse support service (item 10997), which may indicate that all individual item requirements have not been met.

- **Routinely co-claiming GP Management Plans (item 721/229) and Team Care Arrangements (item 723/230), and reviews of GPMP and TCA services**
  - Providers may be routinely claiming GP Management Plans and Team Care Arrangements (and reviews of these CDM plans) on the same day at high volumes and proportions, which may indicate that all individual item requirements have not been met.

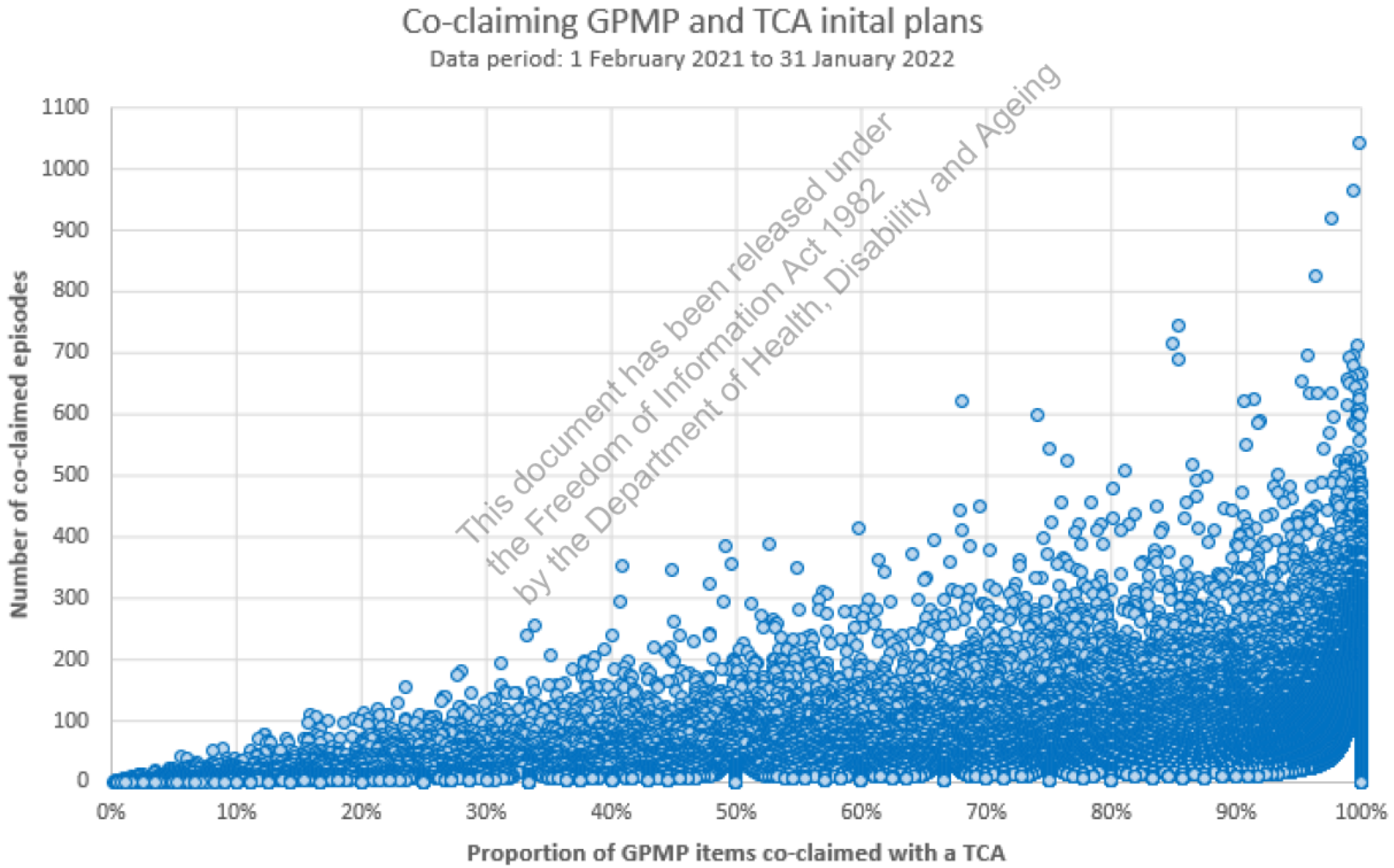
- **Claiming MBS benefits when a provider is overseas on the date of service**
  - Providers are claiming Medicare benefits for services rendered on a date they are overseas, which is not consistent with Section 10 of the *Health Insurance Act 1973*.

Concern 1: Routinely co-claiming Chronic Disease Management (CDM) items and practice nurse support services (item 10997)

Data period 1 March 2021 to 28 February 2022



Concern 2: Routinely co-claiming GP Management Plans (item 721/229) and Team Care Arrangements (item 723/230), and reviews of GPMP and TCA services



Concern 3: Claiming MBS benefits when a provider is overseas on the date of service

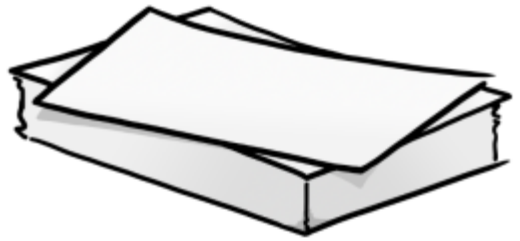
Preliminary findings* (data period 1 July 2020 to 30 June 2021):

- Provider A – Delivered 4,697 services (36.3% of total MBS claims) whilst overseas
- Provider B – Delivered 4,340 services (37.1% of total MBS claims) whilst overseas
- Provider C – Delivered 3,406 services (38.1% of total MBS claims) whilst overseas
- Data indicates several providers have exhibited the same behaviour.

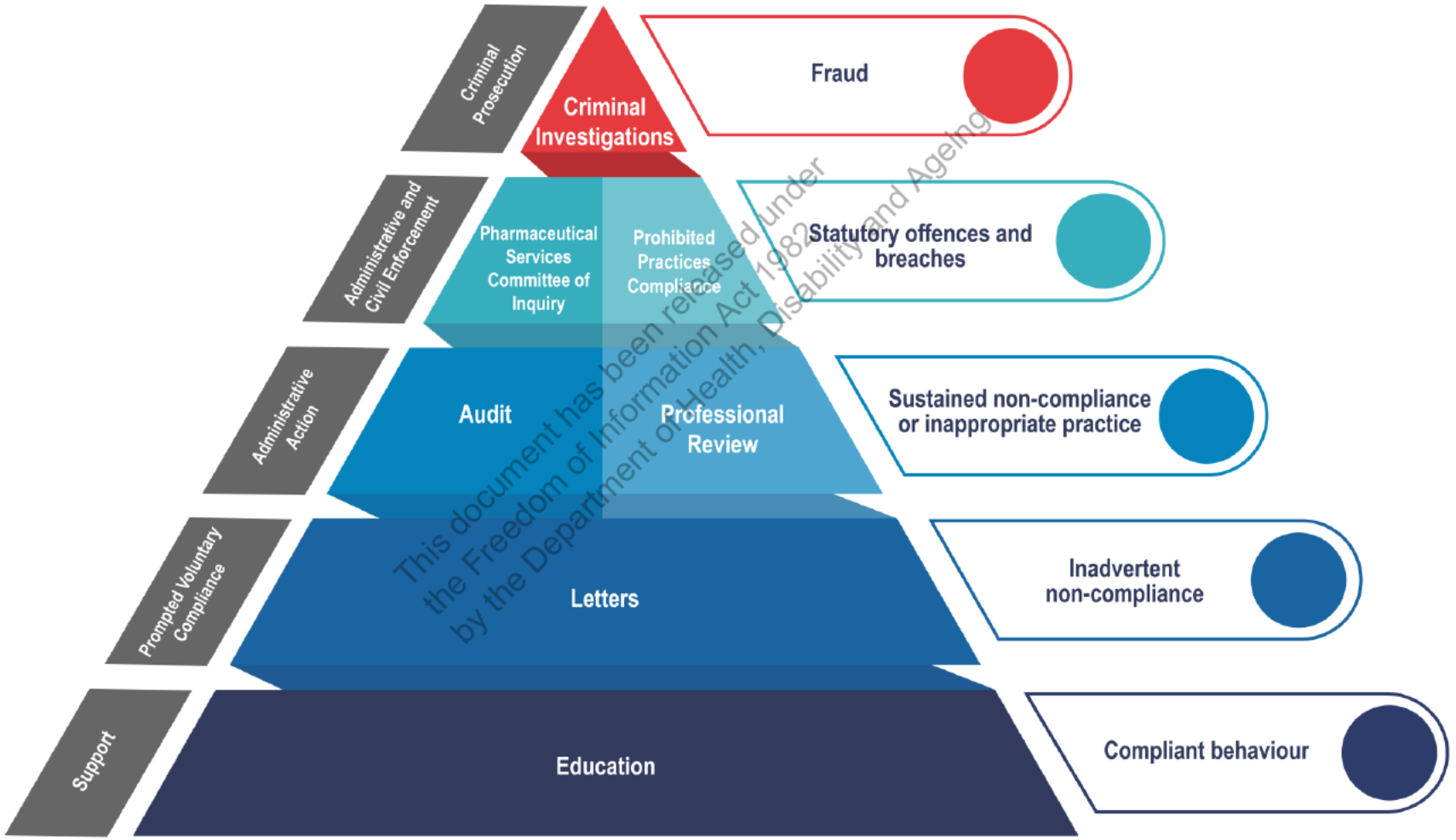
**Preliminary findings are subject to the completion/finalisation of the data matching activity and therefore are indicative findings only.*

Documents to substantiate MBS services

- During an audit, practitioners may be requested to provide documents to assist in determining whether a Medicare benefit paid in respect of a professional services should have been paid.
- An audit is not an assessment of the quality of care provided.
- If a practitioner does not produce documents that properly substantiate that the benefit should have been paid or does not respond to the request, then a Notice to Produce (NTP) may be issued.
- Any document provided to the department should have been created during or as soon as practicable after the treatment occurred. It should include the patient's name and the date of treatment.
- Examples of documents may include:
  - An operation report
  - A diagnostic imaging report
  - A pathology report
  - An excerpt from the patient's clinical record
  - Patient or diary notes



Health Provider Compliance Pyramid



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Treating compliance risks

- Potential compliance responses to this concern may include:
  - **Professional Review** – engagement by a Departmental medical adviser with a provider to discuss services and practices of question.
  - **Audit** – engaging with providers to request evidence of claiming to be reviewed by the department.
  - **Targeted letter** – engaging with providers in a letter inviting them to review their claiming.
  - **Targeted awareness raising** – working with stakeholders to identify education and information gaps.
- Our compliance approach will be informed by feedback on the concern as presented.
- Timing of compliance activities will be informed by the COVID-19 situation and in consideration of operational capacity.

How can Compliance Education help?

We can assist with:

- Organising a presentation for your events
- Answering your compliance education queries
- Assisting with contextualising our standard compliance education resources to meet the needs of your members
- Co-designing compliance education for your members

Email us if you require support:
compliance.education@health.gov.au

Resources:

AskMBS email advice service
AskMBS@health.gov.au

Health Professional Compliance page
www.health.gov.au/health-professional-compliance

MBS Online
www.mbsonline.gov.au

PBS Online
www.pbs.gov.au

Services Australia MBS information
www.medicareaust.com/index

Doctorportal Medicare Billing eLearning Module
www.doctorportal.com.au

Next steps

- Thank you for your valuable input you have provided today. The department will take on board what has been discussed to further inform our next steps.

- The department welcomes any additional feedback you wish to provide us, and would appreciate if this feedback could be provided by **10 August 2022**.

- Feedback can be provided to s47E(d) [redacted] @health.gov.au

Questions and discussion

Australian Government
Department of Health

Benefits Integrity and Digital Health Division
Compliance Enforcement and Professional Review Branch
Professional Review Section

Practitioner Review Program
Case Progression and Outcomes Report

Project: **GP non-referred attendances**

Scope: This project addresses GPs that claim non referred attendance items focusing on CDM items health assessments and mental health treatment plans case conferencing BBI and professional attendance items.

Project approval year: *2017*
Number of cases loaded: *161*

Statistics	
Closed after entity analysis (prior to interview) – no concerns found	27
Sent directly to the delegate prior to interview – ie concerns of a serious nature to not warrant an interview	2
Closed after interview – concerns no longer remain	10
Placed in a six-month review – all/some concerns remain	106
Closed after six-month review	89
Not offered a six-month review – sent directly to the delegate after interview, concerns of a serious nature to not warrant a review period	15

Key Findings

Of the 161 cases loaded:

- 27 cases were closed prior to interview and 10 cases were closed following an interview, meaning 22% of the practitioners identified under the strategy were compliant. This suggests the project's thresholds were slightly too low for practitioner identification.
- 89 cases were closed after a six-month review, indicating significant behavioural change resulting from PRP intervention
- 1 case is with a Delegate for consideration to refer to PSR
- 8 cases were closed after a Delegate review
- 28 cases have been referred to the PSR to date

Of the 28 cases with PSR

- 15 cases were referred to a delegate directly following the interview. Of these:
  - 14 cases had a PSR outcome with debts raised totalling $3,865,000 (average of $276,071 per case)

- 1 case is awaiting a PSR outcome
- 11 cases were referred to a delegate following a six-month review and subsequently referred to PSR. Of these:
  - 14 cases had a PSR outcome with debts raised totalling $1,935,000 (average of $138,214 per case)
- Recoveries were made for the incorrect billing of CDM items (items 721 to 732) in all 24 cases, indicating accurate targeting.
- Recoveries also were consistently made for the incorrect billing of items 23 and 36 (professional attendance items) and items 2700-2717 (GP mental health treatment plans), demonstrating that the identified practitioners had broader concerns than those identified in the project.

Additional analysis:

- A sample of the top 10 cases based on debt raised were reviewed, of which:
  - 7 cases were referred to a delegate after the interview
  - 9 cases had 3 or more concerns reviewed and noted in the PSR outcome letter
- 77% of cases under this project resulted in savings either through a debt raised after a PSR outcome or a behavioural savings following a six-month review
- 9% of cases in this project were referred to a delegate after an interview
- 55% of cases were placed in six-month review
- 6% of cases were referred to a delegate and accepted by PSR following a six-month review

This project was quite successful.

The project's most successful case resulted in a debt raised of $710,000. Recoveries were made for the incorrect billing of 12 MBS item numbers, including 3 CDM items, 1 item related to health assessments and 8 items unrelated to the project's key concerns.

This project was effective in identifying many high value and high-risk cases; however, it also identified quite a few low value/low risk practitioners that were not suitable for PRP.

Noting that highest value/risk practitioners were also non-compliant across several other MBS services, it is important to ensure that a broader view is taken when identifying practitioners for compliance intervention to ensure that high value/risk concerns are also captured.

Where concerns were significantly high resulting in a case being referred to a delegate directly after interview, the average debts raised per case is significantly higher than when concerns were less severe, but still resulted in a review by PSR.

Inappropriate Practice- Practitioner Review Program (PRP)

Context

Routine data monitoring identified a non-VR GP who was at variance to peers in their use of telehealth items and their rendering of long and prolonged consultations.

Analysis of data

Review of MBS and PBS data under the PRP identified the following concerns:

- Itemisation of Level C and D consultations
- Telehealth items – 91800, 91801, and 92113

Analysis showed timed item requirements totalling more than 9 hours a day were provided as well as claims for other complex and time consuming services, such as CDM and procedural items on the same day.

The practitioner was also at the 95th percentile for MBS item 91800 (80 level B telehealth services), the highest ranked provider nationally for MBS items 91801 (1,200 telehealth level C) and 92113 (telehealth GP mental health treatment plan of at least 40 minutes).

Practitioner interviewed

At interview, the practitioner advised they selected the following as explanation of their variance to peers:

- Higher case load due to staffing and the effects of COVID-19
- MBS items were selected based on the GP's assessment of the complexity and skill level required for the consultation rather than time.
- Challenges with operating in a virtual environment and accessing previous patient history.

The reviewing Professional Adviser was concerned the practitioner may not have met the minimum time required for professional attendance on the patient.

Due to the concerns over the extent of possible inappropriate practice this case was referred directly to a delegate of the Chief Executive Medicare (CEM) without a period of review.

Referred to the Delegate of the CEM

Based on the level of variance to peers the Delegate was concerned that the practitioner may not have met the MBS requirements for all services or may not have been able to provide an appropriate level of clinical input into each service and may not have kept adequate clinical notes.

The practitioner was referred to the Director of Professional Services Review.

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Prescribed pattern of services (the 80/20 rule) – what you need to know

The 80/20 rule aims to address consistently high volumes of rendered services by medical practitioners.

The 80/20 Rule

A medical practitioner engages in inappropriate practice if they have rendered or initiated 80 or more relevant professional attendance services on each of 20 or more days in a 12-month period (known as a 'prescribed pattern of services'). This is commonlyreferred to as the "80/20 rule".

From 1 July 2022, telehealth services including telephone and video consultations are included in the 80/20 rule. The introduction of a 30/20 rule for relevant phone services has been postponed.

The *Health Insurance Act 1973* requires a request to be made to the Director of Professional Services Review (Director) if the delegate of the Chief Executive Medicare (delegate) becomes aware of a breach of the 80/20 rule. This pattern of service is deemed to constitute inappropriate practice, except in exceptional circumstances.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. Professional attendance services include the following groups as listed in the Health Insurance (Professional Services Review Scheme) Amendment (2022 Measures No. 2) Regulations 2022 (legislation.gov.au):

- **A1** General practitioner attendances to which no other item applies
- **A2** Other non-referred attendances to which no other item applies
- **A5** Prolonged attendances to which no other item applies
- **A6** Group therapy
- **A7** Acupuncture
- **A9** Contact lenses - attendances
- **A11** Urgent attendances after hours
- **A13** Public health physician attendances to which no other item applies
- **A14** Health assessments
- **A15** GP management plans, team care arrangements and multidisciplinary care plans and case conferences
- **A17** Domiciliary and residential medication management reviews
- **A18** General practitioner attendances associated with Practice Incentive Program (PIP) payments
- **A19** Other non-referred attendances associated with PIP payments to which no other item

applies

- **A20** Mental health care
- **A21** Medical practitioner (emergency physician) attendances to which no other item applies
- **A22** General practitioner after-hours attendances to which no other item applies
- **A23** Other non-referred after-hours attendances to which no other item applies
- **A27** Pregnancy support counselling
- **A35** Services for patients in Residential Aged Care Facilities
- **A39** Bushfire Recovery Access Initiative – GP and Medical Practitioner Focused Psychological Strategies
- **A41** COVID-19 Additional focussed psychological strategies
- **A42** Mental health planning for care recipients of a residential aged care facilities
- **A43** Care Recipient of a Residential Aged Care Facility Planning and Contribution items
- **A45** Nicotine and smoking cessation counselling
- **A36 Subgroup 1 or 4** Eating disorders psychological treatment (EDPT) services
- **A40 Subgroups 1; 2; 3; 10; 11; 13; 15; 16; 19; 20; 21; 27; 28; 29; 39; 40; 41** telehealth and phone attendance services
- **A29 Item 139** Early intervention services for children with autism, pervasive developmental disorder or disability
- **A36 Items 90264 and 90265** EDPT services.
- **A40 Subgroup 17 Item 92142** telehealth and phone attendance services, COVID-19 GP, Specialist and Consultant Physician Autism Service – Telehealth Service
- **A40 Subgroup 25 Item 92170 and 92171** telehealth and phone attendance services, COVID-19 Review of an Eating Disorder Plan – Telehealth Service
- **A40 Subgroup 26 Item 92176 and 92177** telehealth and phone attendance services – COVID-19 Review of an Eating Disorder Plan – Phone Service

More information

How 80/20 breaches are detected and next steps

Exceptional Circumstances

Australian Government
Department of Health and Aged Care

Common compliance issues associated with findings of inappropriate practice

Information on the common issues associated with inappropriate practice based on Professional Services Review (PSR) outcomes.

Common themes in findings of inappropriate practice

There are common themes where there is an outcome of inappropriate practice after a review under the PSR Scheme. Some common concerns, and examples of why there was a finding of inappropriate practice include:

- *MBS requirements not always met:* MBS item time requirements were not met, and/or the services did not meet the item descriptor. Examples of services not meeting the item descriptor include:
    - for MBS item 723, not collaborating with at least two other healthcare providers, or patients did not have eligible chronic conditions
    - urgent after-hours services rendered to patients who did not require urgent assessment or treatment
    - for MBS item 104 and 105, insufficient evidence of personal attendance or no referral requesting a specialist consultation for MBS items.
- *Inadequate records*: the documentation would not assist another practitioner to manage the patient's condition, the records did not record or justify the service provided, there were inadequate patient history and summaries, the records did not reflect adequate clinical input, there was insufficient documentation of referred specialist consultations, and/or records were not contemporaneous.
- *Insufficient clinical input*: insufficient evidence of assessment, examination or consideration of underlying conditions relating to the service provided, Chronic Disease Management (CDM) or GP Management Plans were not comprehensive or sufficiently individualised.
- *Not all services were clinically indicated*: the treatment provided for the patient's presenting complaint did not appear to be clinically indicated, co-claiming MBS items where not clinically indicated.
- *Patient consent not adequately recorded*: either not always obtained or not documented.
- *Prescribing*: practitioner did not always comply with PBS restrictions, prescribing without appropriate clinical indication, prescribing while otherwise inadequately managing a patient's condition.