Australian Government
Department of Health

Frequently asked questions about Medicare billing in public hospitals

These FAQs provide answers to some of the more commonly asked questions on public hospital funding for public patients, and appropriate Medicare billing for private patients in public hospitals.

How are public hospitals funded?

Public hospitals are funded by both the Australian Government, and state and territory governments. The Australian Government contributes funding for public patients in public hospitals primarily through Activity Based Funding (ABF), whereby hospitals get paid for the number and mix of patients they treat. The Australian Government also contributes to block funding, which contains a fixed and a variable component. Block funding is generally paid to smaller rural and regional hospitals.

Governmental contributions to hospital funding are calculated by the National Health Funding Body (NHFB) according to prices set by the Independent Hospital Pricing Authority (IHPA). The NHFB and IHPA are independent bodies set up under the National Health Reform Agreement (NHRA). States and territories are responsible for funding the remainder of the cost of public hospital care once the Governmental contribution is determined.

Regardless of whether public hospitals are funded through ABF or block payments, the funding hospitals receive covers the entire cost of a patient's episode of care, and, other than in specified exempt circumstances, no Medicare billing should occur for public patient care.

I've been asked to give a billing officer access to my provider number for Medicare billing purposes – what should I know before agreeing?

It is not uncommon for medical practitioners to provide their provider number to practice/hospital billing offices, but there are some risks involved in allowing a third party to bill on your behalf - incorrect and/or duplicate billing could occur.

Key points to consider:

- Billing, referrals and requests for services under your provider number are your responsibility. You should be aware of what is being billed in your name.
- Most services listed in the MBS must be billed against the provider number of the practitioner rendering the service.
- Headline billing – billing on behalf of other practitioners - may occur under regulations for specific services generally provided in the specialties of radiation oncology, diagnostic imaging, and pathology. For other services, including attendances, the service must be personally performed by the medical practitioner claiming Medicare benefits and cannot be claimed on behalf of another practitioner. Although essential assistance can be provided by another practitioner according to accepted clinical practice.
- Shared debt or other provisions may apply to cases where a third party has incorrectly billed against another's provider number. The determination as to whether a debt is shared or owed by another party is made by the Chief Executive Medicare or delegate.
- The person whose name has been billed against will be the first point of contact in relation to any concerns about Medicare billing.

As a practitioner working in a public hospital, it is very important that you establish if a service is eligible to be billed under Medicare. Medicare billing for practices/services at a public hospital carries a risk of being non-compliant unless you can verify the private status of the patient, or an exemption has been made under Section 19(2) of the *Health Insurance Act 1973* allowing Medicare billing for a public patient.

I think a MBS item has been incorrectly billed against my provider number, or that a duplicate payment has been made. What should I do?

If you find out a MBS item has been incorrectly claimed on your behalf, or the service has been funded through hospital funding as well as Medicare billing (a duplicate payment), you can ask the billing officer to rectify it by submitting a Voluntary Acknowledgement of Incorrect Payment form. If you believe your provider number is being used inappropriately or without your consent, you may wish to consider contacting your medical defence organisation.

What constitutes an episode of public care for funding purposes?

An episode of care involves all the care needed for the treatment of the patient's condition, under the financial arrangements the patient has agreed (public funded or privately funded care). Timeframes for episodes of care, as well as the services involved, vary according to the clinical and care needs of the patient. The principle for every episode of public care is that all the services needed for the patient's care will be provided free of charge and funded through public hospital funding arrangements.

Examples of what medical services would generally form part of an episode of care include, but are not limited to:

- A patient presenting to the hospital with lobar pneumonia might require X-rays, ward care and a scheduled follow up in the medical clinic (aftercare) to confirm resolution of the illness.
- A patient referred for management of inguinal hernia might require an initial assessment visit, pre-anaesthesia consultation, ward time, theatre time, surgery, anaesthesia, post-operative removal of sutures at appropriate times and reviews as needed until the patient is formally discharged as 'cured'.
- A patient referred for crescendo/unstable angina might require angiograms, pre-anaesthesia consultation, theatre time, ICU time, ward time, surgery and rehabilitation, as well as a final review by the surgeon.

All of these would be provided free of charge and funded through public hospital funding arrangements.

What is a duplicate payment?

A duplicate payment occurs when two funding systems – such as Medicare and hospital funding - pay for a clinical service without an explicit exemption allowing this kind of 'double billing' to occur.

Using the situations noted above, please see the below for duplicate payment examples:

Case A

If the hospital requests the X-rays for the patient while the patient is admitted, and X-rays are billed against Medicare, the Medicare payments will be duplicates.
Why: Imaging costs for public patients are covered under the hospital's funding.

Case B

If the anaesthetist bills an MBS item for a pre-anaesthesia consultation, this would be a duplicate payment.

Why: Public hospital funding provides for the holistic care of inguinal hernias. The hernia requires surgery, and the pre-anaesthetic consultation is required for the patient's anaesthesia during surgery. On this basis, billing to the MBS constitutes a second payment for the service.

Case C

Two surgeons scrub in for an emergency surgery to remove a blockage causing the patient's unstable angina (angioplasty). The patient has elected to receive public care. One surgeon is salaried by the public hospital, but the other only works in the hospital under rights of private practice. The latter surgeon bills an MBS item for the surgery and bulk bills the cost so the patient is not out of pocket. The MBS rebate is a duplicate payment.

Why: In this case, the patient is a public patient therefore all required care is funded through public hospital arrangements. While the surgeon generally operates under rights of private practice, this does not entitle the surgeon to bill an MBS item when providing care for a public patient. The hospital should have (solely) funded the service. Bulk billed services are not equivalent to public services. Public services involve no additional charge to any party, including the patient and, importantly, the Australian Government and other entities. In contrast, bulk billed services involve a cost to the Australian Government.

We will endeavour to recoup duplicate payments to ensure the appropriate expenditure of public monies.

I have been advised all patients being seen in an out-patient clinic must have a referral to a named specialist in the clinic. What should I know about providing named referrals for my patients?

The requirement for a named referral is determined by whether the patient is being seen in the out-patient clinic as a public or private patient. Under the National Health Reform Agreement (NHRA), private services can be provided in public hospital outpatient clinics as long as:

- a named referral has been provided to a medical specialist who is exercising a right of private practice
- the patient has chosen to be treated as a private patient, and
- the referrer has obtained the patient's informed financial consent to be treated privately.

A named referral is, therefore, a fundamental requirement for private services in an out-patient setting. Patients being seen in an out-patient clinic as a public patient do not require a named referral.

The NHRA requires that referral pathways to hospitals, including outpatient clinics, must not be controlled so as to deny access for patients to free public hospital services. Practitioners are not required to provide named referrals for patients to receive services but can and should do so if the patient has asked to be seen as a private patient.

How can providers ascertain if a patient has elected to receive public or private care?

Prior to billing for services, it is important to identify if a patient is public or private to ensure any Medicare billing is compliant. There are several sources of potential information, including:

- referral forms,
- discharge summaries/clinical handover notes,
- request forms (for pathology and diagnostic imaging, noting most forms explicitly request information on the patient's public/private status), and,
- the patient.

In some cases, the above sources may not be able to adequately answer the question, and a practitioner may need to contact the requester, hospital administrator, discharging officer or another party for certainty. While this may take additional time, providing the service without confirmation means the practitioner assumes the risk that billing is non-compliant, and may be asked to make repayments for the services rendered.

Providers in public hospitals may be asked to substantiate that the patient chose to be a private patient. Guidelines on how practitioners can substantiate services provided under rights of private practice at public hospital outpatient departments can be found on the Department of Health website.

I have concerns about a request to write a named referral, a referral I've received, or another matter involving a public hospital. What are my options for communicating these concerns?

Depending on the concern, it is generally preferable to first discuss, and hopefully resolve, your concerns with the person who has written the referral, request, discharge summary, or been directly involved in the patient's care.

Commonly, bigger hospitals/hospital networks have 'hospital liaison officers', who are often also medical practitioners. These officers can assist with resolving any issues with requests, referrals, discharge summaries etc. Primary Health Networks are another resource that assist in this space.

When can a medical practitioner providing clinical supervision in the public hospital setting bill a professional attendance under the MBS?

For a consultation to qualify as a professional attendance, a medical practitioner must personally attend and have seen a patient.

While attendances can be claimed where essential assistance is provided by another practitioner, such as a trainee, Medicare benefits are not payable where public funding contributes to the cost of the service, such as for the salary of a practitioner providing essential assistance to a public hospital patient.

Can interns, registrars, or nurse practitioners provide Medicare rebateable services in the Emergency Department of a public hospital? What about other practitioners?

Under the National Health Reform Agreement, states and territories have committed to providing public hospital emergency department services 'free of charge' – no charge is to be incurred by the patient or the MBS.

State or territory salaried practitioners, including interns, registrars and nurse practitioners, are employed by the public hospital system and as such are generally not eligible to bill MBS items for public hospital emergency department patients. This includes Medicare billing for pathology and diagnostic imaging services provided to public patients.

It is noted there may be some hospitals, in very specific situations, where private emergency treatment services may be provided by GPs and funded through the MBS as a single source of funding. However, this arrangement is rare and by exception, and can only be entered into with the agreement of relevant Health departments.

There are also exemptions under the *Health Insurance Act 1973*, subsection 19(2), allowing some services provided in public hospital emergency departments and outpatient clinics to be billed under Medicare.

I think (a public hospital funded service) has a 19(2) exemption allowing it to also be billed to Medicare – how can I check?

In the first instance, you should contact your state or territory health department to confirm whether a public hospital service can be billed to Medicare.

Information on hospitals and health services approved to bill Medicare under the Council of Australian Governments (COAG) Improving Access to Primary Care in Rural and Remote Areas – *COAG s19(2) Exemptions Initiative* can be found online by going to www.health.gov.au and searching for 'COAG 19(2) exemption initiative'.

Where can I get other information on Medicare billing?

AsKMBS enquiries and advice

If you couldn't find an answer to your question on our FAQ page, please email us

AskMBS@health.gov.au.

Provider enquiry line

If you are seeking advice in relation to Medicare billing, claiming, payments or obtaining a provider number, please contact Services Australia on the Provider Enquiry Line

Ph:13 21 50