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

Updated October 2022

# Contents

# 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 October 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 October 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 and Aged Care

## 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 (and its telehealth equivalent) must be met prior to claiming the item, up to and including offering the patient a completed copy of the plan. This includes an attendance for the purpose of discussing TCAs with the patient.

The collaboration requirement for item 723 involves more than simply gaining the consent of the collaborating providers to participate in the TCAs. The relevant regulations specify that to claim item 723 the medical practitioner must complete the following:

a. consult with at least two collaborating providers, each of whom will provide a different kind of treatment or service to the patient, and one of whom may be another medical practitioner, when making arrangements for the multidisciplinary care of the patient; and
b. prepare a document that describes:
    i. treatment and service goals for the patient;
    ii. treatment and services that collaborating providers will provide to the patient; and
    iii. actions to be taken by the patient;
    iv. arrangements to review (i), (ii) and (iii) by a date specified in the document; and
c. explain the steps involved in the development of the arrangements to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);
d. discuss 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; and
e. record the patient's agreement to the development of TCAs;
f. give copies of the relevant parts of the document to the collaborating providers;
g. offer a copy of the document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
h. add a copy of the document to the patient's medical records.

A practitioner can claim item 723 whenever these requirements are fulfilled. This may require more than one face-to-face consultation with a patient. If 723 is co-claimed with another service, such as item 721, then all the requirements of that second service must also be fulfilled.

## 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.

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.

## 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.