SA Health

Policy

Medicare Billing for Private Outpatients

Version 4.0

Approval date: 06 October 2022

PDS Reference No: D0249

Government of South Australia

SA Health

1 Name of Policy

Medicare Billing for Private Outpatients

2 Policy statement

This policy provides the mandatory requirements and obligations for participating medical practitioners seeking to bill private outpatient services to the Commonwealth (Medicare) through exercising Rights of Private Practice (ROPP) in accordance with:

- the 2020-25 National Health Reform Agreement (NHRA) and its business rules, including those relating to specialists billing under Rights of Private Practice (ROPP);
- legislative requirements as defined by the *Health Insurance Act 1973*; and
- the Medicare Benefits Schedule (MBS).

This policy has been developed in consultation with the Commonwealth Department of Health and Ageing to reflect agreed principles and practices that constitute compliant billing activity, in addition to this policy a best practice *Medicare billing for private outpatients'* guideline has been developed to assist medical practitioners in the application of this policy.

3 Applicability

This policy applies to all employees of SA Health involved in the Medicare billing of outpatient services. This includes employees and contracted staff of the Department for Health and Wellbeing, Local Health Networks (including state-wide services aligned with those Networks) and SA Ambulance Service.

Where a medical practitioner intends to provide private outpatient services, a formal ROPP agreement must be in place with the LHN in which they intend to provide private outpatient services before private services may be offered. This applies where the medical practitioner is employed full time by SA Health or is employed part time and the services are rendered within the scope of SA Health employment.

Private practice billing must be performed in accordance with the ROPP agreement. Professional services provided under ROPP include specialist outpatient consultations, procedures and associated diagnostic services such as pathology and radiology.

Professional services rendered by a medical specialist pursuant to their Rights of Private Practice are rendered under a contract between the medical practitioner and the patient, and not by, or on behalf of or under an arrangement with the State.

Where the Specialist engages in private practice the Specialist shall be indemnified under and in accordance with the Department's Professional Indemnity (Medical Malpractice) Program ("Program") against any description of civil liability whatsoever (subject to the exceptions specified in the Program) incurred by the Specialist in connection with the conduct of private practice by the Specialist whether or not the Specialist continues to be employed by the Employing Authority at the time that they are notified of any claim leading to such civil liability.

1. Out of Scope of this Policy

1. Private Practice outside SA Health employment

Where the medical practitioner is employed part time, and private practice is conducted outside their LHN employment/FTE, this will be performed in their independent non-SA Health employment capacity and the doctor is entirely responsible for all matters including fees, administration and insurance. Private practice conducted outside of LHN employment/FTE is not considered billing under a Right of Private Practice.

2. Services Rendered Outside the employing LHN

Where a medical practitioner wishes to perform "off-site" private services within their LHN employment, written approval must be obtained as per clause 5.9 of the standard ROPP agreement "Private Practice Outside the Hospital".

Where a medical practitioner is rostered to perform services in another SA Health LHN (incorporated under the *Health Care Act 2008*) outside of their employing LHN, billing must be remitted through the ROPP agreement. The relevant SA Health location must be specified as a "Nominated Health Service" in the Schedule to their ROPP agreement.

3. Visiting Medical Specialists

Visiting Medical Specialists (VMS) do not have Rights of Private Practice agreements in connection with their employment. The provision of private patient services by a VMS must be rendered in their independent practice time whilst not in a SA Health employed capacity. Where the choice to be treated as a private patient has been made, this Policy must be met, before the service may be billed to Medicare.

VMS must comply with the Visiting Medical Specialists – Private Practice Billing Policy.

4 Policy principles

The principles underpinning this policy are:

- We will comply with the NHRA with respect to ROPP.
- We will provide access to outpatient services strictly on the basis of clinical need within a clinically appropriate period regardless of a patient's choice to be a public or private patient.
- We will treat a patient presenting at a public hospital outpatient department as a public patient unless they are referred to a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient.
- We will ensure a patient making a choice to be treated as a private patient does so on the basis of informed financial consent, which is substantiated in writing.

- We will ensure that billing is compliant with the provisions of the *Health Insurance Act 1973* and MBS obligations under the NHRA and its Business Rules, and all other relevant requirements for public hospital specialist outpatient clinics providing private services (including telehealth), as specified by the Commonwealth Department of Health.

5 Policy requirements

This Policy provides the requirements within which participating medical practitioners and LHNs must operate to ensure SA Health patients are afforded access to fair and equitable public and private outpatient services, in accordance with relevant legislation, policy and operational compliance requirements.

1. Addendum to National Health Reform Agreement 2020-2025 Requirements

An eligible patient presenting at a public hospital outpatient department must be treated free of charge as a public patient unless:

- there is a third-party payment arrangement with the hospital or the State to pay for such services; or
- the patient has been referred to a named medical specialist who is exercising a right of private practice; and
- the patient chooses to be treated as a private patient.

2. Medicare billing requirements

All medical practitioners participating in Medicare billing must:

- have a valid Medicare provider number for the location at which private outpatient services are provided and subsequently billed. Where offering private services at multiple locations the medical practitioner must register a provider number for each location in which they offer private outpatient services.
- be responsible for all billing under their provider number
- not use another practitioner's provider number for requesting other services, such as diagnostic tests.
- personally perform services, unless an exception applies.
- Comply with the requirements for assignment of benefit under section 20A of the Health Insurance Act.

MBS items billed must be determined by the treating medical practitioner.

The treating medical practitioner must meet the requirements of the MBS item claimed, for a full list of the MBS items refer to *www.mbsonline.gov.au*.

The assigning of an MBS item number to a service must only be completed by the treating medical practitioner. Administrative staff or anyone else other than the billing medical practitioner must not attempt to determine which MBS items should be claimed.

It is recognised that SA Pathology and South Australia Medical Imaging have automated, auditable billing systems and these fulfil the requirement of the treating medical practitioner determining the MBS items to be billed.

3. Access to Services

Access to public or private outpatient services must be provided strictly upon the basis of clinical need. Patient choice must in no way influence a patient's access to services. Access to services shall remain unchanged regardless of whether a patient chooses to be treated in public or private capacity.

Professional outpatient services must not be provided on an exclusively private basis. This means that where a specialist medical service is available to private outpatients in an LHN, a public service in the same specialty field must also be accessible. This requirement must be satisfied by:

- ensuring that where a specialist medical service is available to private outpatients, a public specialist outpatient clinic in the same specialty field is also accessible within the same hospital; and/or
- offering patients the choice to be treated as public patients in specialist outpatient clinics that offer private (Medicare bulk billed) services.

Referrals must be obtained from both public and private patients to ensure there is a clinical need for a patient to see a medical specialist.

Named referrals must not be made a prerequisite for access to outpatient services. Patients must not be defaulted to being privately billed or having services billed to Medicare. Referral pathways must not be controlled to restrict access to free public services.

Patients referred to an outpatient clinic from a hospital emergency department cannot choose to be private outpatients and may only be treated in a public capacity.

4. Referral Compliance

A valid referral must be received by a specialist outpatient clinic in order for patients to access specialist outpatient services.

The Commonwealth Department of Health and Aged Care (Medicare) and the NHRA impose specific requirements which referrals must satisfy in order to be considered compliant for Medicare billing purposes.

If a referral fails to meet all Commonwealth and NHRA requirements for a private patient, the referred patient cannot be afforded the choice to be seen as a private patient. The patient must be seen as a public patient by a doctor chosen by the LHN.

For a referral to be considered valid to access private outpatient services, all of the following referral requirements must be met:

- the referring medical practitioner must have undertaken a professional attendance with the patient, turned his or her mind to the patient's need for referral and have communicated relevant information about the patient to the specialist practitioner;
- the referral must be in writing (this includes referrals transmitted securely via electronic transmission);
- the referral must be signed and dated by the referring medical practitioner;
- the referral must be received on or before the occasion of service to which the referral relates;
- the treating medical practitioner must accept the referral and therefore accept to take responsibility for the patient's care and treatment under the auspices of the referral;
- the instrument of referral is required to be retained by the medical practitioner (hospitals are required to retain referrals within the patient's hospital case notes on behalf of medical

practitioners).

5.4.1 Referral Compliance (Consultation Services)

Wherever Medicare requires a referral for an outpatient service to be billed against the MBS, the NHRA business rules impose an additional requirement that the patient must be referred to a named medical specialist who is exercising a Right of Private Practice.

General practitioners are regarded as the primary source of referrals. Cross referrals between medical practitioners should usually occur in consultation with the patient's general practitioner.

Where a patient wishes to access private outpatient services, in the absence of a valid referral, LHNs can recommend patients request a new (compliant) referral from their referring practitioner. Where a named referral is sought to facilitate a private attendance, it must be clearly communicated that the request is to facilitate the patient's choice and is not aimed at defaulting the patient to private care.

5.4.2 Request Form Compliance (Pathology, Diagnostic Imaging and Procedural Services)

Procedural and diagnostic services must be accessed by a 'request' completed by a Medicare authorised practitioner who determined the clinical need/relevance for the test/s.

A written request (not a written referral to a named medical practitioner) is required by the *Health Insurance Act 1973* and MBS rules in order to access MBS billing for pathology, diagnostic imaging and most procedural Services. Where a procedural service requires a request, it must be stated in the item descriptor.

Reference must be made to the MBS for more specific request form requirements in order to facilitate MBS billing. Billing must be in accordance with the patient's election status at the time of the request being generated and if there is any doubt whether the patient is private and eligible to have services billed to Medicare, further enquiries must be made.

5. Patient Choice – Public and Private Outpatient Services

1. Public Patients

Eligible persons are entitled to receive public hospital services free of charge as a public patient. LHNs must ensure that equivalent public outpatient services are always available in conjunction with private outpatient services. Private outpatient services must only be offered where equivalent public services are available within the same hospital.

Public outpatient services cannot be billed to Medicare or to the patient.

Public patients are treated by a Medical Practitioner chosen by the hospital.

Where a patient chooses to be treated as a public outpatient at the commencement of the Non-Admitted Service Event, the patient's choice to be treated as a public patient must apply to all subsequent services provided included within the Non-Admitted Service Event (which may include pathology and diagnostic imaging).

Patient administration systems must record outpatient services to Medicare eligible patients as public patients, unless and until the patient has elected in writing to be a private patient.

2. Private Patient Choice

A patient referred to a named medical specialist who is exercising a Right of Private Practice may be provided with the choice to be treated as a private outpatient (Medicare billed) where mandatory billing requirements have been met. In order for a patient to choose a private outpatient service and the service billed to Medicare, the following must occur:

- the service is eligible and not already funded by other means.
- the patient is eligible for a Medicare benefit.
- a referral (or diagnostic request) has been received that is valid for the purpose of billing (MBS) items.
- the medical practitioner to which the patient has been referred accepts the patient referral and is exercising a Right of Private Practice.
- the patient's choice to be private must be substantiated by the clinic and be provided as part of any audit. LHNs must retain evidence regarding the patient's election status, LHN patient administration systems must record the Non-Admitted Service Event for the patient as "private" or "PRNI" only after the patient has elected in writing to be a private patient.

3. Non-Admitted Service Event

Patient choice applies to each Non-Admitted Service Event. In general, each medical consultation or procedure is a separate Non-Admitted Service Event, for which a patient may elect public or private.

Diagnostic services are not a separate Non-Admitted Service Event and must inherit the public/private election status of the medical consultation or procedure that requested the diagnostic service.

The Commonwealth Independent Hospital Pricing Authority Tier 2 Definitions Manual contains a list of classifications which allocates services into groupings and must be referred to when classifying Non-Admitted Service Events.

The Commonwealth specific rules that apply for public/private patient election for Non-Admitted Service Events are outlined in the *Medicare Billing for Private Outpatients Guideline*.

6. Informed Financial Consent

Patients provided the choice to be treated as private at SA Health outpatient clinics must do so on the basis of informed financial consent.

Patients must be made fully aware of any financial implications associated with choosing to be treated as a private outpatient for all medical services provided as part of the Non-Admitted Service Event.

Most private outpatient services provided in SA Health public hospitals are bulk billed to Medicare, with no "gap" to the patient. Financial consent includes consenting to Medicare being bulk billed for the service.

In some cases, the Medical Practitioner may choose not to bulk bill. In these cases, the medical practitioner will raise a charge for the full Medicare schedule fee, and the patient will claim a benefit from Medicare, resulting in a 'gap'. Any 'gap' arrangement must be disclosed to the patient before the patient makes the choice to be private.

LHNs must ensure that a patient's choice to be treated as a private outpatient can be adequately substantiated.

Clear and consistent signage, for on-site services, or otherwise information of a patient's right to be treated as a public or private patient for specialist outpatient services must be available at LHNs. This includes the patient's right to make decisions with informed financial consent.

6 Mandatory related documents

The following documents must be complied with under this Policy, to the extent that they are relevant:

- Australian Government Department of Health Medicare Benefits Schedule
- Addendum to National Health Reform Agreement 2020-25
- *Department of Health Private Practice Agreement 2008*
- Health Insurance Act 1973
- Commonwealth Independent Hospital Pricing Authority Tier 2 Definitions Manual

7 Supporting information

- Medicare Billing in Public Hospitals – Department for Health and Ageing *https://www.health.gov.au/health-topics/medicare-compliance/public-hospitals*

8 Definitions

Activity Based Funding (ABF): Activity Based Funding (ABF) is a way of funding hospitals whereby they get paid for the number and mix of patients they treat.

For further information: https://www.ihpa.gov.au/what-we-do/activity-based-funding

Aftercare: Treatment after an operation provided by or on behalf of medical practitioners and includes any attendances necessary for the purposes of the post-operative treatment of the patient, including the final check or examination, regardless of where the attendances happen.

Gap: A 'gap' refers to an out-of-pocket expense experienced by a patient. In the context of Medicare outpatient billing at SA Health public hospitals, a 'gap' usually occurs where a Medical Practitioner seeks to charge 100% of the Scheduled Fee associated with the item number billed for the service provided. The amount outstanding between the Medicare rebate amount for the service item and the scheduled fee amount constitutes the gap owing by the patient.

Medical Benefits Schedule (MBS): The Medicare Benefits Schedule is a list of the medical services for which the Australian Government will pay a Medicare rebate, to provide patients with financial assistance towards the costs of their medical services.

For further information: http://www.mbsonline.gov.au/

Medical Practitioner: A medical practitioner refers to a person appropriately qualified by the Commonwealth to provide medical treatment / services.

Medical Specialist: a medical practitioner recognised by Medicare as a medical specialist or consultant physician

Non-Admitted Service Event: as defined by the Independent Hospital Pricing Authority Tier 2 definitions for ABF counting purposes. This is:

> *".. an interaction between one or more health care provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record. The interaction may be for assessment, examination, consultation, treatment and/or education."*

Off-site private practice refers to locations which are not part of a SA Health incorporated hospital/ health service. Examples will include private hospitals and consultant's rooms.

Professional Service: A professional service is a clinically relevant service which is listed in the MBS. A medical service is clinically relevant if it is generally accepted in the medical profession as necessary for the appropriate treatment of the patient.

Public patient: Any patient who elects to be treated as a public patient for services provided as part of the patient's Non-Admitted Service Event. Public services are provided by medical practitioners nominated by the hospital and no charges are raised against the MBS.

Private patient: Any patient who elects to be treated as a private patient for services provided as part of the patient's Non-Admitted Service Event. The patient may receive medical services from a medical practitioner selected by the patient and medical fees may be billed against the MBS where requirements of the MBS and NHRA business rules have been met.

Referral: A referral is a request to a medical practitioner for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s).

Request: A written request is required by the *Health Insurance Act 1973* and MBS rules in order to access MBS billing for Pathology, Diagnostic Imaging and many Procedural services. A written request must be signed and dated and contain the name and address or name and provider number in respect of the place of practice of the requesting practitioner.

Rights of Private Practice (ROPP): Eligible medical practitioners may be granted limited rights of private practice by written agreement, enabling participating medical practitioners to offer private services and bill private patient services to Medicare.

Third Party Payment Arrangement: A third party arrangement relates to payment arrangements for services provided to non-Medicare patients or compensable patients such as those that may be subject to a Return to Work SA, CTP Regulator, or other liability claim.

9 Compliance

This policy is binding on those to whom it applies or relates. Implementation at a local level may be subject to audit/assessment. The Domain Custodian must work towards the establishment of systems which demonstrate compliance with this policy, in accordance with the requirements of the *System-wide Integrated Compliance Policy*.

Any instance of non-compliance with this policy should be reported to the Domain and the Domain Custodian for the Risk, Compliance and Audit Policy Domain.

10 Document ownership

Policy owner: Director Safety & Quality as Domain Custodian for the Clinical Governance, Safety and Quality Domain

Title: Medicare Billing for Private Outpatients Policy

ISBN: 978-1-76083-173-8

Objective reference number: A4781935

Review date: 6 October 2025

Contact for enquiries: *RSBHelpDesk@sa.gov.au*

Document history

Version	Date approved	Approved by	Amendment notes
V4.0	06/10/2022	Deputy Chief Executive, Commissioning and Performance DHW	Updated to new SA Health Policy framework requirements Updated for changes to Commonwealth interpretations and new information as per Fact Sheet
V3.1	19/07/2019	Chief Finance Officer - DHW	Minor amendments made for clarification.
V3.0	27/03/2019	SA Health Policy Committee	Amendments include changes to the title, billing arrangements and NHRA inclusion.
V2.0	28/07/2016	Portfolio Executive	Amendments include: • Continuation of existing named referral requirement (NHRA 2011) • Medicare billing rule change 'personal performance' for specific services • Rules for retention of Medicare assignment of benefit forms • More detail for aftercare services Minor wording changes
V1.0	06/02/012	PE Endorsed	Original approved version

11 Appendices

1. Mandatory Instructions

1. **Assignment of Benefit Form**
2. **Commonwealth Funded Services**
3. **Hospital treatments and services attracting 75%, 85% and 100% rebates**
   - 3.1 Sunrise EMR
4. **Provision of Services – personally performed**
5. **Evidencing patient choice (substantiating Medicare claims)**
6. **Patient Unable to Sign**
7. **Pre-operative anaesthesia and consultation services**
8. **Case Conferences**
9. **Aftercare**
   - 9.1 Public Patients
   - 9.2 Private Patients

Appendix 1: Medicare Billing for Private Outpatients Mandatory Instructions

The following instructions must be complied with to meet the requirements of the Medicare Billing for Private Outpatients policy.

1. Assignment of Benefit Form

Where a patient is bulk billed, the patient assigns their Medicare benefit to the Medical Practitioner, and the medical practitioner accepts the assignment in full payment for services. This is governed by section 20A of the Health Insurance Act 1973.

The legislative requirements for the assignment of benefit are:

- an agreement must be made between the patient (assignor) and the medical practitioner for the assignment of benefit
- the agreement is evidenced through the use of the assignment of benefit form
- the patient is required to sign the form
- a copy of the agreement must be provided to the patient.

The patient or other responsible person must not sign a blank or incomplete assignment of benefit form. The form must be printed, provided to the patient to review, sign and given to retain for their records.

In addition to the assignment of benefit form, LHNs must demonstrate the patient has elected in writing to be a private outpatient.

The patient or other responsible person must not sign a blank or incomplete assignment of benefit form. The form must be printed, provided to the patient to review, sign and given to retain for their records.

Where a medical practice is using Medicare Online electronic billing, the assignment of benefit form (DB4) does not need to be stored. However to confirm that the service was provided to a patient, Medicare will seek alternative evidence that the service was provided. Evidence may include electronic billing information, notes in practice software appointment records, and, if the practice chooses to retain them, the copy of the assignment of benefit form.

2. Commonwealth Funded Services

The NHRA: Schedule A – Sustainability of Funding for Public Hospital Services stipulates that:

> *A9. The Commonwealth will also continue to support private health services through the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS) and Private Health Insurance Rebate. Subject to any exceptions specifically made in this Addendum or through variation to the Addendum, the Commonwealth will not fund patient services through this Addendum if the same service, or any part of the same service, is funded through any of these benefit programs or any other Commonwealth program.*

In accordance with NHRA Schedule A9 and MBS legislation, hospitals must not seek to bill private outpatient services to Medicare where those services are Commonwealth or State funded through other means. This does not include/affect private patient services attracting Commonwealth contributions through NHRA funding, which are eligible to be billed to Medicare. Clause G19 of the NHRA supports the provision of private patient services on public hospital sites, where requirements around the patient having a referral to a named specialist, and making a decision to be private, have been met.

3. Hospital treatments and services attracting 75%, 85% and 100% rebates

Most services provided at a hospital, or with the involvement or approval of a hospital or the hospital administration (including in hospital in the home arrangements) are considered hospital treatments under the definitions set out in the *Health Insurance Act 1973* and related definition in the *Private Health Insurance Act 2007*.

These do not include services provided at an emergency department, or services specified as 'Type C' services (see below).

Hospital treatments must attract a 75% rebate of the relevant Medicare Schedule Fee.

Relevant to the above, the Commonwealth *Private Health Insurance (Benefit Requirements) Rules 2011* contain a list of MBS item numbers that are Type A, B or C procedures.

Where an item is listed as Type A or Type B, and the service is provided in a public hospital setting, the service is a hospital treatment. The Medicare benefit applicable is therefore 75% of the Medicare Schedule Fee. Associated anaesthesia for the type A or type B procedure is also paid at 75%.

Type A procedures are generally surgical procedures, and type B procedures are those which are usually same day procedures without overnight admission. Common examples that might be performed as outpatients include gastro/colorectal scopes, bronco scopes, cardiology tests (ECG, EEG), ophthalmology procedures, specific radiation oncology procedures involving implantation and minor surgery, transfusions and infusions or parenteral administration of chemotherapy.

Type C services generally cover those services that do not require a hospital setting to be provided, including most consultation services, pathology services and diagnostic imaging services.

Type C services are generally rebated at 85% of the Medicare Schedule Fee - unless it is certified by a medical practitioner in writing that due to the medical condition of the patient or because of the special circumstances specified, it would be contrary to accepted medical practice to provide the procedure to the patient except in a hospital. This is referred to as a 'Type C certificate' and is usually utilised where a patient is to be admitted for a Type C service. A Type C certified service may be billed to a private health insurer, for a privately insured patient who has elected to be a private patient.

While not common for GPs to provide services at public hospital sites, all GP services attract rebates at 100% of the Schedule Fee. This might occur for privately provided services by non-SA Health employed GPs at country sites.

As at 1-March-2022, there are 2582 items listed as Type A, B and C services. An Excel file containing these MBS items can be found at:

https://www.health.gov.au/resources/collections/private-health-insurance-clinical-category-and-procedure-type

"In hospital" procedures must be transmitted to Medicare with a "H" hospital indicator as part of the claim data, to correctly claim payment at 75%. If the H indicator is not transmitted as required, Medicare will pay incorrect benefits and the amount overpaid would be required to be repaid. It is important that any impacted systems take this into account.

Note: The above rules apply where the service is rendered in a public hospital outpatient setting. It does not apply to non-hospital settings e.g. GP Plus, Sefton Park, off location services at private rooms.

SA Health corporate systems Sunrise EMR and PBRC comply with these requirements.

3.1 Sunrise EMR

- Sunrise EMR has a Billing Type "In Hospital Bulk Billing Electronic" – which will default for any item on the Type A or Type B list – to claim the 75% benefit.
- Associated MBS items such as anaesthesia for a Type A/B procedure are payable at 75% CMBS via user selection of the "*In Hospital Bulk Billing Electronic"* billing type.
- Other outpatient MBS charges not on the Commonwealth Type A/B list, are paid by Medicare at 85% of CMBS. In Sunrise EMR bulk billed services that are not Type A/B default as "*Bulk Billing Electronic",* unless the user selects otherwise.

4. Provision of Services – Personally Performed

Most outpatient services only attract Medicare benefits if the service is personally performed by the medical practitioner. The obligation for personal attendance by the medical practitioner applies whether or not another person provides essential assistance in accordance with accepted medical standards.

For service items not subject to personal performance requirements, and are rendered on behalf of a medical practitioner, the service must be billed in the name of the medical practitioner who is then required to provide supervision and accept full responsibility for the service. While the supervising medical practitioner need not be present for the entire service, they must have direct involvement in the provision of at least part of the service.

Before claims to Medicare are generated, medical practitioners must ensure that the provision of services for service items intended for billing have met personal performance and supervision requirements.

Some medical services or parts of medical services are not required to be personally performed and hence may attract Medicare benefits if:

- a person, other than the medical practitioner (in whose name the service is being claimed), who is employed by a Specialist Practitioner or, in accordance with accepted medical practice, acts under the supervision of a Specialist Practitioner; or
- it is a service where a part of the service is performed by a technician employed by or, in accordance with accepted medical practice, acting under the supervision of the medical practitioner; or
- the service is one of a group of services which is permitted under regulations to be 'headline billed' – diagnostic imaging, radiation oncology, and most, but not all pathology services. These services can be billed under a single provider number despite being performed by a practitioner other than the billing practitioner.

Reference should be made to the relevant item number in the Commonwealth Department of Health and Aged Care MBS (online at *www.mbsonline.gov.au*) for further detail.

5. Evidencing Patient Choice (Substantiating Medicare Claims)

SA Health outpatient clinics offering private services must ensure mechanisms are implemented to recognise and record a patient's choice to be seen in a private capacity. The outpatient clinics must obtain a patient's signature and date accompanying the following statement at the point at which the patient's choice (to be private) is made:

> *"I acknowledge that as a patient referred to a SA Health outpatient specialist; I have a right to be treated as a public or private patient. I hereby choose to be treated as a private patient.*
>
> *This medical appointment will:*
>
> ☐ *Be Medicare Bulk Billed (no patient charges) for this service**
> ☐ *Incur an out-of-pocket charge (gap)*
>
> *(*Strike out or remove non-applicable option)*
>
> *I understand that by electing to be treated as a private patient subsequent outpatient medical services provided (including any requested diagnostic imaging or pathology testing) in treatment of the condition for which I was referred will be private services and may incur an out of pocket charge. If charges apply for subsequent medical services, I will be advised prior to that appointment."*

This consent must be obtained before Medicare has been billed. By submitting a Medicare claim, a provider is agreeing that a patient is eligible for Medicare, and the provider has fulfilled all the requirements of the item being claimed, including that the patient is a private patient. If it is a return patient, a new patient election does not need to be obtained, unless it is a new referral, as this indicates a new course of treatment.

6. Patient unable to sign

If the patient cannot assign their right to a Medicare benefit for manual and online claiming, Medicare can accept a signature on the assignment form from a third party – for example, the patient's parent, guardian, power of attorney or another responsible person.

The medical practitioner must:

- note in the Patient Signature field that the patient is unable to sign;
- note in the Provider Use field, why the patient is unable to sign – for example injured hand;
- initial or sign their notes.

7. Pre-Operative Anaesthesia and Consultation Services

A pre-operative anaesthesia or medical consultation that is directly related to an inpatient episode being provided for a public patient must be provided free of charge and not billed to Medicare. This does not include consultations or tests to inform a decision to refer the patient to a hospital specialist or determine the patient's need or fitness for specialist care or surgery.

If the patient has elected to be a privately admitted patient for the inpatient episode and signed the completed MR5A Patient Election Form as a private inpatient, the pre-operative anaesthesia or medical consultation may be billed to Medicare.

8. Case Conferences

The advice below was provided by the Commonwealth Department of Health and Aged Care "AskMBS" service.

MBS case conference items can only be claimed for patients who have elected to be treated as private patients. A referral, while not required for Medicare purposes for case conference items to be claimed, is required under the NHRA for MBS services provided to a private patient in a public hospital.

Patient consent to the case conference must be obtained before the conference is conducted. The consent of the patient or the patient's agent can be obtained verbally and should be noted in the patient's file.

A named referral is not required for participants in the case conference, however participants must be invited by the case conference organiser. Documentation is required in the event of an audit.

Case conferences are separate services from a course of treatment, and informed consent must be obtained for each case conference.

Each billing practitioner must ensure that their patient is informed that a Medicare item will be charged for the case conference for which a Medicare benefit will be payable (i.e. even if the service is bulk billed a Medicare payment will be made to the practitioner and the claim will appear on the patient's Medicare claiming history. The patient must consent to the bulk billing for this service).

A patient can assign their right to a Medicare benefit to an eligible provider by signing a completed assignment of benefit form or by indicating 'Yes' or 'OK' on an electronic claiming platform. Agreement can be provided by the patient or another person such as the person's carer or family member. Where practicable, each individual provider should obtain a patient's signature in whichever way is appropriate to their needs.

Only providers with rights of private practice can claim MBS items for services provided in the course of their employment to private patients in public hospitals. Non-treating practitioners may be counted towards the numbers of participants in a case conference but cannot claim any item for their participation.

9. Aftercare

Aftercare includes all post-operative treatment rendered by medical practitioners and includes all follow-up outpatient attendances following and in relation to an admitted episode of care.

Medical practitioners must determine each individual patient's aftercare period. The amount and duration of aftercare following a patient's admitted episode is dependent upon the patient's clinical need and can vary between patients.

9.1 Public Patients Aftercare

Where a patient has received treatment as a public inpatient, aftercare directly related to that episode of admitted care must be provided free of charge, with no charges being raised for the patient or the Commonwealth MBS, as part of the public hospital service.

Where a public admitted patient independently chooses to receive aftercare privately, as a matter of election (this includes if the aftercare is delivered by medical practitioners exercising rights of private

practice in a public outpatient clinic) then any clinically relevant service provided by the medical practitioner may attract Medicare benefits.

Hospitals and hospital staff should not request that patients seek privately funded aftercare, nor request that community-based GPs provide components of aftercare and bill the MBS for those services. It is open to patients as a matter of choice to seek private aftercare.

9.2 Private Patients Aftercare

Medicare benefits are not generally payable for any outpatient attendances related to an inpatient episode during an aftercare period. Typically, MBS items designating Medicare benefits payable for inpatient episodes include a component of aftercare. Therefore, no Medicare benefits are paid for aftercare services provided to private admitted patients unless the MBS item descriptor for the procedural service excludes aftercare.

Medicare benefits are payable for attendances following the performance of a procedure where such attendances are not considered to be routine aftercare (i.e., service provided during the aftercare period for a condition unrelated to the operation). Medicare will process the claim more readily if the account states that the service is 'not normal aftercare' or includes a brief reasoning for the additional service.

Medical practitioners are responsible for identifying whether a non-admitted service provided, following an inpatient procedure, is directly related to that inpatient episode and forms part of the patient's aftercare service.