Government of **Western Australia**
Department of **Health**

MBS Billed Non-Admitted Services Manual

health.wa.gov.au

Purpose of this Manual

The purpose of this Manual is:

- To assist medical practitioners and Health Service Providers (HSPs) considering the implementation of MBS billed non-admitted services across WA Health; and
- To assist in ensuring that the operation of MBS billed non-admitted services are sustainable, support patient choice and align with regulation and best clinical and business practice.

Acknowledgement

WA Health would like to acknowledge that this document has been developed and adapted from resources developed by South Australia, Victoria and Queensland Health. WA Health has included information relevant to its jurisdiction, and adapted the information as required to meet the needs of its specific hospitals, health services and legislative requirements.

Contents

Introduction

This manual provides information to assist medical practitioners and Health Service Providers (HSPs) in respect of Medicare Benefit Schedule (MBS) billed non-admitted services.

Medical practitioners and HSPs must comply with the requirements of the MBS, the *Health Insurance Act 1973*, the *National Health Reform Agreement 2011* and other relevant commonwealth and state government legislation.

The types of non-admitted services and the methods of providing these will differ between HSPs, therefore, the information provided in this manual may not apply in full to all non-admitted services in WA. The manual outlines key policy and legislative requirements relating to the operation of MBS billed non-admitted services in HSPs. However, HSPs may require their own legal, financial and/or industrial advice about how these requirements should be met in practice.

Non-Admitted Services Funding Models

Current funding for specialist outpatient services

The majority of WA Health non-admitted services are funded via the Activity Based Funding (ABF) model. The ABF model funds HSPs for the number and mix of patients they treat. Individual HSPs may institute 'caps' or ceilings on this activity as, overall, there is a fixed number of National Weighted Activity Units (NWAUs) available to each health service and to the system more broadly.

It is acknowledged that there are other funding models currently used, however they are in a lessor capacity and not discussed in this document.

Currently there are limited opportunities for growth within the ABF model for provision of specialist outpatient services. This coupled with identified increasing demand poses a challenge for WA Health to meet growing service demands.

The implementation of MBS billed non-admitted services in areas of identified need may optimise revenue opportunities, improve integration of public and private provider arrangements and enable WA Health to better meet services demands, enhancing financial sustainability of the public health system into the future.

MBS Billed Non-Admitted Services in Public Hospitals

Under the MBS, the Commonwealth Government funds medical practitioners for services provided to eligible patients. This funding extends to salaried medical practitioners exercising a right of private practice within the State's public hospitals. The right to private practice is conferred on medical staff under the terms of their own individual employment contract.

There is a long history of MBS billed specialist clinics being located in public hospitals across Australia. In general these services are bulk billed against the relevant item number in the MBS, meaning that there is no additional charge to the patient.

There are many reasons why MBS billed non-admitted services have been established in, or near, public hospitals. These include:

- Providing patients with a choice of receiving treatment as a public or private (MBS billed) patient;
- Enabling salaried medical practitioners to exercise a right of private practice, which is an important tool in recruiting and retaining a skilled medical workforce for public hospitals; and
- The co-location of MBS billed specialist clinics at, or near, public hospitals can assist public hospitals to have available medical practitioners who are able to provide inpatient and outpatient services. It can also broaden the training opportunities for junior medical staff.

Therefore, while the State Government's ABF funding covers the majority of non-admitted services in WA hospitals, MBS funded non-admitted services may also be established.

Overview of legislation and agreements

It is the responsibility of medical practitioners and HSPs to ensure they:

- Comply with all relevant agreements, regulatory requirements including relevant policies, directives and standards; and
- Identify and articulate regulatory requirements to all staff involved in the operation of MBS billed non-admitted services.

Key principles

- MBS billable services must comply with the *Health Insurance Act 1973*
- A professional service provided by a medical practitioner engaging in private practice is rendered under a contract between the clinician and the patient
- Where support staff are involved in providing a service, the treating medical practitioner is responsible for meeting supervision requirements and must also attend to the patient where there is a requirement to do so
- Where contractually agreed, a medical practitioner engaging in private practice authorises the hospital as the agent to undertake the billing process on their behalf and facilitate payment of service fees relating to the medical practitioner's private practice.

Key legislation and agreements

The following legislation and agreements must be observed when implementing MBS billed non-admitted services in public hospitals. The business practice implications of each legislation and agreement have been outlined in the *Business Practice* section.

Medicare Benefits Schedule

The Medicare Benefits Schedule (MBS) lists the professional services that can be claimed against the Commonwealth-funded Medicare system and the requirements that must be met before making such claims.

The MBS can be accessed at:
http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home

The Health Insurance Act

The *Health Insurance Act 1973,* as amended, governs the payment of MBS benefits.

The Act can be accessed at:
http://www.legislation.gov.au/comlaw/management.nsf/lookupindexpagesbyid/IP200401412?OpenDocument

National Healthcare Agreement

The *National Healthcare Agreement 2008* defines the roles and responsibilities that guide the Commonwealth and states and territories in the delivery of services across the health sector, including public hospital services.

The *National Healthcare Agreement 2008* can be accessed at: http://www.federalfinancialrelations.gov.au/content/npa/health/_archive/healthcare_national-agreement.pdf

National Health Reform Agreement

The *National Health Reform Agreement 2011* sets out the funding arrangements for public hospitals and details business rules that give effect to the Medicare Principles, which underpin the *National Healthcare Agreement 2008*.

The *National Health Reform Agreement 2011* can be accessed at: http://www.federalfinancialrelations.gov.au/content/npa/health/_archive/national-agreement.pdf

AMA Industrial Agreement

Through their employment agreements, medical practitioners are granted rights to conduct private practice, consistent with the terms and conditions of their agreement with their employer.

The WA Health System – Medical Practitioners – AMA Industrial Agreement 2016 can be accessed at: http://www.health.wa.gov.au/AwardsAndAgreements/

Medical Indemnity Applying to Salaried Medical Practitioners

The contractual indemnity is a formal contract between the Minister for Health and the individual Salaried Medical Officer providing medical services within or on behalf of the WA public sector health system.

Information on the indemnity, including the terms and conditions, can be accessed at: http://www.health.wa.gov.au/indemnity/salaried/index.cfm

Business Practice

This section provides summary information regarding the business implications of the above legislation and agreements when operating MBS billed non-admitted services in public hospitals. When billing for private consultation services, it is the responsibility of medical practitioners to ensure they comply with the relevant legislation. The requirements have been broadly categorised into the following sections:

- Referral requirements;
- Service requirements;
- Practitioner requirements;
- Procedural Items; and
- Billing requirements.

Referral Requirements

Both the MBS and the *National Health Reform Agreement 2011* impose a number of business rules with respect to the validity of referrals for Medicare billing. For a referral to be valid all of the following 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 medical specialist or consultant physician;
- The referral must be in writing;
- The referral must be signed and dated by the referring doctor;
- The referral must be received on or before the occasion of service to which the referral relates;
- The referral must be made by another medical practitioner; and
- The referral must be addressed to a named medical practitioner who is exercising a right of private practice for the service to be billed against the MBS. 'Dear Doctor' or 'Dear Clinic' referrals are not valid for Medicare billing.

Additionally it is important to note:

- Referral pathways must not be controlled so as to deny access to free public hospital services or so that a named referral is a prerequisite for access to outpatient services
- Patients referred to an outpatient department from an emergency department can only be public (not MBS billed) patients;
- Patients must be able to access 'aftercare' (non-admitted care following an episode of admitted care) free of charge when admitted as a public patient. However, where a public admitted patient independently chooses to consult a private medical specialist for aftercare, then the patient ceases to be a public patient and, subject to a correct referral, the service provided during this attendance may be eligible for Medicare benefits;

- Interdepartmental referrals of private patients are acceptable for Medicare billing (except from the emergency department) if the doctor making the referral has a Medicare Provider number with referral rights for the service;
- HSPs must retain written referrals for a minimum of 18 months from the date of the last service covered by the referral. Note, State Records legislation may be applicable with longer prescribed retention periods;
- Referrals have a defined period commencing from the date of first service rendered under that referral. GP referrals are valid for 12 months unless otherwise specified. Specialist referrals are valid for 3 months. For further information on the 'Active Life of Referrals' refer to the Specialist Outpatient Services Access Policy found here; https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Services-Planning-and-Programs/Mandatory-requirements/Outpatient-Services/Specialist-Outpatient-Services-Access-Policy.

Reference made to a 'referral' for a consultation service in this section does not refer to written 'requests' made for pathology, diagnostic imaging and specific procedural services as specified in the MBS rules.

Service Requirements

In establishing MBS billed non-admitted services the following requirements should be observed:

- Medicare benefits are claimable only for 'clinically relevant' services. A 'clinically relevant' service is defined in the MBS as one which is generally accepted by the relevant profession as necessary for the appropriate treatment of the patient;
- Medicare benefits cannot be paid for services funded under an existing arrangement with the Australian government or a State or Territory government.

Note: As services provided by a practitioner under their right of private practice are rendered under a contract between the practitioner and the patient, and not by, for, or on behalf of the hospital, this is not in breach of this requirement. It is important that MBS billed activity is correctly recorded and reported to ensure such activity does not also attract public (ABF) funding.

Structure of clinics

Where MBS billed services are provided, services for both private and public patients must be available. This can be achieved either by:

- Providing dedicated private (MBS billable) specialist outpatient clinics in parallel to public clinics of the same specialty field; or
- Providing mixed private and public clinics where private and public services are available within the same clinic

Patient Choice

Patients must be provided with the choice of attending as a private (MBS billed) or a public (not MBS billed) patient regardless of whether or not any out of pocket expenses will be incurred.

- Clear and consistent signage and information must be made available to patients to make an informed choice as to whether they wish to be treated as a public or private patient;
- Clerical procedure manuals should contain statements to assist staff to reinforce the capacity for an eligible patient to choose to be a public or private patient where appropriate. An example of what these statements might be are outlined in Appendix 6;

Evidence of the patient's election choice must be recorded for each billable occasion of service.

Communicating with referrers

HSPs should make information accessible to GPs / referrers regarding the referral requirements for specialist outpatient services offered within their jurisdiction. Where MBS billed services are offered the following information should be accessible via the hospital website and/or other appropriate means:

- The specialty areas that offer MBS billed non-admitted services;
- The names of medical practitioners who offer MBS billed non-admitted services in each specialty;
- Information regarding any financial implications for patients (i.e. bulk-billed or a gap); and
- Why a GP might choose to make a referral to a MBS billed non-admitted service.

HSPs can make appropriate communication with GPs / referrers to support referrals meeting the requirements to enable MBS billing. Appendix 5 has sample letter templates that may be used to advise GPs / referrers of referral options for MBS billed services.

Practitioner Requirements

In order for a non-admitted service to be claimable against the Medicare system a number of medical practitioner requirements must be met including:

- The medical practitioner must be recognised as a specialist or consultant physician as specified under the *Health Insurance Act 1973*. (Medical practitioners registered in an approved specialist trainee program as specified under section 3GA of the *Health Insurance Act 1973* can provide limited services that will attract Medicare benefits);
- The medical practitioner must have a valid provider number for the location where the services are provided;
- A provider number must not be used to claim against the MBS without the expressed permission from the medical practitioner. A written agreement between the HSP and medical practitioner should be established as evidence;

- Medical services (specified in G.12.1 of the MBS) will only attract benefits if they have been personally performed by the medical specialist. The obligation for personal attendance by the medical specialist applies whether or not another person provides essential assistance in accordance with accepted medical standards;
- Medical services including, those in Categories 2 and 3 which are not listed in section G.12.1 of the MBS and Category 5 (Diagnostic Imaging) services, continue to attract Medicare benefits if the service is rendered by:
    - The medical practitioner in whose name the service is being claimed; and
    - A person, other than a medical practitioner, who is employed by a medical practitioner or, in accordance with accepted medical practice, acts under the supervision of a medical practitioner;
- Where professional services are rendered on behalf of medical practitioners, it is the responsibility of the medical practitioner to provide supervision. The supervising medical practitioner need not be present for the entire service, however they must have direct involvement in at least part of the service;
- Medical practitioners must maintain adequate and contemporaneous records of all services attracting a Medicare benefit payment;
- Where the specific medical practitioner is unavailable, another medical specialist in the same clinic (exercising a right of private practice) may see the patient for and on behalf of the specialist as a private patient, provided both medical specialists have equal qualifications in the same discipline;
- Processes must be in place that provide the medical practitioner with evidence (which would satisfy Medicare Australia) that the patient has chosen to be treated privately;
- The medical practitioner is responsible for determining and assigning the clinically appropriate item number(s) to the non-admitted service. This responsibility cannot be assigned.

Procedural Items

Procedural, pathology and diagnostic imaging services can attract a benefit from Medicare. The following requirements must be observed:

Requests versus referrals for procedural services

- Under MBS billing rules, procedural services do not require a named referral (see section G.6.1). Procedural services are accessed via a request for service (i.e. a request form). Reference should be made to the MBS to identify relevant procedural services;
- It is not necessary that a written request for a diagnostic imaging service be addressed to a particular provider or that, if the request is addressed to a particular provider, the service must be rendered by that provider;
- The requesting doctor's provider number details, including the requesting doctor's provider number must be present on the 'request for service' to facilitate billing against the MBS;

Separation of service

- Where a radiology or pathology service is performed or partly performed during a public appointment time/occasion of service, then that service is considered to be a component of the public appointment time/occasion of service and must be provided free of charge;
- Equally, where a radiology or pathology service is performed or partly performed during a private appointment time/occasion of service, then that service is considered to be a component of the private appointment/occasion of service and can be billed against the MBS;
- Where a radiology or pathology service is provided separately to the appointment time/occasion of service, then this is considered to be a separate service to the appointment. A new patient election point arises in relation to that radiology or pathology service which can be billed against the MBS if the patient elects to be treated privately;
- Evidence of the patient's election for separate MBS billable services must be recorded on all occasions.

Billing Requirements

Although it is usual for private medical services offered in public hospitals to be bulk billed to Medicare, the medical practitioner, exercising their right of private practice, may choose not to bulk bill. In this instance, the medical practitioner will raise a charge for the full fee and the patient will claim a benefit from Medicare, resulting in a 'gap'.

- Unless otherwise agreed with the HSP, the maximum fee charged by a clinician for professional services will be an amount which achieves a no-gap result for the patient who has chosen to be treated privately;
- Where fees for professional services result in out of pocket expenses to the patient, this may only occur if the patient has provided informed financial consent prior to the service.
- The amount billed by the medical practitioner for a private patient service is based on the MBS. Each item number in the MBS specifies the services covered and in some cases specific requirements for the service provided.

Assignment of Benefit Form

Patients are required to sign a Medicare 'Assignment of Benefit' form (referred to as the DB2 or DB4) for direct bulk billing to Medicare to occur.

The legislative requirements for the assignment of benefit are:

- An agreement must be made between the patient (assignor) and the billing 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 after the service is completed; and
- A copy of the agreement must be provided to the patient.

Patients should be reminded to bring their Medicare card to their outpatient appointment and it should be noted that it is a legal requirement that patients cannot sign the Assignment of Benefit form until after the service has been completed.

- If a patient leaves without signing, the Assignment of Benefit form can be mailed to the patient for signing. Clerical processes should be robust to ensure that patients do not leave without signing.
- If a patient is unable to sign, the patient's parent/guardian or other responsible person may complete the form. However, the responsible person must be somebody other than the practitioner or hospital staff. The reason that the patient is unable to sign should also be stated. If a responsible person is unavailable, the patient's signature section should be left blank and an explanation given (e.g. broken arm) in the practitioner's use section as to why the patient was unable to sign. This note should be signed or initialled by the practitioner.

Hospital copies of Assignment of Benefit forms are no longer required to be stored by the HSP if Medicare Online is used. However, if Medicare needs to confirm that the service was provided to a patient, they may seek alternative evidence that the service was provided.

Evidence may include:

- Electronic billing information;
- Notes in the HSP's medical record and patient administration system; and
- If the HSP chooses to retain them, a copy of the Assignment of Benefit forms.

For manually submitted bulk bill claims, it is recommended HSPs keep a copy of the signed Medicare assignment of benefit form for a period of 2 years from the date of service to ensure claims can be substantiated if requested to do so by Medicare.

Reporting and Assurance

- A weekly reconciliation of patients and MBS items is recommended;
- In accordance with the AMA Industrial Agreement HSPs must provide medical practitioners with quarterly statements to enable medical practitioners to reconcile activity that is being billed against their provider number, and ensure that incorrect billing is not occurring;
- Further information relating to compliance with billing Medicare can be accessed via the Australian Government, Department of Health website. This information will assist in understanding the legal obligations when billing under Medicare for patients in public hospitals.

Remuneration Models

There are three main types of MBS billed non-admitted services that HSPs may consider. These are:

- Arrangement A Model;
- Arrangement B Model; and
- Licensed MBS Model

The decision about which model to employ must occur in agreement between the HSP and medical practitioner.

Arrangement A Model

- The medical practitioner is exercising their right of private practice to see patients that elect to be treated privately;
- The medical practitioner authorises their employer to act as an agent for the purposes of billing the services to Medicare;
- All private practice income rendered in the HSP is assigned to medical practitioner's employer;
- In exchange, the employer gives the medical practitioner access to staff, facilities and equipment to support the care of private patients. The Arrangement A salary rate is also paid to compensate for the foregone private income;
- Private patients are seen during the medical practitioner's contracted hours of work, as per their agreement with the HSP;
- Arrangement A medical practitioners exercising their rights to private practice are covered under the WA Health Indemnity.

Arrangement B Model

- The medical practitioner is exercising their rights of private practice to see patients that elect to be treated privately;
- The employer may be authorised to render accounts in the practitioner's name and provide use of facilities, administrative and nursing support;
- The medical practitioner retains the private practice (including MBS) revenue they generate and pays an agreed proportion to the HSP for use of facilities, administrative and nursing support;
- The WA Health System Medical Practitioners AMA Industrial Agreement 2016 specifies what is retained by the medical practitioner and what is retained by the hospital as facility and administrative fees. Medical practitioners can retain a proportion of their private practice earnings up to an agreed amount;
- Private patients are seen during the medical practitioner's contracted hours of work, as per their agreement with the HSP;

Licensed MBS Model

- The medical practitioner has entered into a commercial relationship with the HSP to pay for the use of facilities to operate their own standalone private practice.
- Any private practice conducted under this model is outside of employment in WA Health and is completely separate from any services rendered in connection with WA Health employment.
- As part of the commercial arrangement with the medical practitioner, the HSP may agree to provide, in return for payment, a number of services including but not limited to:
    - Billing service;
    - Medical Record service;
    - Clinical and clerical support staff; and
    - Sterilisation/equipment
- The use of a site for the private practice can either be through a lease or a license agreement. This service arrangement must have a commercial basis for the services used by the private practice.
- There must be documentation of the agreement between the parties. Such an agreement should contain the core components expected of any contract with an external party. Assurance should be sought that the medical practitioner has their own indemnity coverage for provision of their medical services.

This arrangement can occur where:

- A part time medical practitioner is performing services in their non-WA Health employment capacity (i.e. outside their employment rights of private practice agreement and paid FTE);
- A clinical academic is conducting private practice independently in their own right that is not in connection with their WA Health employment; and
- A visiting medical practitioner is performing services in their private non-WA Health capacity and is not being remunerated by WA Health for the service.

Management of Revenue

- Under agreement with medical practitioners HSPs can take on the functions of billing, collection and distribution of MBS billed non-admitted services revenue. Accurate and timely process monitoring mechanisms should be implemented;
- Revenue raised by hospitals through the operation of MBS billed non-admitted services can be returned to the HSP that generated the revenue.
- HSPs through their executive teams can determine how the revenue is allocated, accessed and used in line with appropriate WA Health legislative and accounting frameworks;
- Where a medical practitioner is engaged under Arrangement A, HSPs as the billing agents acting on behalf of the clinician, retain 100 per cent of all revenue through the tax invoice method;
- Where a medical practitioner is engaged under Arrangement B, HSPs as the billing agents acting on behalf of the clinician raise service fees in accordance with the WA Health fees and charges register, and the provisions set out in the medical practitioner's employment agreement;
- MBS rates in many categories are not designed to fund full practice costs and hence generating income solely from MBS revenue may not cover costs. HSPs will need to undertake local financial analysis to determine where the operation of MBS billed non-admitted services is viable, with particular regard to the ABF model, and may require review annually;
- HSPs are encouraged to contact the Department of Health's Revenue Strategy and Support Unit who can assist with analysis.

Service fees for Arrangement B model

- The right to exercise private practice is granted on the proviso that this occurs alongside employment to treat public patients. Service fees are payable by medical practitioners delivering MBS billed non-admitted services under Arrangement B as contribution to costs relating to service delivery. Service fees are calculated as a percentage of the collected gross billings for a private outpatient service.

Disbursement of revenue and service fees

Service fees collected under Arrangement B and revenue received under Arrangement A will be used by HSPs to cover the costs of operating MBS billed non-admitted services, which may include:

- Office space including utilities
- Business equipment (including information and communication technology)
- Off-the-shelf consumables
- Patient transport
- Interpreting services

- Cleaning and sterilisation of equipment
- Equipment loan services
- Patient record management
- Referral management to ensure referrals are valid and active
- Booking and scheduling of appointments
- Clinic nursing and support services
- Billing processes to ensure all necessary information is included and accurate before it is submitted to Medicare.

Revenue generated via MBS billed non-admitted services will be accounted for in accordance with the *Financial Management Act 2006*.

- HSPs should ensure that clear processes with appropriate monitoring and controls are in place for all billing and disbursement of revenue requirements;
- Access to, and use of funds should be clearly outlined in an agreement between the contributing medical practitioner(s) and the employing HSP.

Governance, Performance and Accountability

The delivery of MBS billed non-admitted services must be effectively managed and monitored to achieve key deliverables and desired outcomes. HSPs should:

- Ensure appropriate and effective governance is established and sustained. For example, meaningful key performance indicators are set and used as a tool to measure scheme performance;
- Establish a local performance and governance approach that clearly defines objectives and performance expectations, with a central point of accountability to ensure that local private practice activities achieve their objectives in a sustainable manner; and
- Ensure internal controls are in place to ensure overall business integrity and compliance with policies, directives and frameworks.

Governance Approach

Medical practitioners, together with HSPs, are responsible for the successful implementation and operation of MBS billed non-admitted services at the local level and should implement a robust governance framework to ensure the following:

- Compliance with Commonwealth and State legislation, policies and directives;
- Local operational policy is developed and implemented;
- Objectives of MBS billed non-admitted services and outcomes are clearly defined and regularly measured against key performance indicators and remedial action is taken where appropriate;
- Robust governance and internal controls are maintained;
- Establish and monitor performance criteria to ensure the delivery of MBS billed non-admitted services achieve their desired outcomes in a sustainable manner; and
- Initiate remedial action where required and/or escalate the matter where appropriate.

Performance and Accountability

Internal controls should be in place to ensure:

- The activities of private practice are conducted in a manner that facilitates the achievement of its objectives and the delivery of its services in an orderly and efficient manner;
- Error, fraud and other irregularities are prevented as much as possible and promptly detected through a systematic approach if they do occur;
- Assets and consumables used in the delivery of MBS billed non-admitted services are safe-guarded from unauthorised use or disposal and are adequately maintained and monitored; and
- Financial and management performance reports are timely, relevant, reliable and accurate.

Staff Education

Best practice suggests that staff who undertake duties specific to the delivery of MBS billed non-admitted services should be supported by an education framework that provides access to training resources to enable them to successfully undertake those duties.

- All staff involved in the delivery of MBS billed non-admitted services should have access to, and should regularly participate in appropriate education activities; and
- Comprehensive training programs and educational material should be provided to target audiences in various forms to facilitate compliance and support clinicians in the effective delivery of MBS billed non-admitted services.

The regulatory and legislative instruments that govern the business operation of participation in the delivery of MBS billed non-admitted services are complex and should be well understood prior to engaging in these activities. Staff (both clinical and support) require information that clearly defines their roles and responsibilities and outlines the correct processes to be undertaken.

The following principles should be considered when developing local education and training standards and programs:

- To foster and support a collegiate environment for employees to participate in the delivery of MBS billed non-admitted services through the terms of their engagement by:
    - Providing educational tools and training to facilitate compliance, and support clinicians and support staff in the effective delivery of MBS billed non-admitted services
    - Developing and maintaining high quality teaching and learning resources for all staff involved in MBS billed non-admitted services activities.
- To facilitate best practice it is desired that staff have a working knowledge of this Manual. Training packages and educational materials should be provided in various forms to suit the audience (e.g. power point presentations, online training etc.).

Locally tailored training packages should be developed and delivered to staffing groups as suggested in the following table:

Audience	Training Focus
Boards and executives	Understanding of the supporting documents
Finance managers, directors of medical services and senior management	Comprehensive training on the legislation and agreements impacting on MBS billing. Comprehensive understanding of private patient funding and the cost drivers relevant to private and public patient services
Medical practitioners	Comprehensive training with particular focus and support on MBS
Private practice / revenue managers	Expert level competency, with training focusing on the MBS, the relevant legislation and agreements. Comprehensive understanding of private patient funding and the

Audience	Training Focus
	cost drivers relevant to private and public patient services.
Private practice support and administration staff	Comprehensive understanding of the MBS and supporting documents, in particular the key requirements.

Appendix 1: Links to Additional Information

1. MBS Online and the Medicare Benefits Schedule
   http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home

2. Australian Government Department of Health: Billing Medicare in public hospitals
   http://www.health.gov.au/internet/main/publishing.nsf/Content/ph-compliance-billing-medicare

3. Australian Government Department of Health: Health provider compliance audits and reviews
   http://www.health.gov.au/internet/main/publishing.nsf/Content/compliance-audits-and-review

4. WA Health System – Medical Practitioners – AMA Industrial Agreement 2016
   http://www.health.wa.gov.au/AwardsAndAgreements/docs/WA%20Health%20System%20-%20Medical%20Practitioners%20-%20AMA%20Industrial%20Agreement%202016.pdf

5. Health Insurance Act 1973
   http://www.legislation.gov.au/comlaw/management.nsf/lookupindexpagesbyid/IP200401412?OpenDocument

6. National Healthcare Agreement 2012
   http://www.federalfinancialrelations.gov.au/content/npa/health/_archive/healthcare_national-agreement.pdf

7. National Health Reform Agreement 2011
   http://www.federalfinancialrelations.gov.au/content/npa/health/_archive/national-agreement.pdf

8. WA Health Medical Indemnity Publications
   http://www.health.wa.gov.au/indemnity/salaried/index.cfm

9. Financial Management Act 2006
   https://www.slp.wa.gov.au/legislation/statutes.nsf/main_mrtitle_333_homepage.html

10. Specialist Outpatient Services Access Policy
    http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=13112

Appendix 2: Summary of Key Requirements

The table below has been collated as a guide only to assist with the assessment of key requirements when entering into arrangements to deliver MBS billed non-admitted services.

Criteria	
1	**Referral**
1.01	A 'valid' referral has been received: - Documented in writing - Signed and dated by the referring medical specialist - Referred by another medical practitioner (not referring to self) - Received on or prior to the patient's first occasion of service - Addressed to a named medical specialist who is exercising a right of private practice
1.02	The referral is not from an Emergency Department
1.03	The referral is not for aftercare (post admission) - unless a public admitted patient has independently chosen to consult a private medical specialist for their aftercare and a compliant referral has been received
1.04	For procedural / diagnostic services a valid 'request for service' has been received (does not need to be named)
1.05	Referral pathways are not controlled so that a referral to a named medical practitioner is a prerequisite for access to outpatient services
2	**Scheduling**
2.01	The patient is scheduled to be seen in accordance with clinical need
2.02	The service is not offered on an exclusively private basis (equivalent public services in the same specialty field are accessible)
2.03	The referral is active at the time of the appointment (for subsequent appointments)
3	**Consultation / Treatment**
3.01	The patient is Medicare eligible
3.02	Clear and consistent signage and information materials are accessible to ensure that eligible patients who have elected to be treated as private patients have done so on the basis of informed financial consent
3.03	The patient has freely been given the choice between public or private even if the patient does not incur any out of pocket expenses
3.04	Acceptable evidence of the patient's election has been recorded and provided to the practitioner
3.05	The practitioner is recognised as a specialist or consultant physician as specified under the *Health Insurance Act 1973*
3.06	The practitioner has a valid provider number for the location where the service is being provided
3.07	The practitioner is exercising a right of private practice
3.08	Where the named practitioner is unable to consult the patient a different medical specialist with equal qualifications within the same discipline consults the patient
3.09	The consultative services are being provided personally OR the procedural services performed by trainees are personally and continuously supervised

Criteria	
3.10	Adequate and contemporaneous records of all services are kept
3.11	The patient is provided with an Assignment of Benefit form to sign and keep after the consultation
4	**Billing**
4.01	The practitioner personally determines the item numbers to be billed
4.02	Only clinically relevant services listed in the MBS are claimed
4.03	Claims are not made against a provider number without the expressed permission of the practitioner
4.04	Additional services (pathology, diagnostics and procedural items) performed or partly performed during the appointment are considered a component of that appointment
4.05	The MBS billed service is correctly coded so as to not attract funding under any other Commonwealth or State arrangement
4.06	The practitioner accepts the relevant Medicare benefit as full payment where services are bulk-billed (additional fees are not raised against the patient)
4.07	Written referrals are retained for a period of at least 18 months from the date of the last service covered by the referral (longer periods may exist under State Records legislation)
5	**Reporting**
5.01	The practitioner is provided with regular reports (at least quarterly) detailing MBS revenue earned and paid over against their provider number
5.02	The practitioner is able to regularly review reports to ensure claims align with what they have authorised
6	**Evaluation**
6.01	Local financial modelling is conducted to determine where the operation of MBS billed non-admitted services is viable
6.02	Information is available and accessible to referrers regarding the MBS billable services offered and the names of the medical practitioners offering those services
6.03	Regular training and education for all staff involved with the conduct of MBS billed non-admitted services is provided
6.04	Procedures exist for the escalation of issues and correction of billing errors
6.05	A clear process with appropriate monitoring and controls is in place for all billing and disbursement of revenue including how funds are accessed and used
6.06	Procedures are regularly reviewed and align with the manual and relevant legislation
6.07	Audits are conducted on accounts rendered to ensure compliance with relevant Acts and guidelines

Appendix 3: Frequently Asked Questions

Benefit and Compliance Questions

What are the benefits of MBS-billable outpatient services?

There are a number of reasons to develop more MBS-Billable in public hospitals.

These include:

- There are limited opportunities to expand service delivery within the existing ABF funding model. For hospitals and health service to meet the increasing demand for access to outpatient services, we must look at alternate options to deliver care. Utilising a combination of ABF funded and MBS-billable outpatient services enables WA Health to maximise growth within available resources, and ensure financial sustainability over time.
- Increases patient choice – by increasing the availability of MBS-billable outpatient services, patients have more choice in the way they receive their care in the outpatient sector.
- Offering different remuneration models for outpatient services is an opportunity for WA Health to attract and retain a quality workforce by offering differing employment conditions that meet the needs of the medical practitioner and health services.
- It provides an opportunity for optimal resource use within the system – both fixed assets and human capital).
- Increasing revenue opportunities within the system supports overall improvements in health care delivery and providing quality patient services.

How will this improve patient access to care?

There are limited opportunities for growth within existing activity-based funded specialist outpatient services. By establishing MBS-billable clinics, hospitals and health services will receive revenue from the Commonwealth for those patients seen under this model. This allows for service expansion, and thus improves access for patients to care.

Will MBS-billable clinics eventually replace existing specialist outpatient services across the system?

No. Public specialist outpatient services will be maintained across the system. It is a Commonwealth requirement for public hospital services to be provided to patients free of charge (i.e. with no billing against the MBS). In other words, outpatient clinics cannot be provided on an exclusively private basis.

It is the expectation that MBS-billable services will be established within specific specialty areas, as identified by the HSPs to have a business (i.e. be financially viable) and clinical need, and these services will be established to receive new referrals to the system only.

Existing referrals within the system would continue to be seen by services currently provided under ABF funded specialist outpatient services.

How does this initiative achieve compliance with 19(2) of the Commonwealth health Insurance Act (1973)?

In the circumstance when the provision of service by the medical practitioner is pursuant to his or her right of private practice, this service is rendered under a contract between the practitioner and the patient, and not by, for, or on behalf of the hospital.

Given this agreement to be treated as a private patient between the patient and medical practitioner, medical practitioners exercising rights of private practice in public hospitals does not constitute a breach of section 19(2) of the Act.

Does this initiative contravene the "cost shifting" provisions of the Australian Healthcare Agreement?

No. The National Health Reform Agreement, consistently with the Health Insurance Act 1973, explicitly permits patients to choose to be treated as a private patient through referral to a named medical practitioner exercising a right of private practice at a public hospital outpatient department. (Business Rule G19 National Health Reform Agreement)

Medicare Australia has a legitimate interest in ensuring that Medicare funds are properly incurred. Western Australia is fully within its rights to seek the correct funding outcome for patients who are properly classed as privately referred, non-inpatients. Unlike other States and Territories, WA has made minimal use of the provisions in the Agreement that permits the private referral of patients.

What will happen to PRNI?

The Privately Referred Non-Inpatient (PRNI) remuneration model offered doctors a financial benefit for treating private patients – PRNI had a limited implementation and has essentially ceased to operate with the exception of a very small number of doctors.

In preparation for the implementation of MBS-billable clinics it is a recommendation to allow those doctors that are currently utilising PRNI arrangements to continue to see patients under this model, but cease the arrangement being available for doctors to sign up to in the future.

Patient Questions

What choices are available for patients?

Eligible patients must be given the choice to be treated as a private patient (i.e. Medicare billed) or a public patient (i.e. not Medicare billed). Patients must be informed of any financial implications of a decision to be treated as a private patient prior to making their election choice.

All patients, regardless of their choice to be treated as a public or private patient, must be seen and prioritised on the basis of clinical need.

Where a specialist outpatient service is available to private outpatients within a HSP, a public service in the same speciality field must also be made available.

Public patients

- are treated free of charge and there is no billing to Medicare.
- do not see a doctor of choice and will be seen by a doctor chosen by the hospital.

Private patients

- are mostly bulk billed to Medicare so there is no out of pocket expense to the patient (exceptions may apply however patients will be made fully aware of any costs prior to election)
- normally see the doctor they are referred to, who may supervise other components of the service for which the patient is referred. Where the doctor the patient has been referred to is unavailable, another doctor of equal qualification (exercising their rights of private practice) may see the patient on behalf of the named medical specialist.

Will this initiative adversely affect access to medical services by patients who wish to be treated as public patients?

No. Whether patients elect to be treated as private patients will be immaterial in terms of how they are prioritised for clinical purposes and patients will continue to be seen on the basis of clinical need.

What happens to patient care?

There will be no change to the way patients are treated. Patients will continue to be treated according to their clinical presentation, not related to their election to be treated publicly or privately.

It is the patient's choice to elect to be treated privately, and therefore referred to an MBS billable clinic. The patient always has the right to be treated publicly.

Can clinics be in the same physical location as public outpatient clinics? i.e. can hospitals provide mixed clinics?

Yes. There needs to be clear and transparent processes for differentiating between MBS billable patients, and those seen as public patients funded under ABF.

Hospitals are required to display clear signage and institute appropriate guidelines and procedures that enable the patient to make an informed choice to be treated as a public or private (Medicare billed) patient. That is, it should be clearly displayed whether the clinic is private, public or mixed, and that all clinical decisions are made based on the presenting clinical requirements of the patient and this is not influenced by their election of private or public status.

Referral Questions

What are the referral requirements?

To enable Medicare billing, all of the MBS requirements listed below must be met.

- The referral must be in writing;

- The referral must be signed and dated by the referring doctor;
- The referral must be received on or before the service is provided to the patient and;
- The referring doctor must have seen the patient, and turned his/her mind to the patient's need for referral.

Additionally, the NHRA 2011 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. The referral therefore needs to be addressed specifically to a named medical specialist and 'Dear Doctor' or 'Dear Clinic' referrals are not valid for Medicare billing.

Can referrals come from within the hospital?

From ED: No. Patients referred from the emergency department to outpatients cannot be billed against the MBS.

From Inpatients: Patients must be able to access 'aftercare' (non-admitted care following an episode of admitted care) free of charge when admitted as a public patient. However, where a public admitted patient independently chooses to consult a private medical specialist for aftercare, the service provided during this attendance will attract Medicare benefits as long as all mandated referral requirements have been met.

From another Outpatient department: A medical practitioner seeing a patient in a private capacity can refer the patient to a practitioner of another specialty. The patient must elect to be private before Medicare benefits are claimed for the separate service or attendance.

How long are referrals valid?

Referrals from a GP are valid for 12 months.

- GP referrals can be valid for a longer or shorter period; the GP can indicate in writing 3 months, 6 months, 18 months or indefinite.
- Referrals valid for longer than 12 months should only be used where the patient's clinical condition requires continuing care and management of a specialist or consultant physician for a specific condition or specific conditions.

Referrals from a specialist are valid for 3 months only.

What is meant by the referral period?

The referral is valid from the date of the first service covered by the referral.

Example:

- A GP referral is dated 1 September 2016.
- The first consultation covered by the referral occurs 1 February 2017.
- The referral is valid until 1 February 2018 (i.e. 12 months from the date of the first consult; not from the date of referral).

Who can refer / request?

- Referrals are to be made by another medical practitioner

- A referral from a hospital registrar is valid for Medicare billing, if the registrar has a Medicare Provider Number for the site with referral rights
- The general practitioner is regarded as the primary source of referrals
- Cross referrals between specialists and/or consultant physicians are acceptable but generally should occur in consultation with the patient's general practitioner

How long do referrals need to be kept?

Medicare requires written referrals to be retained for 18 months from the date of the last service covered by the referral.

How will patients and GPs know what MBS billed services are available?

In order for a patient to access an MBS billed service they must have a named referral to the medical practitioner. Referral guidelines for MBS billed non-admitted services will need to be made available by HSPs and communicated to GPs and referrers, for example on hospital internet sites.

The Central Referral Service (CRS) will continue to support referral allocation to named specialists who provide MBS billed Specialist Outpatient Services.

It is recommended that HSPs provide information to WAPHA/HealthPathways and the CRS regarding which clinics require a named referral in order to support referral flow.

Practitioner Questions

Can a hospital GP, Registrar or Nurse Practitioner provide MBS billed services in Public Hospitals?

No. Under the NHRA 2011, only medical specialists can claim Medicare benefits for outpatient services provided in a public hospital setting.

The only exception is where the Commonwealth Minister for Health and Ageing specifically approves GP billing under section 19(2) of the Health Insurance Act 1973.

Does the billing doctor need to personally provide the attendance to the patient?

Yes. Medical consultation services and other medical services specified in section G.12.1 of the MBS will attract Medicare benefits only if they have been personally performed by the medical specialist.

Only medical services specified in section G.12.2 of the MBS will attract Medicare benefits if the service is rendered by, or on behalf of the medical practitioner in whose name the service is being claimed. If the service is being rendered on behalf of the medical specialist, the medical specialist must provide supervision, take full responsibility for the service provided and have direct involvement in at least part of the service.

It is the billing specialist's responsibility to ensure compliance with the Medicare billing rules and the NHRA 2011 business rules.

What are the Indemnity requirements for medical practitioners?

Indemnity is a formal contract between the HSP and an eligible medical practitioner, whereby and subject to the Terms and Conditions the Minister undertakes to indemnify the eligible medical practitioner for any claims of negligence, omission or trespass that may arise from the treatment of public or private patients in public hospitals or other agreed health care institutions.

Medical practitioners should be familiar with the particular conditions of their employment arrangement to understand their indemnity relevant to exercising their right to private practice.

In summary, salaried medical practitioners employed by a public hospital with a right to private practice who are providing MBS-billed specialist outpatient services under Arrangement A are covered under the WA Health Indemnity policy.

Medical practitioners operating under Arrangement B or a private MBS specialist model are not covered under the WA Health Indemnity policy and therefore need to rely on their own insurance. (Note, practitioners operating under Arrangement B within regional areas are covered under the WA Health Indemnity policy).

Specific information relating to indemnity for Salaried Medical Officers can be accessed via:

http://www.health.wa.gov.au/indemnity/salaried/index.cfm

Procedural Questions

Is a named referral required for MBS billed procedural services?

A request for service, rather than a named referral, is required in order for procedural services to attract Medicare benefits. Reference should be made to the MBS to identify the requirements for relevant procedural services.

When can a procedural service be MBS billed?

Procedural services can be MBS billed where:

- There is a request for service; and
- The procedural service is carried out by a medical specialist exercising a right of private practice; and
- The procedure is carried out either during a private specialist outpatient consultation service or, at a separate occasion of service where the patient has elected to be a private patient.

Can pathology and radiology be MBS billed?

Yes. Patients who elect to be treated as a private (MBS billable) patient in a public hospital specialist outpatient clinic can receive MBS billed pathology and diagnostic imaging services.

Billing Questions

Can the Medicare Voucher or Assignment of Benefit Form be signed before the patient is seen?

No. It is a Medicare requirement that the patient signs the form after receiving the service.

Will participating doctors be provided with regular statements as to monies raised in their name?

Yes. Hospitals have billing software compliant with Medicare billing requirements and capable of reporting this information. Each medical practitioner should be provided with the information as requested or, at a minimum, quarterly.

How will the revenue be managed that is generated through the operation of MBS billed non-admitted services?

Revenue raised by hospitals through the operation of MBS billed non-admitted services can be returned to the HSP that generated the revenue.

HSPs through their Executive teams can determine how the revenue is allocated, accessed and used in line with the appropriate WA health system legislative and accounting frameworks. Revenue gained through these arrangements may be used to support improvements in health care delivery at a local level.

Will MBS billed non-admitted services be financially viable?

Before establishing any MBS billed services, HSPs should undertake local financial analysis for the intended clinical specialty areas. MBS billed services should support the business requirements of HSPs in achieving efficient and cost-effective service delivery. HSPs are encouraged to contact the Department of Health's Revenue Strategy and Support Unit for access to modelling tools which can assist with local analysis.

Appendix 4: Sample Patient Signage

HSPs should use consistent signage to support a patient's private election.

The following sample signage can be used in all non-admitted service areas depending on the type of MBS service provided:

Fully Private Clinic – Bulk Billed

This is a private Medicare bulk billed clinic. You will incur no out of pocket expense. Please present your Medicare card.

You have the choice to be seen as a public (non bulk billed) patient. Public outpatient services are available at:

[insert name of clinic, location and contact phone number]

Fully Private Clinic – Not Bulk Billed

This is a private patient clinic.

You may incur an out of pocket expense. Please discuss this with your doctor, or reception staff.

You have the choice to be seen as a public patient free of charge. Public outpatient services are available at:

[insert name of clinic, location and contact phone number]

Mixed Private/Public Clinic – Bulk Billed

Public or Medicare Bulk Billed – It's Your Choice

You have the choice to be Medicare bulk billed (private) or a public outpatient.

Medicare bulk billing helps the specialist and hospital provide better services and equipment.

You will incur no out of pocket expense.

You also have the choice to be seen as a public (non bulk billed) patient. Public patients do not have a choice of doctor.

Mixed Private/Public Clinic – Not Bulk Billed

Public or Private – It's Your Choice

You have the choice to be a private or a public outpatient.

A private patient can usually see the doctor of choice.

A private patient may incur an out of pocket expense. Please discuss this with your doctor, or reception staff.

You have the choice to be seen as a public patient free of charge. Public patients do not have a choice of doctor.

Radiology/Pathology Signage

Public or Medicare Bulk Billed – It's Your Choice

You have the choice to be Medicare bulk billed (private) or a public outpatient.

Medicare bulk billing helps the hospital to provide better services and equipment.

You will incur no out of pocket expense. Just present your Medicare card.

You also have the choice to be seen as a public (non bulk billed) patient. Please advise reception staff of your choice.

Appendix 5: Sample Letters for Referrers and Patients

Sample letter to referrer: for use when a named referral has not been received

[Date]

[Referrer's Address Details]

Dear [Referrer Name]

Our records indicate that you are the referring Medical Practitioner for [Patient Name], DOB [Patient DOB] who has been referred for a Specialist Outpatient Service with [Hospital] [Specialty].

[Hospital] [Specialty] provides both private (Medicare bulk billed) and public services. Patients have the choice to be treated either as a private or public patient.

In accordance with the National Health Reform Agreement 2011 business rules, if your patient wishes to see their doctor of choice as a private (bulk billed) patient, a named referral to one of our consultants is required.

If your patient does not have a named referral, they will be treated as a public patient of the hospital by the doctor on duty.

To enable your patient to elect to be treated as either a public or private (Medicare bulk billed) patient, please complete and provide a new referral marked to the attention of [Clinic Consultant's Name].

If you have any queries in relation to this matter, please do not hesitate to contact the [Hospital] Outpatient Department.

Thank you for your assistance in this matter.

Kind regards

[Hospital] Outpatient Department

Sample letter to referrer: for use when a referral has expired

[Date]

[Referrer's Address Details]

Dear [Referrer Name]

Our records indicate that you referred [Patient Name], DOB [Patient's DOB] for a Specialist Outpatient Service with [Hospital] [Specialty]. The initial referral has expired and as such we request a new referral.

[Hospital] [Specialty] provides both private (Medicare bulk billed) and public services. Patients have the choice to be treated either as a private or public patient.

In accordance with the National Health Reform Agreement 2011 business rules, if your patient wishes to see their doctor of choice as a private (Medicare bulk billed) patient, a named referral to one of our consultants is required.

If your patient does not have a named referral, they will be treated as a public patient of the hospital by the doctor on duty.

If you would like your patient to have the choice to be seen as a private or public patient, please complete and provide a new referral marked to the attention of [Clinic Consultant's Name].

If you have any queries, please do not hesitate to contact the [Hospital] Outpatient Department.

Thank you for your assistance in this matter.

Yours sincerely

[Hospital] Outpatient Department

Sample letter to patient: for use when a referral has expired

[Date]

[Patient or Parent / Guardian's Address Details]

Dear [Patient Name or Parent / Guardian Name]

Our records indicate that [Referrer Name] was your referring medical practitioner when you first attended the [Clinic Name] clinic at [Hospital].

In accordance with the National Health Reform Agreement 2011 business rules, if you wish to see your doctor of choice as a private (Medicare bulk billed) patient, a named referral to one of our consultants is required.

Your initial referral has expired and we have been unable to obtain a new referral from [Referrer Name].

We therefore need you to advise your General Practitioner that a new referral is required marked to the attention of [Clinic Consultant's Name] before your next appointment.

You have the choice to be seen as a public patient. If you choose to be a public patient (without a named referral) you will be seen by the doctor on duty.

If you have any queries in relation to this matter, please do not hesitate to contact the [Hospital] Outpatient Department.

Thank you for your assistance in this matter.

Yours sincerely

[Hospital] Outpatient Department

Appendix 6: Sample Script for Administration Staff

The sample script below can guide outpatient administration staff as to what to consider when speaking to patients about the choice to be treated as a private or public patient.

Hello

Did you know that you have the choice to be treated as a private Medicare bulk billed or a public outpatient?

Medicare bulk billing helps the Doctor and the hospital provide better services and equipment.

You will not incur any out of pocket expense.

Would you like to be treated as a bulk billed private patient?

More information is provided in the patient information brochure.

This document can be made available in alternative formats
on request for a person with a disability.