PRIMARY HEALTH NETWORK

Medicare Benefits Schedule (MBS) Overview

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16 March 2023

WE ACKNOWLEDGE THE TRADITIONAL OWNERS & CUSTODIANS OF THE LAND THAT WE LIVE & WORK ON AS THE FIRST PEOPLE OF THIS COUNTRY.

LEARNING OUTCOMES

- Perform accurate MBS billing processes
- Determine what MBS item the patient is eligible for
- Clarify procedure for compliance

MEDICARE AND BILLING

Practice billing policies will vary between practices.

Bulk billing

Bulk billing is when a doctor bills Medicare directly for the services provided to the patient, so they have no out-of-pocket expenses.

Private billing

Operating as a private business, GPs are free to determine reasonable fees that are reflective of the services they provide.

Split billing

Split billing allows the patient to be bulk billed for some items and privately bill for others.

SCHEDULE FEES AND MEDICARE BENEFITS

GN.10.26

There are presently three levels of Medicare benefit payable:

1) 75% of the Schedule fee
2) 100% of the Schedule
3) 85% of the Schedule fee

Medicare benefits are claimable only for **'clinically relevant'** services rendered by an appropriate health practitioner. A 'clinically relevant' service is one which is generally accepted by the relevant profession as necessary for the appropriate treatment of the patient.

SERVICES THAT DO NOT ATTRACT MEDICARE BENEFITS GN 13.33

- Telephone consultations (with the exception of COVID-19 telehealth services)
- Issue of repeat prescriptions when the patient does not attend a consult;
- Non-therapeutic cosmetic procedures
- Euthanasia and any service directly related to the procedure
- Are for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability
- Medical examination for the purposes of life insurance, superannuation
- Mass immunisation (with exception to the Covid-19 vaccination)
- The issue of a death certificate
- Pre-employment screening services
- Some health screening services
- Services rendered to a doctor’s dependants, practice partner or practice partner’s dependants

MBS ONLINE

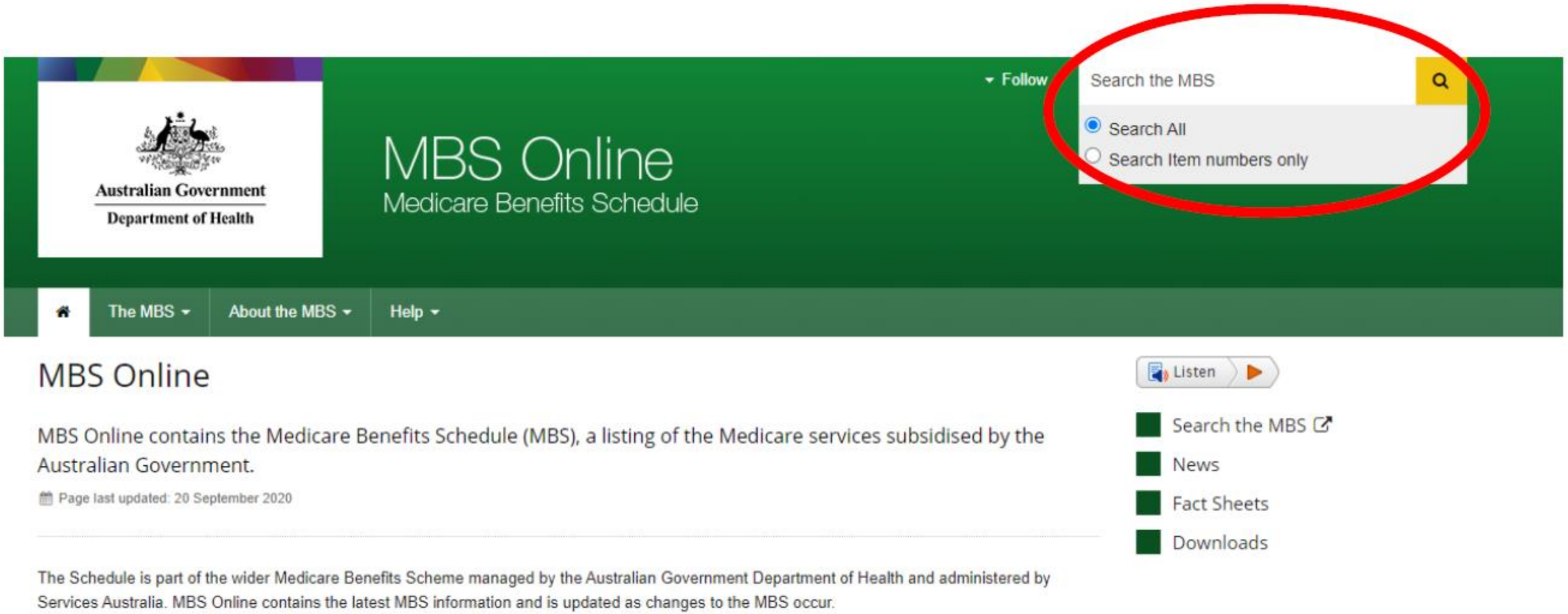
AskMBS Email Advice Service

If you have a query relating exclusively to interpretation of the Schedule, you should email **askMBS@health.gov.au**.

If you are seeking advice in relation to Medicare billing, claiming, payments or obtaining a provider number, please contact Services Australia on the Provider Enquiry Line - 13 21 50

AskMBS issues **Advisories** summarising responses to frequently asked questions on specific subject areas.

MBS ONLINE


Australian Government
Department of Health
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Medicare Benefits Schedule
Follow
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About the MBS
Help
MBS Online
MBS Online contains the Medicare Benefits Schedule (MBS), a listing of the Medicare services subsidised by the Australian Government.
Page last updated: 20 September 2020
The Schedule is part of the wider Medicare Benefits Scheme managed by the Australian Government Department of Health and administered by Services Australia. MBS Online contains the latest MBS information and is updated as changes to the MBS occur.
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MBS ONLINE

Category 1 - PROFESSIONAL ATTENDANCES

23

Group A1 - General Practitioner Attendances To Which No Other Item Applies

Subheading 2 - Level B

Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant:

(a) taking a patient history;

(b) performing a clinical examination;

(c) arranging any necessary investigation;

(d) implementing a management plan;

(e) providing appropriate preventive health care;

for one or more health-related issues, with appropriate documentation-each attendance

Fee: [illegible] **Benefit:** 100% = $38.20

(See para AN.0.9 of explanatory notes to this Category)

Extended Medicare Safety Net Cap: $114.60

Previous - Item 4

Next - Item 24

MBS ONLINE

Category 1 - PROFESSIONAL ATTENDANCES

AN.0.9

Attendances by General Practitioners (Items 3-4, 23-24, 36-37, 44, 47, 193, 195, 197, 199, 585, 594, 599, 2095, 2144, 2180, 2193, 2497-2559, 5000-5067 and 90020-90051)

Attendances by General Practitioners (Items 3-4, 23-24, 36-37, 44, 47, 193, 195, 197, 199, 585, 594, 599, 2497-2559, 5000-5067 and 90020-90051)

Items 3-4, 23-24, 36-37, 44, 47, 193, 195, 197, 199, 585, 594, 599, 2095, 2144, 2180, 2193, 2497-2559, 5000-5067 and 90020-90051 relate to attendances rendered by medical practitioners who are:

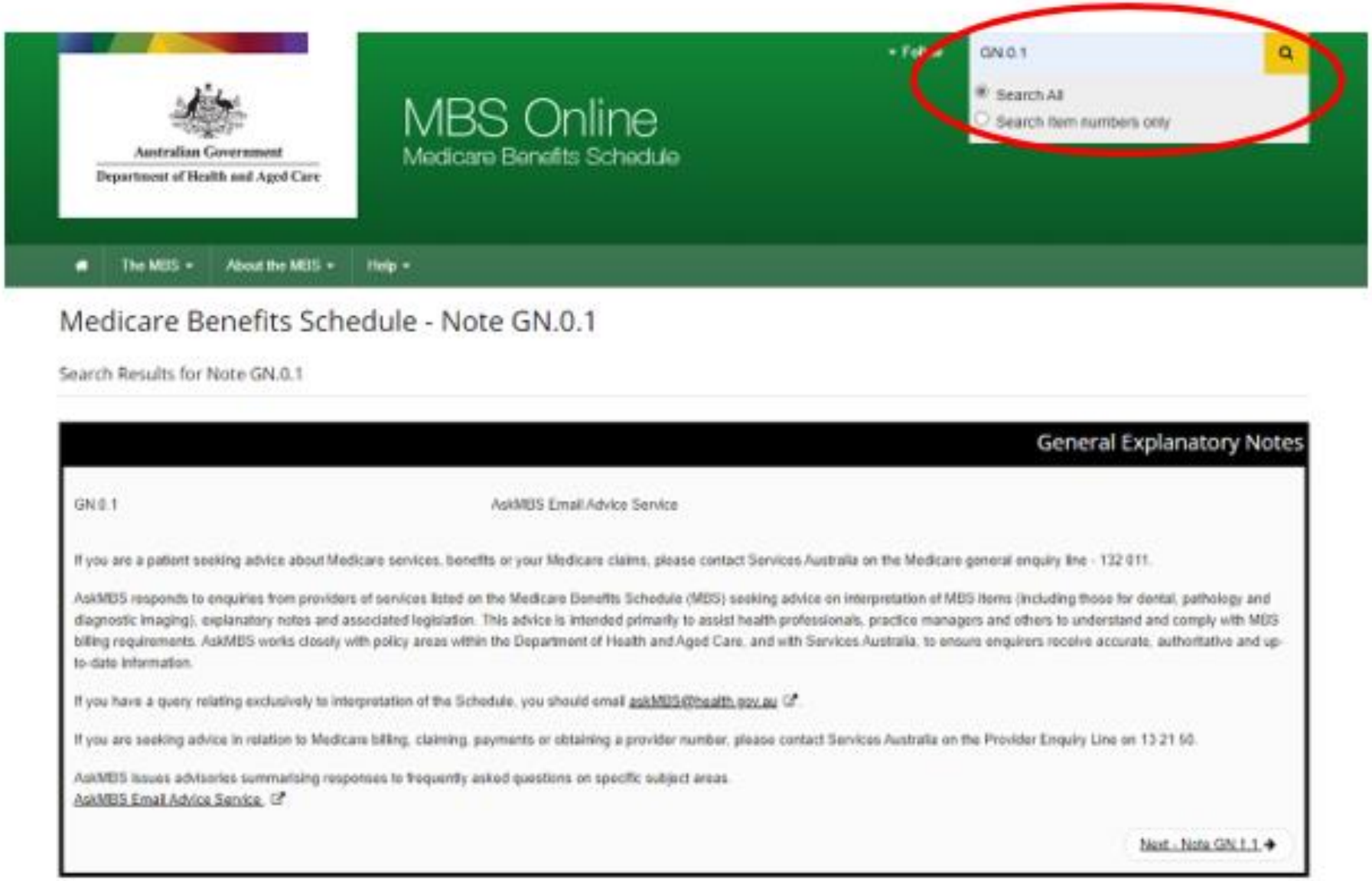
- listed on the Vocational Register of General Practitioners maintained by the Department of Human Services; or
- holders of the Fellowship of the Royal Australian College of General Practitioners (FRACGP) who participate in, and meet the requirements of the RACGP for continuing medical education and quality assurance as defined in the RACGP Quality Assurance and Continuing Medical Education program; or
- holders of the Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) who participate in, and meet the requirements of the Australian College of Rural and Remote Medicine (ACRRM) for continuing medical education and quality assurance as defined in ACRRM's Professional Development Program; or
- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FRACGP or training recognised by the RACGP as being of an equivalent standard; or
- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FACRRM or training recognised by ACRRM as being of an equivalent standard.

To assist general practitioners in selecting the appropriate item number for Medicare benefit purposes the following notes in respect of the various levels are given.

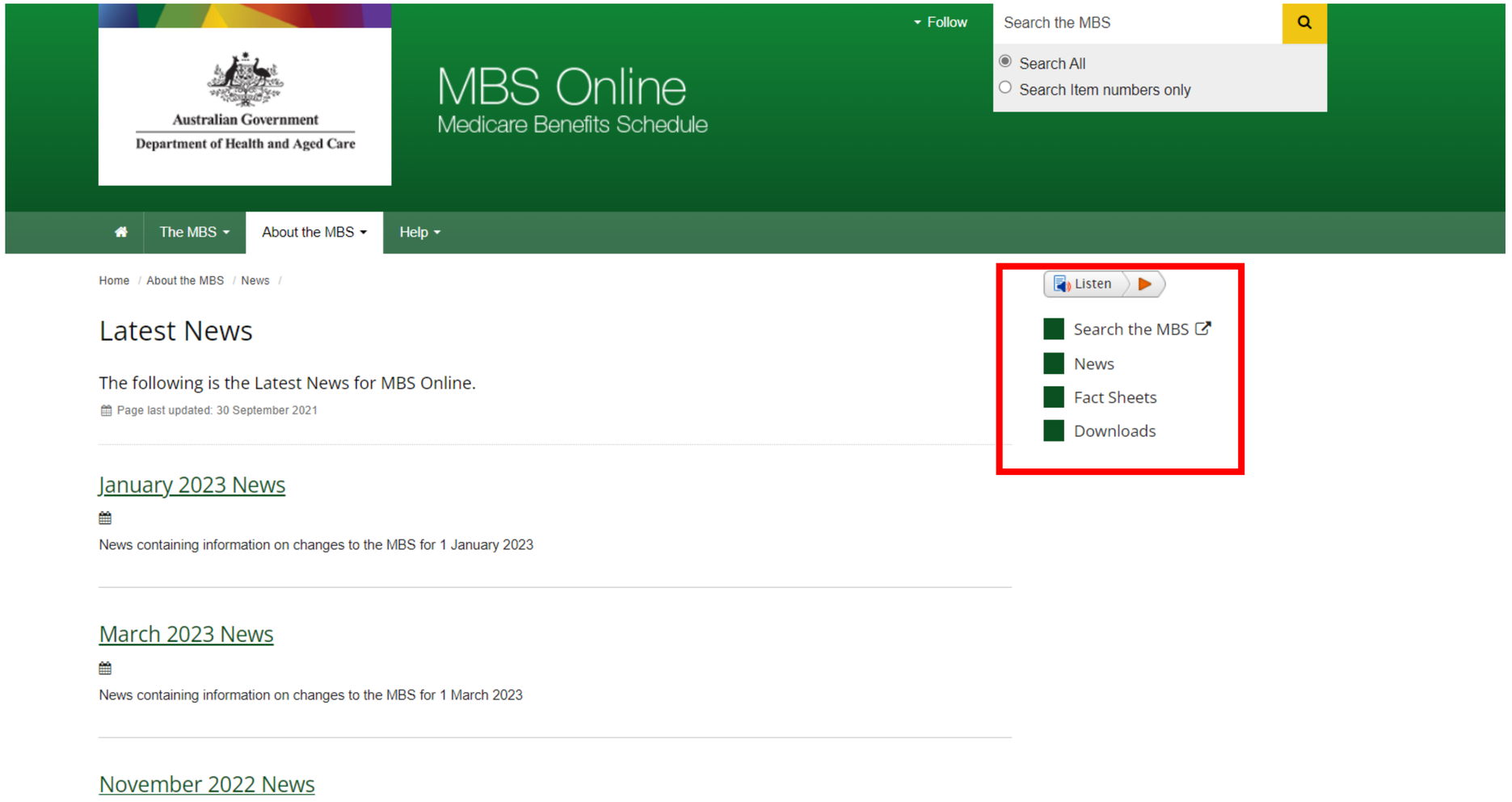
LEVEL A

A Level A item will be used for obvious and straightforward cases and this should be reflected in the practitioner's records. In this context, the practitioner should undertake the necessary examination of the affected part if required, and note the action taken.

MBS ONLINE


Australian Government
Department of Health and Aged Care
MBS Online
Medicare Benefits Schedule
GN.0.1
Search All
Search item numbers only
The MBS
About the MBS
Help
Medicare Benefits Schedule - Note GN.0.1
Search Results for Note GN.0.1
General Explanatory Notes
GN.0.1
AskMBS Email Advice Service
If you are a patient seeking advice about Medicare services, benefits or your Medicare claims, please contact Services Australia on the Medicare general enquiry line - 132 011.
AskMBS responds to enquiries from providers of services listed on the Medicare Benefits Schedule (MBS) seeking advice on interpretation of MBS items (including those for dental, pathology and diagnostic imaging), explanatory notes and associated legislation. This advice is intended primarily to assist health professionals, practice managers and others to understand and comply with MBS billing requirements. AskMBS works closely with policy areas within the Department of Health and Aged Care, and with Services Australia, to ensure enquirers receive accurate, authoritative and up-to-date information.
If you have a query relating exclusively to interpretation of the Schedule, you should email askMBS@health.gov.au
If you are seeking advice in relation to Medicare billing, claiming, payments or obtaining a provider number, please contact Services Australia on the Provider Enquiry Line on 13 21 50.
AskMBS issues advisories summarising responses to frequently asked questions on specific subject areas.
AskMBS Email Advice Service
Next - Note GN.1.1

MBS ONLINE


Follow
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Latest News
The following is the Latest News for MBS Online.
Page last updated: 30 September 2021
January 2023 News
News containing information on changes to the MBS for 1 January 2023
March 2023 News
News containing information on changes to the MBS for 1 March 2023
November 2022 News

HealthPathways login details

Hunter New England

Community HealthPathways | Hunter New England

https://hne.communityhealthpathways.org/

Username: hnehealth

Password: p1thw1ys

Central Coast

Central Coast NSW HealthPathways

https://centralcoast.healthpathways.org.au

Username: centralcoast

Password: 1connect

patient info HUNTER NEW ENGLAND

http://patientinfo.org.au/

No password required

patient info CENTRAL COAST

https://www.ccpatientinfo.org.au/

No password required

Relevant pathways

- Guide to MBS Items
- Chronic Disease Management MBS Items
- Claiming MBS Items for Aboriginal and Torres Strait Islander Health Care
- Aboriginal and Torres Strait Islander Health Assessment (MBS Item 715)

Guide to MBS Items

This page is a quick reference guide to Medicare Benefits Schedule (MBS). It is not designed to replace the MBS and associated guidance. It remains the responsibility of the registered practitioner to have read the relevant MBS descriptors and explanatory notes and ensure all MBS requirements are met for each item number used.

- Review eligibility prior to billing.
- If seeking advice in relation to Medicare billing, claiming, payments or obtaining a provider number, contact Services Australia on the Provider Enquiry Line – **13-21-50**. See MBS Infographics.
- Email askmbs@health.gov.au for queries related exclusively to interpretation of the Schedule.
- See AskMBS Advisories page for a summary of frequently asked questions on specific subject areas.

Incorporating VR MBS fees at 1 January 2023.

SEND FEEDBACK

See also Telehealth.

Guide to MBS Items

- Chronic Disease Management Monitoring and Support including Telehealth Items
- Diagnostic Procedures
- Eating Disorder Services including Telehealth Items
- Health Assessments
- Annual Veterans' Health Checks
- Heart Health Assessment
- Medication Review
- Mental Health Services including Telehealth Items
- Minor Procedure Items
- Nicotine and Smoking Cessation Counselling including Telehealth
- Procedures – Women's Health
- Pregnancy Support and Obstetric Service including Telehealth Items
- Residential Aged Care Items

SEND FEEDBACK

MENTAL HEALTH

The GP Mental Health Treatment items incorporate a model for best practice primary health treatment of patients with mental disorders, including patients with both chronic or non-chronic disorders, that comprises:

- assess and plan;
- provide and/or refer for appropriate treatment and services;
- review and ongoing management as required.

These items are for patients with a mental disorder who would benefit from a structured approach to the management of their treatment needs.

World Health Organisation, 1996,
Diagnostic and Management Guidelines for
Mental Disorders in Primary Care:
ICD-10 Chapter V Primary Care Version

MENTAL HEALTH TREATMENT PLAN

What is considered a mental disorder for the purpose of these items?

- Alcohol use disorders
- Chronic psychotic disorders
- Acute psychotic disorders
- Depression
- Phobic disorders
- Mixed anxiety and depression
- Unexplained somatic complaints
- Eating disorders
- Sleep problems
- Enuresis
- Mental Disorder, Not Otherwise Specified
- Drug use disorders
- Generalized anxiety
- Bipolar disorder
- Dissociative (conversion) disorder
- Panic disorder
- Adjustment disorder
- Neurasthenia
- Conduct disorder
- Sexual disorders
- Bereavement disorders
- Hyperkinetic (attention deficit) disorder

Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of the GP Mental Health Treatment items.

MENTAL HEALTH – WHAT IS INVOLVED

Preparation of a GP Mental Health Treatment Plan

Once a GP Mental Health Treatment Plan has been completed and claimed on Medicare, a patient is eligible to be referred for up to 10 Medicare rebateable mental health services per calendar year for psychological therapy or focussed psychological strategy services.

Patients will also be eligible to claim up to 10 separate services for the provision of group therapy.

Review of a GP Mental Health Treatment Plan

The recommended frequency for the review service, should occur between four weeks to six months after the completion of a GP Mental Health Treatment Plan. A further review can occur three months after the first review.

GP Mental Health Treatment Consultation

The GP Mental Health Treatment Consultation item is for an extended consultation with a patient where the primary treating problem is related to a mental disorder. Consultations associated with this item must be at least 20 minutes duration.

FAMILY AND CARER PARTICIPATION UNDER THE BETTER ACCESS INITIATIVE

From 1 March 2023, new Medicare Benefit Schedule (MBS) items are available to facilitate family and carer participation in a patient's mental health treatment under the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS initiative (Better Access) initiative.

There are new time-tiered MBS items to allow providers to deliver up to two Medicare-subsidised services per calendar year, to a person other than the patient, where:

- The patient has been referred for Better Access services (for allied health practitioner delivering these services),
- The treating or referring practitioner determines it is clinically appropriate,
- The patient consents for the service to be provided to the person as part of their treatment,
- The service is part of the patient's treatment, and
- The patient is not in attendance.

CHRONIC DISEASE MANAGEMENT

Description	Item No	Claiming Interval
Preparation of a GP Management Plan (GPMP)	721	24 months
Coordination of Team Care Arrangements (TCAs)	723	24 months
Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	729	6 months
Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care Plan, for a resident in an aged care facility	731	6 months
Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements	732	6 months

CDM services may be provided more frequently in the exceptional circumstances defined below.

Exceptional circumstances exist for a patient if there has been a significant change in the patient's clinical condition or care requirements that necessitates the performance of the service for the patient.

TEAM CARE ARRANGEMENT – WHAT DOES COLLABORATION MEAN?

GPs are required to collaborate with **two or more** other health or care providers in the development of Team Care Arrangements (TCAs).

Collaboration means communicating with the other providers to discuss potential treatment or services they will provide.

Only **one** specialist or consultant physician can be counted towards the minimum of two contributing team members who, with the coordinating GP, make up the core TCAs team.

Collaboration ‘should relate to the specific needs and circumstances of the patient’.

AskMBS Advisories

CHRONIC DISEASE MANAGEMENT – SMART GOALS

SPECIFIC

- Clear

TIME-BOUND

- Date

What is a SMART Goal

? ? ?

MEASURABLE

- Numbers

RELEVANT

- Meaningful

ACHIEVABLE

- Realistic

NURSE ITEM NUMBER (10997)

Provision of monitoring and support for a person with a chronic disease by a practice nurse or Aboriginal or Torres Strait Islander Health Practitioner

Item 10997 may be used to provide:

- checks on clinical progress;
- monitoring medication compliance;
- self management advice, and;
- collection of information to support GP/medical practitioner reviews of Care Plans

Item 10997 may be claimed up to a maximum of 5 times per patient per calendar year.

The services provided by the practice nurse or Aboriginal and Torres Strait Islander health practitioner should be consistent with the scope of the GP Management Plan, Team Care Arrangements, or Multidisciplinary Care Plan.

HEALTH ASSESSMENTS (ITEM 701, 703, 705, 707)

Target Group	Frequency of Service
A type 2 diabetes risk evaluation for people aged 40-49 years (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool	Once every three years to an eligible patient
A health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease	Once only to an eligible patient
A health assessment for people aged 75 years and older	Provided annually to an eligible patient
A comprehensive medical assessment for permanent residents of residential aged care facilities	Provided annually to an eligible patient
A health assessment for people with an intellectual disability	Provided annually to an eligible patient
A health assessment for refugees and other humanitarian entrants	Once only to an eligible patient
A health assessment for former serving members of the Australian Defence Force	Once only to an eligible patient

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

A 715 health assessment is available to all people of Aboriginal and Torres Strait Islander descent.

Changes to the Practice Incentive Indigenous Health Incentive

- **All** patients with a chronic condition can be registered for the PIP Indigenous health incentive annually
- GP Mental Health Care Plans items will be added as eligible items for the purposes of outcomes payments
- The requirement to deliver a certain number of services in a calendar year will be replaced with a 12-month rolling window
- The program will start moving towards a back-ended payment structure

All eligible patients are entitled to be registered for Closing the Gap (CTG). This is a **once only** registration.

DOMICILIARY MEDICATION MANAGEMENT REVIEW (ITEM 900)

A Domiciliary Medication Management Review (DMMR), aims to maximise a patient's medication regimen, and prevent medication-related problems through a team approach, involving the patient's GP and preferred community pharmacy or accredited pharmacist.

1. The benefit is not claimable until all the components of the item have been rendered.

- referral to a community pharmacy or an accredited pharmacist
- Obtaining consent from the patient
- Providing the patient’s preferred pharmacist, with relevant clinical information, including diagnosis, relevant test results, medication history and current medications.

CLAIMING A DOMICILIARY MEDICATION MANAGEMENT REVIEW CONT.

2. Discussion of the review findings and report including suggested medication management strategies with the reviewing pharmacist

- Receiving a written report from the reviewing pharmacist;
- Discussing the relevant findings and suggested management strategies with the pharmacist (either by phone or face to face);
- Developing a summary of the relevant review findings as part of the draft medication management plan

3. Development of a written medication management plan following discussion with patients

- Developing a draft medication management plan and discussing this with the patient; and
- Once agreed, offering a copy of the written medication management plan to the patient and providing a copy to the pharmacy or pharmacist

MBS TELEHEALTH SERVICES

MBS telehealth introduced on a temporary basis in response to the COVID-19 pandemic have now been made permanent.

- A service may only be provided by telehealth where it is safe and clinically appropriate to do so.
- All providers are expected to obtain and document informed financial consent from patients prior to charging private fees for telehealth services.

Reminder: On 1 October 2022, a new prescribed pattern of service (30/20 rule) for phone consultations was commenced.

MBS TELEHEALTH SERVICES

Who is eligible?

An *established relationship* means the medical practitioner performing the service:

• has provided at least one face-to-face service to the patient in the 12 months preceding the telehealth attendance; or

• is located at a medical practice where the patient has had at least one face-to-face service arranged by that practice in the 12 months preceding the telehealth attendance or

• is a participant in the Approved Medical Deputising Service program, and the Approved Medical Deputising Service provider employing the medical practitioner has a formal agreement with a medical practice that has provided at least one face-to-face service to the patient in the 12 months preceding the telehealth attendance.

• The established relationship requirement is a rolling requirement applying to every telehealth consultation. For each telehealth consultation, the patient must meet one of the eligibility requirements outline above.

MBS TELEHEALTH SERVICES

The *established relationship* requirement does not apply to:

- children under the age of 12 months;
- people who are homeless;
- patients receiving an urgent after-hours (unsociable hours) service; or
- patients of medical practitioners at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service.

AND patients accessing specific MBS items for:

- blood borne viruses, sexual or reproductive health consultations (new items); and
- pregnancy counselling services (under MBS Group A40);
- mental health services (under MBS Group A40); and
- nicotine and smoking cessation counselling (new items).

MBS TELEHEALTH SERVICES

Medicare Support for Covid-19 Vaccinations

These changes simplify and streamline the claiming of COVID-19 vaccine suitability and associated services.

Co-claiming booster incentives will no longer be needed as the MBS benefit will incorporate it.

The flag-fall payment has been increased, so services at a residential aged care facility, residential disability facility, or a patient's home will receive a higher benefit.

Covid-19 high risk group temporary exemption from established relationship requirement

Until 31 March 2023, the temporary exemption for high risk COVID19 positive patients from the established relationship for telehealth consultations to seek a request to a private pathologist for PCR testing will apply.

MBS TELEHEALTH SERVICES

Assignment of benefit requirements

You need your patient’s agreement to bulk bill the items, before Medicare can pay the benefit

You can get the patients agreement either:

- **In writing**
- **By email**
- **Verbally during the consult**

You must keep a record of the agreement

MBS TELEHEALTH SERVICES

How will this look?

Email Agreement

Step 1

At the telehealth video consultation, tell the patient you wish to bulk bill Medicare for the service. To do this the patient will need to:

- agree to the service being bulk billed
- check the details in the email sent to their nominated email address
- reply to your email, which will be considered a signature agreeing to assign the benefit.

MBS TELEHEALTH SERVICES

Email Agreement

Step 2

Before submitting the claim, you need to send an email to the patient that includes:

- **The details of the service**

  - item numbers or a description of the services
  - benefit amount for both the base and derived fee items
  - date and time of the services
  - patient's name (don’t include the Medicare card number)
  - practitioner's name (don’t include the provider number)

MBS TELEHEALTH SERVICES

- **This statement**

  'If you (the patient) agree to the assignment of the Medicare benefit directly to the provider (bulk bill), reply to this email including the following words:

  - Yes, I agree to the assignment of the Medicare benefit directly to the provider, and
  - your (the patient's) name'

- **This privacy note**

  'Your personal information is protected by law, including the Privacy Act 1988, and is collected by Services Australia for the assessment and administration of payments and services. This information is required to process your application or claim. Your information may be used by the agency or given to other parties where you have agreed to that, or where it is required or authorised by law (including for the purpose of research or conducting investigations). You can get more information about the way in which the agency will manage your personal information, including our **privacy policy**.

MBS TELEHEALTH SERVICES

Step 3

When you get a reply email from the patient with the required information:

- complete assignment of benefit voucher form
- for manually submitted claims write in the signature block ‘unable to sign, written email agreement provided’
- for electronic claims, you don’t need to note the email signature but you must keep the patient's email consent on file

- Submit the claim to Medicare
- Send a completed copy of the assignment of benefit voucher form to the patient
- Keep the email with the patient's consent and email signature, in hard copy or electronic form for audit purposes for at least 2 years.
- By noting 'email agreement' on the assignment of benefit form, you acknowledge you’ve followed steps 1-3.

Example email

Dear Mr Jones (patient)

Details of the telehealth consultation to be claimed with Medicare:

Item number: xx Benefit amount: xx

Item number: xx Benefit amount: xx

Date and time of consultation: xxx, 10:30 am

Patient name: Peter Jones

Provider name: Jane Smith

Agreement

If you (the patient) agree to the assignment of the Medicare benefit directly to the provider (bulk bill), reply to this email including the following wording:

- Yes, I agree to the assignment of the Medicare benefit directly to the provider
- your (the patient's) name or the name of parent or guardian (where a child is the patient and unable to sign).

Regards
Dr Jane Smith

Privacy note: Your personal information is protected by law, including the Privacy Act 1988, and is collected by Services Australia for the assessment and administration of payments and services. This information is required to process your application or claim. Your information may be used by the agency or given to other parties where you have agreed to that, or where it is required or authorised by law (including for the purpose of research or conducting investigations). You can get more information about the way in which the agency will manage your personal information, including our privacy policy.

ADMINISTRATIVE REQUIREMENTS FOR SKIN SERVICES

Determining lesion size for MBS item selection

The necessary excision diameter or defect size includes:

- The lesion size
- A clinically appropriate margin of healthy tissue needed for complete surgical excision

Make sure you take measurements before excision

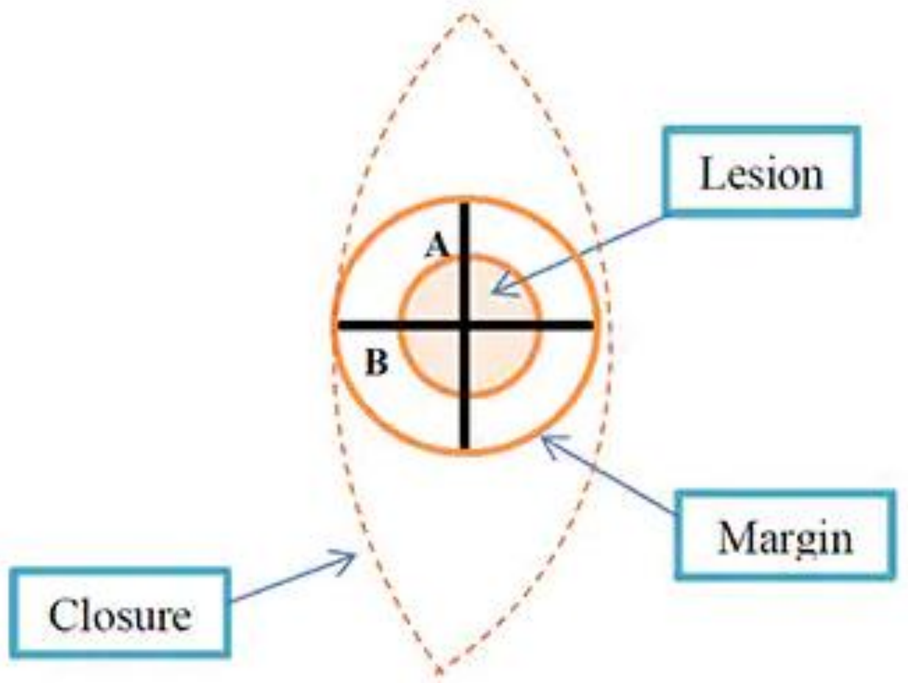
You should determine the margin size in line with these National Health and Medical Research Council guidelines:

- Clinical practice guide: Basal cell carcinoma, squamous cell carcinoma (and related lesions) – a guide to clinical management in Australia November 2008. Cancer Council Australia
- Clinical practice guidelines for the management of melanoma in Australia and New Zealand 2008. Ministry of Health, New Zealand

ADMINISTRATIVE REQUIREMENTS FOR SKIN SERVICES

Determining lesion size for MBS item selection

The image below illustrates the area of the lesion, margin and closure.



$$\text{Defect size} = \frac{\text{excision length (A)} + \text{excision breadth (B)}}{2}$$

ADDITIONAL CHARGES AND BULK BILLING

If you bulk bill a patient, you can’t make additional charges for that service.

This includes, but isn’t limited to:

- any consumables used, including bandages and dressings
- record keeping fees
- a booking fee to be paid before each service
- an annual administration or registration fee

ADDITIONAL CHARGES

Example:

Privately charge the patient

Item 31365	BCC <15mm	$142.25 (85% rebate)
	Non-rebatable item	$ 50.00
Total amount paid by patient		$192.25
Rebate from Medicare		$142.25
Out of pocket cost		**$ 50.00**

Note GN.7.17 Billing Procedures

POST-OPERATIVE TREATMENT AFTERCARE

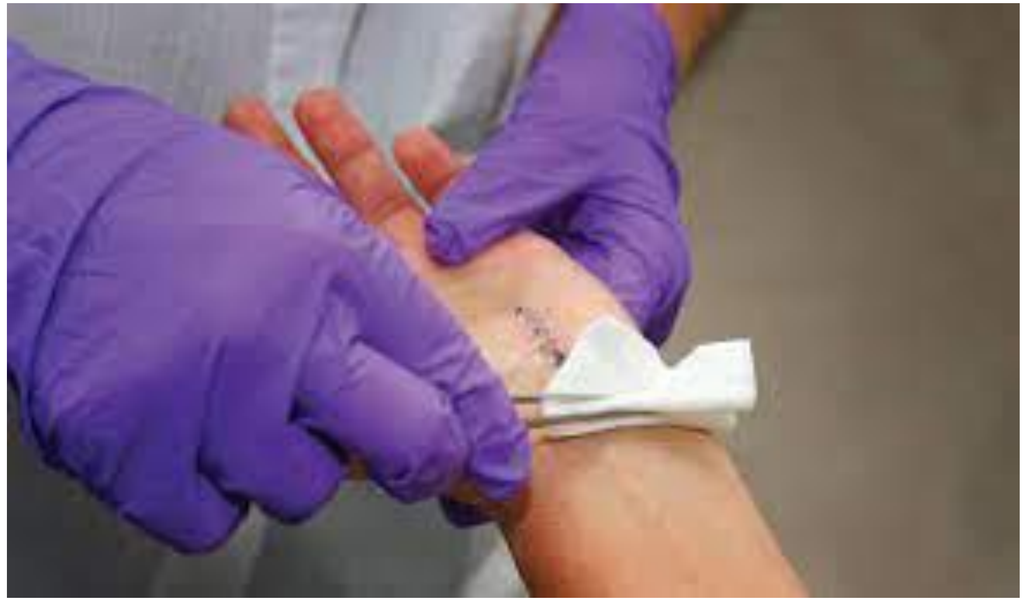
Aftercare is the post-operative care and treatment provided to patients after an operation.

This includes all attendances until recovery and the final check or examination.

The provider can determine an aftercare period based on the patient's needs.

A service isn't normal aftercare if you see a patient for:

- an unrelated condition
- complications from the operation



MEDICARE SAFETY NET

The Medicare Safety Net is a scheme to help Australians who pay out-of-pocket medical expenses, also known as gaps.

What is the Medicare Safety Net Threshold?

The Medicare safety net threshold is **the total amount of money that an individual or family spends on gaps in a calendar year before the Medicare Safety Net applies.** Concession card holders have a lower Medicare Safety Net Threshold than people who do not have a concession card.

Example:

Before meeting your safety net threshold:
You see a GP who charges $85 and you get the Medicare rebate of $40. Your gap is $45.

After meeting your safety net threshold:
The GP still charges $85, you get the Medicare rebate of $40 plus 80% of $45 gap ($36), a total Medicare rebate of $76. Your gap is now $9.

Extended Medicare Safety Net (EMSN) – General

For everyone with a Medicare card.

*Threshold Amount **$2,414.00.***

Extended Medicare Safety Net (EMSN) – Concessional and Family Tax Benefit Part A

The lower threshold applies for any of the following groups:

a. **Individual with a concession card (**Pensioner, Healthcare, Commonwealth Healthcare Card)

b. **Concessional family - at least 2 members** of the Safety Net family must hold a concession card, to form a Concessional Safety Net family, only those with concession cards contribute towards this safety net.

c. **Family Tax Benefit Part A:** Families eligible for Family Tax Benefit Part A.

*Threshold Amount **$770.30***

WHAT IS THE PROCESS TO REGISTER FOR THE MEDICARE SAFETY NET?

Families and couples must register either by;

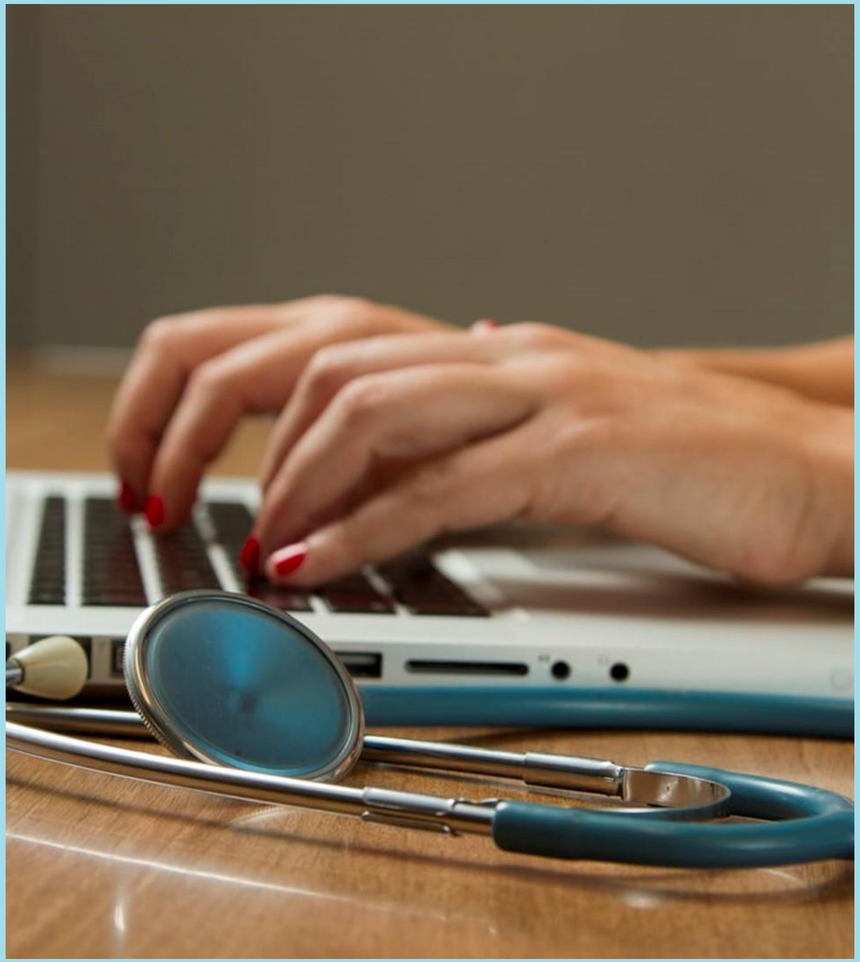
- Calling Medicare on 132 011 or;
- By completing the MS016 form from Medicare
- Then post the forms to the address on the form, or in person at a Services Australia Centre.

RECORDING CLINICAL NOTES

All practitioners who provide or initiate a service for which a Medicare benefit is payable should ensure they maintain **adequate** and **contemporaneous** records.

To be **adequate**, the records need to provide clinical information adequate to explain the type of service rendered or initiated; and needs to be sufficiently comprehensible that another practitioner can effectively undertake the patient's ongoing care.

To be ***contemporaneous***, the patient or clinical record should be completed at the time that the service was rendered or initiated or as soon as practicable afterwards.



GOOD MEDICAL PRACTICE: A CODE OF CONDUCT FOR DOCTORS IN AUSTRALIA

Medical Board of Australia

10.5.1

Maintaining clear and accurate medical records is essential for the continuing good care of patients.

Good medical practice involves:

Keeping accurate, up to date and legible records that report relevant details of clinical history, clinical findings, investigations, diagnosis, information given to patients, medication, referral and other management in a form that can be understood by other health practitioners.

INAPPROPRIATE PRACTICE

Prescribed pattern of service

A practitioner engages in inappropriate practice in rendering or initiating services during a particular period if the circumstances in which some or all the services were rendered or initiated constitute a prescribed pattern of services.

This includes**:**

- Medical practitioners who provide more than **80 professional attendances on each of 20 or more days in a 12-month period (known as the 80/20 rule)**, or
- who provide **30 or more relevant phone services on each of 20 or more days as a 12-month period (known as the 30/20 rule)** are deemed to have engaged in inappropriate practice under the *Health Insurance Act 1973.*

MEDICARE COMPLIANCE

Steps of investigation

- Behavioural insights and interventions
- Data matching
- Targeted letter campaigns
- Audits
- Review of decision
- Practitioner Review Program reviews
- Case referral to the Professional Services Review
- Fraud investigations

AUDIT PROCESS – WHAT DOES IT LOOK LIKE?

Provision for review of individual health professionals

GN.8.18

The Professional Services Review (PSR) reviews and investigates service provision by health practitioners to determine if they have engaged in inappropriate practice when rendering or initiating Medicare services, or when prescribing or dispensing under the PBS.

Education services for health professionals

https://www.servicesaustralia.gov.au/education-services-for-health-professionals?context=20

https://www.servicesaustralia.gov.au/mbs-education-for-health-professionals?context=20

http://medicareaust.com/MISC/MISCP02/index.html

Please email any questions that do not specifically relate to MBS item numbers to: havery@thephn.com.au

MBS questions should be emailed directly to: AskMBS@health.gov.au

PRIMARY HEALTH NETWORK
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An Australian Government Initiative