

# Specialist clinics in public hospitals

A resource kit for MBS-billed services



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## Contents

This resource kit provides information about the operation of specialist clinics in Victorian public hospitals. It includes the following information sheets:

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4. MBS-billed specialist clinics and compliance by public hospitals with the AHCA.
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6. Billing against the Medicare Benefits Schedule for MBS-billed specialist clinics.
7. Medical indemnity issues for MBS-billed specialist clinics.
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Information sheets 1-3 define and outline the context in which MBS-billed specialist clinics exist. Information sheets 4-7 provide guidance to Victorian public hospitals about the implications of MBS-billed specialist clinics being provided at hospital premises.

These information sheets can be read as stand-alone documents to obtain information on a particular issue (such as medical indemnity). In addition, a one-page summary checklist has been prepared to assist public hospitals and medical practitioners in understanding:

- The obligations that must be met if MBS-billed specialist clinics are provided at hospital premises.
- The advantages offered under the preferred 100 per cent donation model for the remuneration of medical practitioners exercising rights of private practice in delivering MBS-billed specialist clinics.

## Summary checklist in establishing and operating MBS-billed specialist clinics

### Scope and obligations

- **Scope:** any services can be provided through the MBS-billed specialist clinics model, subject to meeting other requirements.
- **Australian Health Care Agreement obligations** (see information sheet 4):
  - Services introduced after 1 July 1998 can be provided privately.
  - Where public hospitals offer MBS-billed specialist clinics that were not provided publicly on 1 July 1998, they must ensure that services are also available on a public patient basis, where there is a demonstrated clinical need.
  - Patients accessing MBS-billed specialist clinics should be referred to a named medical practitioner and be offered a choice of treatment as a public or private patient.
- **Medicare requirements** (see information sheet 6):
  - Public hospitals should consult, and comply with, the relevant requirements of the Medicare Benefits Schedule (MBS), the *Health Insurance Act 1973* and any information issued by Medicare Australia.

If MBS-billed specialist clinics operate in public hospitals the model is as follows: (see information sheets 5 and 7)

Public hospitals should seek their own legal, financial and industrial advice on the impact of particular remuneration models and will need to consider their ability to recruit and retain a skilled specialist medical workforce. Within this context, the preferred model is based on medical practitioners being remunerated under the 100 per cent donation model. The advantages of this model include:

- ✓ **Tax:** The Australian Tax Office has approved this model, allowing medical practitioners to deduct remuneration amounts paid over to public hospitals.
- ✓ **Medical indemnity:** The Victorian Managed Insurance Authority (VMIA) Medical Indemnity Policy covers medical practitioners employed by the hospital operating under the 100 per cent donation model, meaning that medical practitioners do not bear liability under their own insurance policies.
- ✓ **Flexible use of funding:** Public hospitals and medical practitioners can reach agreement through Special Purpose Funds on the purposes for which private practice revenue can be spent. This includes teaching of medical staff.
- ✓ **No management fee:** Under the 100 per cent remuneration model, the hospital provides and meets the cost of staffing and administrative services used in providing MBS-billed specialist clinics. There is no management fee payable by the medical practitioner.
- ✓ **Integration and convenience:** The hospital undertakes billing against the MBS on behalf of the medical practitioner; patient records for MBS-billed specialist clinics are integrated with hospital records.

## Information sheet 1

### Defining MBS-billed specialist clinics

This resource kit is about ‘MBS-billed specialist clinics’ that are commonly provided in Australian public hospitals. This term can be broken down into its component elements as follows:

- “MBS-billed” – means services that are provided to a person who has been referred to a medical specialist exercising a right of private practice at a public hospital, resulting in the cost of these services being billable against the Medicare Benefits Schedule (MBS).
- “Specialist” – refers to services that are provided by a medical specialist, again with rights of private practice at a public hospital.
- “Clinics” – means planned or scheduled non-admitted health care services provided at a public hospital.

In broad terms, MBS-billed specialist clinics are similar to specialist medical services provided through Victorian Government-funded public hospital outpatient departments.

For the purposes of this resource kit, MBS-billed specialist clinics do **not** include:

- Non-admitted services provided by GPs in public hospitals.
- Non-admitted services provided on an emergency (unplanned) basis in either a public hospital emergency department or some other setting in a public hospital, provided by a medical practitioner with rights of private practice.

For the purposes of this resource kit, MBS-billed specialist clinics include:

- Services that are direct-billed (commonly referred to as bulk-billed) under the MBS with no additional charge to the patient.
- Services that are not bulk-billed, with a co-payment payable by the patient.

It is anticipated that most MBS-billed specialist clinics provided in public hospitals would be bulk-billed. However, MBS-billed specialist clinics provided in specialists’ private rooms located at public hospitals may not be bulk-billed. These issues are discussed further in information sheet 5 on remuneration models for medical practitioners.

## Information sheet 2

### Rationale for a resource kit on MBS-billed specialist clinics

In 2006, the Victorian Auditor-General completed a review into specialist medical outpatient care in Victorian public hospitals. The Auditor-General made a number of recommendations relating to MBS-billed clinics covering issues such as private practice and licence agreements and compliance with the Australian Health Care Agreement (AHCA) and the *Health Insurance Act 1973*.

The Victorian Government is committed to ensuring that Victorian public hospitals fully comply with all the requirements of the AHCA. As indicated in its response to the Auditor-General's report, the Department of Human Services has previously advised hospitals of their AHCA obligations through hospital circulars.

In its response to the Auditor-General, the Department of Human Services indicated that it would:

- Ensure that hospitals are aware of the requirements of the AHCA and the *Health Insurance Act 1973* as they relate to outpatient services.
- Ensure that hospitals have appropriate documentation in place regarding private practice arrangements and, where appropriate, patient election processes relevant to outpatient services.
- Work closely with hospitals to ensure that they have written agreements in place with private practitioners relating to the use of hospital facilities and services.

This resource kit is one of the ways in which the Department of Human Services is assisting hospitals to promote more uniform adoption of best practice arrangements relating to public and MBS-billed clinics.

## Information sheet 3

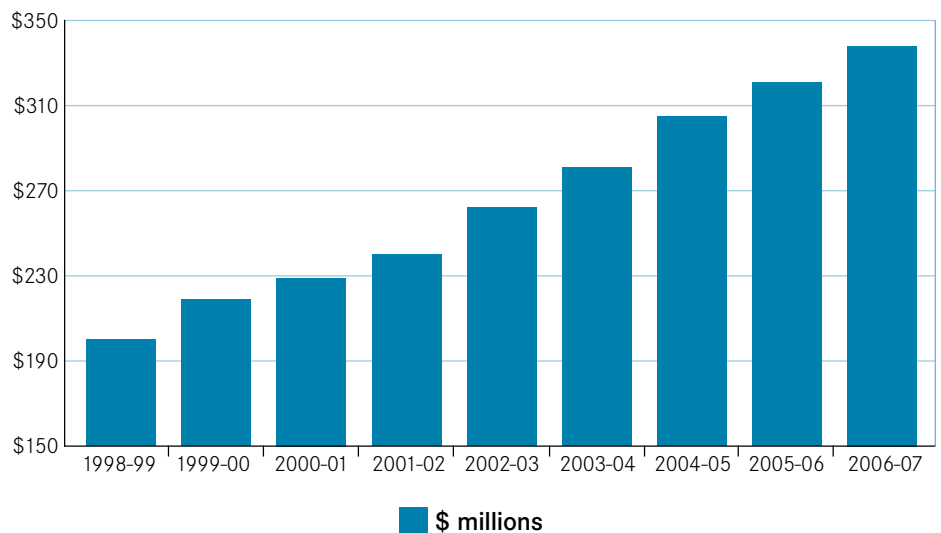
### Overview of the AHCA in relation to specialist clinics

#### Victorian Government's commitment to public outpatient services

Under the 2003-08 Australian Health Care Agreement (AHCA), the Victorian Government agreed to ensure free access for public patients to at least the range of services in public hospitals (including specialist clinics) that were available on 1 July 1998. The Department of Human Services is committed to maximising the availability of funding to support provision of outpatient services.

The Victorian Government's ongoing commitment to the provision of free public specialist clinics is evidenced by the continuing growth in the level of funding allocated by the Department of Human Services for public hospital outpatient services. As Victoria funds most outpatient services on an output basis, the growth in funding has been more than matched by a growth in the level of public outpatient services. Figure 1 shows the growth in the level of funding under the Victorian Ambulatory Classification and Funding System from 1998-99 to 2006-07, while Figure 2 shows the growth in public outpatient services provided over the same period.

**Figure 1: Trends in Victorian Government funding of public hospital outpatient services, 1998-99 to 2006-07**



## Information sheet 3 continued

### Overview of the AHCA in relation to specialist clinics

**Figure 2: Trends in public hospital outpatient services, 1998-99 to 2006-07**



These figures demonstrate how the Victorian Government has more than met its obligations under the AHCA to fund and provide a range of public outpatient services at no less than was available on 1 July 1998.

#### Role of MBS-billed specialist clinics

Concurrently, there is a long history of MBS-billed specialist clinics being provided in public hospitals. There are many reasons why MBS-billed specialist clinics have been established in, or near, public hospital campuses, including:

- Rights of private practice are an important tool in recruiting and retaining a skilled specialist medical workforce for public hospitals.
- The co-location of MBS-billed specialist clinics with public hospitals ensures a critical mass of specialist medical services. It can also help promote more cost-effective use of high-cost technology or support services.
- Locating MBS-billed specialist clinics at, or near, public hospitals can assist public hospitals in having available medical specialists who are also able to provide inpatient and outpatient services to public patients.
- MBS-billed specialist clinics provide patients with a choice about whether to receive treatment as a public or private patient, similar to their choice about inpatient services at public hospitals.

The 2003-08 AHCA does not prohibit the establishment of MBS-billed specialist clinics at public hospitals. Instead, it sets out the Victorian Government's obligations in relation to the conditions under which public and MBS-billed specialist clinics can be provided at public hospitals. Further information on what this means for individual hospitals is included in information sheet 4.

## Information sheet 4

# MBS-billed specialist clinics and compliance by public hospitals with the AHCA

### Background

Public hospitals should understand and comply with the requirements of the Australian Health Care Agreement (AHCA), including for specialist clinics.

The AHCA between Victoria and the Australian Government is available at:

[www.health.vic.gov.au/agreement/index.htm](http://www.health.vic.gov.au/agreement/index.htm)

The Department of Human Services has previously issued the following circulars explaining the obligations of public hospitals under the AHCA:

Circular 33/2003 – Australian Health Care Agreement: Compliance with Medicare principles.

Circular 34/2004 – Australian Health Care Agreement: Compliance with the Medicare principles.

Circular 22/2006 – Australian Health Care Agreement: Compliance with charges for patients other than public patients.

The Department of Human Services circulars are available at:

[www.health.vic.gov.au/hospitalcirculars/index.htm](http://www.health.vic.gov.au/hospitalcirculars/index.htm)

The Commonwealth Department of Health and Ageing has also issued a series of Information sheets on the 2003-08 AHCA. Information sheet number 4 is specifically about outpatient services in public hospitals. These information sheets are available at:

[www.health.gov.au/internet/wcms/publishing.nsf/Content/health-ahca-agreement.htm](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-ahca-agreement.htm)

### Implications of the AHCA for specialist clinics

Public hospitals should consider the following key tests or criteria in interpreting the requirements of the AHCA for specialist clinics. Although the AHCA does not stipulate the priority to be accorded to particular obligations on public hospitals, the criteria are presented below in an ordered, decision-tree format.

Public hospitals should work through these criteria sequentially in making decisions about their future arrangements for public and MBS-billed specialist clinics.

#### 1. *The 1998 rule (Clause 7.1(a) in the 2003-08 AHCA)*

It is a requirement that the range of services that were publicly provided on 1 July 1998, including public outpatient services, continue to be provided to public patients free of charge, with no billing against the Medicare Benefits Schedule (MBS). The implications of this are that:

- Specialist clinics that were introduced after 1 July 1998 can be provided privately (subject to a valid referral and patient choice arrangements discussed later).
- There are no specific requirements or restrictions limiting the types of specialist clinics that can be provided publicly or privately.

## Information sheet 4 continued

### MBS-billed specialist clinics and compliance by public hospitals with the AHCA

#### ***2. Accessibility to specialist clinics for public patients (Clause 7.1 (b))***

It is a requirement that for services where there is a demonstrated clinical need, public hospital services available to private patients should be accessible on a public patient basis. The implications of this are that:

- Even if certain public outpatient services were not provided on 1 July 1998, a public hospital must offer or otherwise arrange for these services to be available to public patients free of charge (with no billing against the MBS) if the services are available on a private basis and there is a demonstrated clinical need. In other words, specialist clinics cannot be provided on an exclusively private basis, notwithstanding that such services may not have been publicly provided on 1 July 1998.
- This requirement may be satisfied in a number of ways including:
  - Operating parallel public and MBS-billed specialist clinics; or
  - Offering patients the choice to be treated as public patients (with no billing against the MBS) in clinics that predominantly provide MBS-billed specialist clinics; or
  - Making arrangements for patients to receive services as public patients in another accessible public hospital.

#### ***3. Referral to a named medical specialist exercising a right of private practice with patient choice of private patient status (Clause 41 (b))***

Assuming that the first two criteria are satisfied, public hospitals must still ensure that medical practitioners engaged in providing MBS-billed specialist clinics are aware of the importance of the referral and patient choice requirements of the AHCA. Particular attention should be paid to:

- The requirement that a referral be to a named medical specialist; and
- The requirement that the patient 'chooses to be treated as a private patient'.

Although there are no standards comparable to the election process for admitted patients, public hospitals should ensure that patients accessing MBS-billed specialist clinics are able to choose treatment as a public or private patient.

## Information sheet 5

### Medical remuneration models for MBS-billed specialist clinics

#### Context and history of remuneration models

There is a long history of MBS-billed specialist clinics being provided in some public hospitals. Accordingly, there are a variety of remuneration models in place between public hospitals and medical practitioners relating to MBS-billed specialist clinics. In addition, these remuneration models exist in a broader context of rights of private practice relating to services provided to inpatients.

Decisions about the establishment of MBS-billed specialist clinics in public hospitals are often driven by the need to recruit and retain a skilled specialist medical workforce.

Given this overarching context, decisions about specific remuneration models for medical practitioners involved in providing MBS-billed specialist clinics must occur at the level of individual public hospitals. However, this Information sheet provides public hospitals with advice on the implications of particular remuneration models that they should consider in establishing MBS-billed specialist clinics.

#### Remuneration options

There are many variations on remuneration relating to the exercise of rights of private practice by medical practitioners in public hospitals. It is not feasible to describe all the possible models. In broad terms, the main options are arrayed along a spectrum and comprise:

1. One hundred per cent donation (to the hospital) model.
2. Fee sharing (between the hospital and medical practitioner) model.
3. One hundred per cent retention (by the medical practitioner) model.

The implications and issues arising from the use of each of these models are discussed below. Information sheet 7 separately outlines the medical indemnity implications of each of these models. It is anticipated that public hospitals will seek their own legal, financial and industrial advice on the impact of adopting particular remuneration models.

#### 100 per cent donation model

The 100 per cent donation model has been comprehensively described and analysed in the context of work undertaken by the Department of Human Services to clarify taxation issues associated with income derived from rights of private practice exercised by medical practitioners in Victorian public hospitals.

Detailed information on the 100 per cent donation model (including the tax implications) is included in the Department of Human Services 2005 Communiqué available at:

[www.health.vic.gov.au/privatepractice](http://www.health.vic.gov.au/privatepractice)

## Information sheet 5 continued

### Medical remuneration models for MBS-billed specialist clinics

It is noted that the Australian Taxation Office (ATO) has sanctioned the 100 per cent donation model, as it is specified in Class ruling 2005/26 (contained within the 2005 Department of Human Services Communiqué). This provides a level of certainty, resulting in this model being preferred by some medical practitioners and hospitals involved in setting up rights of private practice arrangements.

The Department of Human Services has noted that “with respect to all the other rights of private practice models, it is not possible to obtain ATO formal tax sign-off due to the plethora of model variations across the sector”. Public hospitals and medical practitioners should take this into consideration in decision-making on MBS-billed specialist clinics.

In simple terms, the key elements of the 100 per cent donation model as it might apply to remuneration of medical practitioners providing MBS-billed specialist clinics include:

- One hundred per cent of the fee payable under the MBS is donated by the medical practitioner to the public hospital. The sample Private Practice Agreement in the ATO Class Ruling allows for agreement between the medical practitioner and the hospital as to the share of private practice revenue that is allocated to the Craft Special Purpose Fund.
- Within the 100 per cent donation model, there is considerable flexibility as to how the donated funding is used, allowing the hospital and medical practitioner to reach mutually advantageous outcomes. For example, funding allocated to the Craft Special Purpose Fund can be used to pay expenses related to training and education of medical staff, or for the purchase of equipment.
- The requirements of the AHCA in relation to the provision of public and MBS-billed specialist clinics are satisfied (further information on these issues is included in information sheet 4).
- The medical practitioner is an employee of the hospital, is exercising a right of private practice and meets all the billing requirements of the MBS (further information on these issues is included in information sheet 6).
- It is assumed that the fee charged against the MBS in this model would be equivalent to the direct-billing or bulk-billing level of Medicare benefits.
- There is no management fee (previously referred to as a facility fee) payable by the medical practitioner to the hospital.
- The hospital provides and meets the cost of allied health, nursing and administrative support for the medical services provided under this model.
- The hospital manages billing against the MBS on behalf of the medical practitioner.
- Patient records for these services are integrated with hospital records, with patient record management being in compliance with the relevant privacy and confidentiality provisions of the *Victorian Health Records Act 2001* and any other relevant legislation. Ordinarily this would involve making information available to patients. Patients would be advised that records of the consultation will be managed by the hospital and available to the practitioner and the hospital if there was a need for further treatment.

## Information sheet 5 continued

### Medical remuneration models for MBS-billed specialist clinics

#### Fee sharing model

This model is, by definition, broad. It can apply in circumstances where:

- There is bulk-billing as well as circumstances where there is a patient co-payment; and
- The medical practitioner is an employee who is exercising rights of private practice as well as to Visiting Medical Officers (VMOs).

The basis for the fee-sharing is where there is an agreement between the hospital and medical practitioner to:

- Fee-share with a proportion of the total fees donated back (or otherwise ceded) to the hospital;
- Fee-share with a proportion of the total fee paid into a Special Purpose Fund (SPF) or similar, which is referable to the practitioner's use of publicly owned equipment or other assets to generate the (private) income; and/or
- Fee-share with a proportion of the total fee being 'retained' to the benefit of the hospital as a management fee (whether broadly or specifically defined) in relation to services provided by the hospital including:
  - Patient billing and/or claiming of medical benefits.
  - Reception, appointments and medical records.
  - Overhead costs (such as fuel, light and power, linen).
  - Nursing and allied health clinical support services.

In general, it would be expected that the fee sharing model would operate similarly to the 100 per cent donation model by including the following elements:

- It is assumed that the fee charged against the MBS in this model would be equivalent to the direct-billing or bulk-billing level of Medicare benefits;
- The cost of hospital-provided allied health, nursing and administrative support for the medical services under this model are reflected in the management fee.
- The hospital manages billing against the MBS on behalf of the medical practitioner.
- Patient records for these services are integrated with hospital records, with patient record management being in compliance with relevant privacy and confidentiality provisions of the *Victorian Health Records Act 2001* and any other relevant legislation.

## Information sheet 5 continued

### Medical remuneration models for MBS-billed specialist clinics

#### 100 per cent retention model

This model may be in place for some services provided in specialists' private rooms (or similar settings) located at public hospitals. Under this model, there is not necessarily any fee agreement between the hospital and the medical practitioner. Instead, the medical practitioner retains 100 per cent of the fees.

The main elements that would follow from use of this model are:

- The level of fee charged against the MBS is at the discretion of the medical practitioner (and may or may not include co-payments).
- The medical practitioner undertakes their own billing against the MBS with no involvement of, or agency role, for the hospital.
- Patient records are held by the medical practitioner and not integrated with hospital records.
- The medical practitioner directly employs any required nursing and administrative staff that support the medical services provided under this model. If there is any use of hospital-employed staff or other support services, a management fee should be negotiated between the hospital and the medical practitioner.

In both the fee sharing model and the 100 per cent retention model, it is assumed that hospitals will seek to negotiate management fees (or similar arrangements) with medical practitioners that balance the need to have a skilled medical workforce available with the objective of ensuring an equitable and proportionate sharing of financial costs and benefits. In some cases this may occur directly through management fees and in other cases it may involve offsetting obligations on the medical practitioner, for example on-call arrangements.

## Information sheet 6

### Billing against the MBS for MBS-billed specialist clinics

#### Responsibilities of medical practitioners

Billing by medical practitioners providing care in MBS-billed specialist clinics must comply with the relevant provisions of the Medicare Benefits Schedule (MBS) and the *Health Insurance Act 1973*.

This information sheet includes general background information on issues that are important in ensuring appropriate billing for medical services provided in MBS-billed specialist clinics. However, it is the responsibility of individual medical practitioners to ensure that their billing practices comply with all relevant Australian Government requirements. Medical practitioners should consult the current version of the MBS and any other supporting information issued by Medicare Australia. This information sheet does not replace this obligation.

In broad terms, appropriate billing against the MBS is based on the following key elements:

1. Medicare benefits are only payable for **clinically relevant services** which are listed in the MBS.
2. Medical practitioners must meet **eligibility criteria** to be able to provide medical services that will attract Medicare benefits. This includes being a recognised specialist, consultant physician or general practitioner, or being in an approved placement or a temporary resident doctor (subject to the rules and conditions specified under relevant legislation and other information sources).
3. Eligible medical practitioners must have a **valid provider number** for the location where the services are to be provided.
4. Services to be provided by a specialist or consultant physician must meet the **valid referral** criteria. It is noted that there are exceptions to the usual referral requirements for a referral generated during an episode of hospital treatment, in respect of a privately insured service provided or arranged by that hospital, where the hospital records provide evidence of a referral including the referring practitioner's signature.
5. The specific **billing procedure** requirements of Medicare Australia should be met. It is noted that where services are direct billed (commonly referred to as bulk billed), the medical practitioner accepts the relevant Medicare benefit as full payment for the service and additional charges (irrespective of the purpose or title of the charge) cannot be raised against the patient.
6. The appropriate **Medicare benefit level** should be claimed. The Medicare Benefits Schedule outlines the various benefit levels payable (75 per cent, 85 per cent and 100 per cent) and the situations in which these benefit levels are payable.

## Information sheet 6 continued

### Billing against the MBS for MBS-billed specialist clinics

7. Medical services must be rendered **by, or on behalf of, a medical practitioner**. The Medicare Benefits Schedule sets out the relevant supervision requirements for services that are rendered by a person who is an employee of the medical practitioner or otherwise acting under the supervision of the medical practitioner. To attract a Medicare rebate, the service must be billed in the name of the supervising medical practitioner who must accept full responsibility for the service.
8. Medical practitioners must maintain **adequate and contemporaneous** records for services for which a Medicare benefit is payable. The Medicare Benefits Schedule notes that records for hospital patients are usually kept by the hospital.

### Role of public hospitals in management of billing

It is the responsibility of individual medical practitioners providing care in MBS-billed specialist clinics to meet the billing requirements of Medicare Australia. However, billing does not have to be undertaken directly by individual medical practitioners. Public hospitals are able to undertake the management of billing for medical practitioners providing care in MBS-billed specialist clinics. The assumption of responsibility for management of billing by public hospitals would usually be linked to the remuneration arrangements between the medical practitioner and the public hospital, which may or may not include management fees. These issues are discussed further in information sheet 5.

## Information sheet 7

### Medical indemnity issues for MBS-billed specialist clinics

#### Background and history

Public hospitals should be aware of and understand the terms of the Victorian Managed Insurance Authority's (VMIA) policy in relation to indemnity arrangements for medical practitioners providing MBS-billed specialist clinics in outpatient settings where a Medicare benefit is raised for consultations, for instance where a charge is raised against the MBS (either bulk billed or otherwise).

The policy covers these arrangements in the same manner as MBS-billed charges raised by medical practitioners in relation to inpatient services.

Historically, indemnity was provided for medical practitioners employed by public hospitals who had a right of private practice and who remitted fees to a Dillon or other special purpose fund on a not less than 60/40 split. The split quantum is no longer a fundamental criterion, with the policy now referring to remitting "all or part of the fees earned" to a Dillon or other special purpose fund or like arrangement established by the hospital, or remitting all of the earned income to the hospital.

#### Current status

The policy provides that an "Insured" person (someone who is entitled to indemnity) includes:

Registered medical practitioners or other natural persons whilst providing health care services to patients of the health service or organisation named in the Schedule in accordance with the exercise of a right of private practice granted to the registered medical practitioner in his or her capacity as a full time or part time employee of the health service or organisation provided that the terms of the registered medical practitioner's employment contract require the registered medical practitioner to:

- (a) Remit all or part of the fees earned in respect of such patient to a Dillon Fund, special purpose fund, trust or like arrangement established by or in conjunction with the employing health service or organisation; or
- (b) Remit all of the registered medical practitioner's income to the employing health service or organisation.

The *VMIA Medical Indemnity Policy* is available at:

<http://202.148.151.113/skillsEDIT/clientuploads/48/Medical%20Indemnity%20Policy%20Wording%202007-2008.pdf>

VMIA provides explanatory notes in the Public Healthcare Program Insurance Manual and adds the following additional qualifications:

- The medical practitioner is a full-time or part-time employee and enters into an employment contract (as an individual) with the hospital.
- The right of private practice is part of the employment agreement.
- The right of private practice is limited and the practitioner is primarily employed to provide public patient services.
- The hospital bills private patients on behalf of the practitioner.

## Information sheet 7 continued

### Medical indemnity issues for MBS-billed specialist clinics

- These fees are remitted to a Dillon fund, special purpose fund or like arrangement.
- All or some of the fees are remitted to the hospital as a facility fee and any remainder distributed as agreed.
- Sessional VMOs may be eligible to participate where there is an employment arrangement.

The *Public Healthcare Program Insurance Manual for Public Hospitals (Metropolitan) 2007-2008* is available at:

[www.vmia.vic.gov.au/skillsEDIT/clientuploads/48/07-08%20Manual%20-%20Hospitals%20METRO%20230807.pdf](http://www.vmia.vic.gov.au/skillsEDIT/clientuploads/48/07-08%20Manual%20-%20Hospitals%20METRO%20230807.pdf)

It is clear that the VMIA Medical Indemnity Policy covers medical practitioners engaged in providing MBS-billed specialist clinics under both the 100 per cent donation model and agreed fee-sharing model, as discussed in information sheet 5. This is subject, of course, to compliance with the requirements set out in section 4 of the policy and the additional points of guidance set out in the manual.

The “100 per cent retention model” (medical practitioner retaining 100 per cent of the fees) is clearly not covered by the Medical Indemnity Policy and medical practitioners would need to rely on their own insurance.

## Information sheet 8

### The use of MBS item numbers in community health

The funding of services through the MBS has broad applicability for state-funded services. The department is currently undertaking a project to provide information and advice to state-funded community health agencies who may be looking to expand the range of services available to clients through the MBS. Though this sector has a long history of working with general practitioners, reforms to the general medical, allied and dental health schedules of the MBS present further opportunities for this sector to expand the scope of these partnerships.

The project will provide:

- Key messages about using MBS item numbers in community health (see below)
- A website that summarises the suite of new MBS item numbers progressively introduced by the Commonwealth since 1999, their business rules, and client eligibility for these services.  
See [www.health.vic.gov.au/communityhealth/gps/mbs/index](http://www.health.vic.gov.au/communityhealth/gps/mbs/index)
- Community health MBS forums in every DHS region
- A guide, including case studies, to be published shortly.

#### Key messages about using MBS item numbers

##### Relevance to community health

Models supporting effective chronic disease care are of particular relevance to the community health sector because:

- a high proportion of community health clients have chronic and/or complex and mental health conditions
- both State and Commonwealth governments have identified chronic disease management and mental health as high priorities
- the case for integration across the sector is now stronger than ever before, with the State and Commonwealth Governments having similar priorities for health

##### New MBS item numbers

A suite of new MBS item numbers have been progressively introduced to support optimal, evidence-based models of care over the past nine years. The new items:

- encourage a more integrated approach to health care provision
- provide a catalyst for strengthening partnerships with general practice and other public and private primary health providers through Primary Care Partnerships and often involving divisions of general practice who have expertise in GP engagement
- provide impetus for agencies to reconfigure their services to increase client access to services, and maximise care options

## Information sheet 8 continued

### The use of MBS item numbers in community health

#### Service models

Enhanced access to services (public or private) for clients of community health services can be a significant outcome of work by community health services to implement new models of care that involve GPs and incorporate appropriate MBS item numbers.

- Models adopted should not result in a reduction of public allied health services.
- The implementation of new multidisciplinary models of care that incorporate MBS services is relevant to all community health services, whether or not they manage medical clinics, because all clients can benefit from integrated models of care.
- Community health agencies need to ensure that any new service models are compliant with s19(2) of the *Health Insurance Act 1973 (Commonwealth)* by seeking legal advice.
- Services funded through the Medicare Benefits Schedule are in addition to services funded by Primary Health Branch. If an agency is recording an MBS-funded service in the client management software, the funding source should be recorded as 'MBS-funded service'. As the funding source is different, MBS-funded services should not be included by community health services as part of their reporting to Primary Health Branch for Branch-funded activities.
- Community health services will determine which models are likely to be best suited to their clients, often in collaboration with other providers and with the input of clients. These decisions should be based on a local analysis of client characteristics and needs, the prevalence of chronic disease, the availability of local services and providers with whom models of care can be built, and the likely future impact on currently funded client services, community health workforce and demand management strategies .



