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| MBS billing policy in Victorian public hospitals |
| Interpretive guidelines for best practice |
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| MBS billing policy in Victorian public hospitals  Interpretive guidelines for best practice |
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# Introduction

Eligible persons attending public hospitals are entitled to be treated as public patients. Under the National Health Reform Agreement, both the Commonwealth and the state are jointly responsible for funding Victorian public hospitals. This is mostly using activity-based funding (ABF) and block funding in some instances.

The ABF model funds public hospitals for the number and mix of patients that they treat. This activity is capped based on a fixed number of National Weighted Activity Units (NWAU) available to the system with system annual growth currently capped at 6.5%. This means that there are limited opportunities for growth within the national ABF model.

There is a long history across Australia of billing under the Medicare Benefits Schedule (MBS) for services provided to private patients in public hospitals. If a public hospital provides the same services on a private basis, a patient may choose to be treated as a private patient. This allows billing under the MBS and may assist the public hospital with meeting additional demand for services and optimise revenue opportunities for the public hospital.

The Department of Health’s policy document, *MBS billing policy framework: Victorian public hospitals*, states the requirements that apply to Victorian public hospitals billing under the MBS: compliance with Commonwealth and Victorian policies, legislations and agreements, rights of private practice, accessibility of services and patient consent. It also provides Victorian public hospitals with clarity on the Department of Health’s expectations when billing under the MBS.

While the policy document refers to private patients, it is referred to, in its most generic form. For the purpose of this guidance document the term “private patients” will be used to identify those who assign their Medicare benefits and are able to claim under their private health insurance (where available) for those public hospital services. “MBS-billable patients” will be used to identify those who assign their Medicare benefits for the non-admitted services provided by the public hospital.

The policy document applies to all Victorian public hospitals and health practitioners who are exercising a right of private practice within a Victorian public hospital. The services provided refer to all health services provided at a Victorian public hospital urgent care centre, inpatient, outpatient and diagnostic imaging and pathology departments.

This guidance document is to be read in conjunction with the policy document.

# About this document

The *MBS billing policy in Victorian public hospitals: Interpretive guidelines for best practice* states the Department of Health’s guidance on the best practice arrangements when complying with the legal requirements regarding billing of services under the MBS.

## Purpose

The objectives of this document are to:

* Assist Victorian public hospitals with mitigating risks of claims being rejected by Medicare and the recall of incorrectly claimed Medicare benefits identified through data matching.
* Provide clarity and a consistent approach to managing private practice in Victorian public hospitals and interpreting the relevant Commonwealth and Victorian policies, legislations and agreements and how they apply to the department’s policy document, *MBS billing policy framework: Victorian public hospitals*.

## Scope

These best practice guidelines are applicable to all Victorian public hospitals and health practitioners who are exercising a right of private practice within a Victorian public hospital. The services provided refer to all health services provided at a Victorian public hospital urgent care centre, emergency, inpatient, outpatient and diagnostic imaging and pathology departments.

## Acknowledgement

These best practice guidelines have been developed based on input from members of the following groups:

* A small working group consisting of staff working under revenue management from seven public hospitals.
* Health Service Funding Advisory Group (HSFAG)
* Industry Finance Committee (IFC)
* Northern Health
* Specialist Clinics Roundtable
* Victorian General Practitioner Liaison Network
* Workshops organised by the department and attended by Chief Finance Officers (CFOs), Chief Executive Officers (CEOs), administrators and medical staff.

The Victorian Department of Health would like to acknowledge that some resources included in this document have been adapted from resources developed by the Commonwealth, New South Wales, Queensland, South Australia and Western Australia. The Victorian Department of Health has included information relevant to its jurisdiction and adapted information as required to meet the needs of its public hospitals and legislative requirements.

## Implementation

Public hospitals and health practitioners exercising rights of private practice should in following the best practice guidelines:

1. effectively manage and monitor the delivery of private practice in Victorian public hospitals to achieve desired outcomes;
2. implement a robust governance framework that supports the implementation and operation of services provided to private patients at a local level;
3. document and embed internal controls in the operations of management and governance processes; and
4. develop locally tailored training and education programs for staff who manage the billing of services under the MBS.

Section 7 sets out governance, performance and accountability requirements for the implementation of these guidelines. Section 8 sets out the types of training that should be delivered to different staffing groups.

## Review

These best practice guidelines will be reviewed as required to ensure relevance and recency. At a minimum, these guidelines will be reviewed at least every three years.

## Revision History

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| Version | Date | Comments |
| 1 | June 2008 | Original Policy |
| 2 | February 2011 | This version, *Specialist clinics in Victorian public hospitals: A resource kit for MBS-billed services*, has been updated in the context of the National Healthcare Agreement and the Victorian Auditor-General’s 2008 report, *Private Practice Arrangements in Health Services*. This document intended to assist public hospitals in developing business cases for MBS services. |
| 3 | January 2019 | Errata issued, while reviewing the 2011 version of the policy. |
| 4 | July 2022 | This version has been updated in the context of the National Health Reform Agreement and the Victorian Auditor-General’s 2019 report, *Managing Private Medical Practice in Public Hospitals*. This document establishes and separates the policy framework from guidance provided in earlier versions. The policy document, *MBS billing policy framework: Victorian public hospitals,* was published in July 2020. This guidance document, *MBS billing policy in Victorian public hospitals: Interpretive guidelines for best practice,* is published in July 2022. |

# Compliance with Commonwealth and Victorian policies, legislations and agreements

Public hospitals and health practitioners who provide MBS-billed services must comply with the following documents.

***Health Insurance Act 1973***

The *Health Insurance Act 1973* (as amended) states the legislation for the payment of Medicare benefits listed in the MBS (Part II). The Act can be accessed at: <https://www.legislation.gov.au/Series/C2004A00101>

***Health Insurance Regulations 2018***

The *Health Insurance Regulations 2018* also states the regulations that govern the payment of Medicare benefits. This includes special provisions relating to diagnostic imaging and pathology services. It can be accessed at: <https://www.legislation.gov.au/Series/F2018L01365>

**MBS billing policy framework: Victorian public hospitals**

The document, *MBS billing policy framework: Victorian public hospitals*, sets out four principles that apply to billing under the Medicare Benefits Schedule: compliance with national agreements and legislation, accessibility of services, patient consent, and rights of private practice. The objective of this document is to provide hospitals clarity on the Department of Health’s expectations when billing under the MBS occurs within Victorian public hospitals in inpatient, outpatient, pathology or diagnostic imaging departments. It can be accessed at: <https://www.health.vic.gov.au/funding-performance-accountability/mbs-billing-policy-framework-victorian-public-hospitals>

**Medical Indemnity Master Insurance Policy**

The Medical Indemnity Master Insurance Policy by the Victorian Managed Insurance Authority (VMIA) covers Victorian registered health practitioners for claims related to injuries to patients. The policy can be accessed at: <https://www.vmia.vic.gov.au/insurance/policies-and-cover/medical-indemnity>

**Medicare Benefits Schedule (MBS)**

The MBS lists the professional services for which a Commonwealth-funded payment can be claimed under the Medicare reimbursement system. Each professional service is associated with a unique item number, service description, schedule fee and benefit payable. The MBS can be accessed at: <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home>

**National Health Reform Agreement (NHRA)**

The NHRA 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 Addendum to the NHRA can be accessed at: <https://www.health.gov.au/initiatives-and-programs/2020-25-national-health-reform-agreement-nhra>

**Specialist clinics in Victorian public hospitals: Access policy**

The *Specialist clinics in Victorian public hospitals: Access policy* gives the authority for the development of relevant local policies, protocols and procedures for public hospitals to implement government policy related to service delivery for non-admitted specialist services. The Access policy can be accessed at: <https://www.health.vic.gov.au/publications/specialist-clinics-in-victorian-public-hospitals-access-policy>

**Patient fees and charges for public hospitals**

The Commonwealth Department of Health and Victorian Department of Health provide policies about the fees and charges that can be levied on patients of public hospitals for some services that they receive. Further information can be accessed at: <https://www.health.vic.gov.au/hospitals-and-health-services/patient-fees-and-charges-for-public-health-services>

**Elective surgery access policy**

The *Elective surgery access policy* provides guidance to public hospital executives on the delivery of planned surgery and procedures. The policy can be accessed at: <https://www.health.vic.gov.au/patient-care/surgical-services-policies-and-guides>

**Policy and funding guidelines**

The document, *Policy and funding guidelines*, provides the department’s policy framework, objectives, budget, service deliverables, desired outcomes, reporting requirements, program guidelines and funding initiatives. The document can be accessed at: <https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services>

**Private patients: Principles for public health services**

The *Private patients: Principles for public health services* sets out the principles that apply to private patients who receive care in public hospitals. It provides hospitals with the department’s service delivery expectations, including those relating to patient choice and the provision of patient care. This document can be accessed at: <https://www.health.vic.gov.au/publications/private-patient-principles-for-public-health-services>

## Billing under the MBS

Billing under the MBS in a public hospital is allowed if:

* 1. a service (or a component of that service) has not been funded under the NHRA or another Commonwealth Program; or
  2. an exemption has been granted under section 19(2) of the *Health Insurance Act 1973*.

And when:

* 1. eligible patients have a choice to access the same service as a public patient;
  2. eligible patients are enrolled with Medicare and provide informed financial consent to assign their Medicare benefits;
  3. practitioners are eligible to provide services which will attract Medicare benefits; and
  4. practitioners have been granted right of private practice by the public hospital.

Evidence of the patient’s election to assign their Medicare benefits in accordance with Medicare Australia requirements must be documented for each admitted episode of care and non-admitted episode.

Public hospitals performing administrative functions on behalf of health practitioners must have supporting documentation that substantiates billing under the MBS.

### Data matching

The *Addendum to the NHRA 2020-2025* requires that the Administrator of the National Health Funding Pool undertake data matching. Data matching identifies instances where public hospitals may have reported a public hospital service under the NHRA and inadvertently claimed the same service (or a component of that service) under the MBS that do not fall under the exemptions of clause A10 of the Addendum to the NHRA.

Matches may include instances in which a patient has been miscoded as a public patient instead of a private patient. Where this is verified, the NHRA funding amount must be adjusted to reflect that the patient was treated as a private patient.

Where matches have been verified to have been inappropriately funded under both the NHRA and the MBS, the Administrator will refer these records to support Commonwealth MBS compliance activities.

### Exemptions granted from section 19(2) of the *Health Insurance Act 1973*

The Council of Australian Government’s *Improving Access to Primary Care in Rural and Remote Areas (s19(2) Exemptions) Initiative* (Initiative) is targeted at rural and remote hospitals and health services within categories 5-7 of the Modified Monash Model Classification System. Under the Initiative, these facilities are eligible for an exemption from section 19(2) of the *Health Insurance Act 1973*.

Provided all legislative requirements are met, exempted eligible sites can claim under the MBS, meaning bulk-bill for non-admitted, non-referred professional services (including nursing, midwifery, allied health and dental services).

Sites are responsible for ensuring that patients who receive eligible services assign their Medicare benefits in accordance with Medicare Australia requirements. The requirement for the assignment of Medicare benefits is not unique to this initiative and applies to services bulk-billed Australia-wide under ordinary arrangements with Medicare.

### What services are covered by the MBS?

MBS contains a list of services and a description that, if fulfilled, will entitle an eligible person to the payment of a Medicare benefit.

Medicare benefits are payable for professional services as stated in the *Health Insurance Act 1973* (section 10). The interpretation of 'professional service' is a clinically relevant service that is rendered by or on behalf of a practitioner. A service is defined as a clinically relevant service if it is generally accepted by the relevant profession as necessary for the appropriate treatment of the patient (MBS, section GN.1.2 and subsection 3(1) of the *Health Insurance Act 1973*).

For certain services provided by medical specialists and consultant physicians, the Medicare benefit payable is dependent on acceptable evidence that the service has been provided following referral from another practitioner (MBS, section GN.6.16).

### What services are not covered by the MBS?

The *Health Insurance Act 1973* (sections under Part II-Medicare benefits) and the MBS (section GN.13.33) provide details of the services which do not attract Medicare benefits. The list below highlights the main services that are not eligible for Medicare benefits, however the list is not exhaustive:

* Services provided at a public hospital emergency department, before any clinical decision to admit.
* Ambulance services.
* Professional services that are not described by an item number in the MBS.
* Professional services that are rendered by, on behalf of or under an arrangement with the Commonwealth, a State, a local governing body or an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory (*Health Insurance Act 1973*, section 19(2)).

### Patient choice and access to services

A public hospital cannot provide health services exclusively on a private basis (NHRA, clause 11a). Hospitals must ensure that similar services are provided by the public hospital and available to be accessed by public patients free of charge within a clinically appropriate period based on clinical need.

If a public hospital provides the same services on both a public and private basis, eligible persons have the choice to be treated as a public or private patient. To assist eligible persons with this choice:

* Clear and consistent signage and information must be made available to patients.
* Clerical procedure manuals should contain statements to assist staff to reinforce the capacity for an eligible patient to make that choice.

Whether or not a health practitioner in a public hospital may provide MBS-billed services for Medicare eligible patients will depend on the setting of the patient’s treatment. The NHRA allows MBS billing under limited circumstances.

### Patient eligibility

An eligible person must be enrolled with Medicare and provided informed financial consent to assign their Medicare benefits.

Medicare cards may be issued for individuals or families. Persons aged 15 or older may apply for their own Medicare card.

The three different types of Medicare card issued are:

* green Medicare card - for people permanently in Australia
* blue Medicare card (INTERIM CARD) - for people who have applied for permanent residence
* RECIPROCAL HEALTH CARE card (RHCC) - for visitors from countries with which Australia has a Reciprocal Health Care Agreement

RHCC holders are only entitled to free public health care as public patients. They are not covered for treatment as a private patient in a public or private hospital.

Please refer to section AN.0.6 in the MBS for more details.

#### People seeking asylum

While many people seeking asylum are Medicare eligible, eligibility can vary depending on bridging visa type or status. Generally, if a person does not have work rights, they will not be Medicare eligible. Medicare eligibility is tied to having a valid visa and is identified by an interim Medicare card (blue). Note that all refugees including those on temporary visas are Medicare eligible (including Temporary Protection Visas and Safe Haven Enterprise Visas).

#### Prisoners

Medicare benefits cannot be billed for prisoners under section 19(2) of the *Health Insurance Act 1973* for the services listed in the MBS. Prisoners are eligible for free treatment as a public patient in a public hospital.

#### Medicare Ineligible

Ineligible persons attending public hospitals are private patients (please see the Glossary for further details). As such, these patients are responsible for paying all accommodation, medical, prosthesis, diagnostic imaging and pathology costs and must provide informed financial consent (written or electronic). Public hospital services for these patients cannot be billed to the MBS.

### Provider eligibility

All health practitioners providing MBS-billed services in a Victorian public hospital are required to have been granted rights of private practice by the public hospital.

**Under the *Health Insurance Act 1973*, section 19(2):**

* Where a practitioner is employed or engaged by the public hospital, the practitioner can only provide Medicare services in the course of the practitioner providing services pursuant to their right of private practice; and
* Medicare benefits cannot be claimed for professional services that are rendered by, on behalf of or under an arrangement with the Commonwealth, a State, a local governing body or an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory, unless the Minister states otherwise. Please refer to section 3(1) of the Act for the definition of professional services.

**Medical practitioners**

Medical practitioners, to be eligible to provide MBS-billed services, or to provide services for, or on behalf of, another practitioner, must meet one of the following criteria:

1. be a recognised specialist, consultant physician or general practitioner (GP); or
2. be in an approved placement under section 3GA of the *Health Insurance Act 1973;* or
3. be a temporary resident doctor with an exemption under section 19AB of the *Health Insurance Act 1973* and working in accord with that exemption.

**Non-medical practitioners**

Non-medical practitioners (allied health professionals, dentists, and dental specialists, participating midwives and participating nurse practitioners) to be eligible to provide MBS-billed services under the MBS items 10950-10977, 80000-88000, 82100-82140 and 82200-82215, must meet both the following criteria:

1. registered according to State or Territory law or, absent such law, be members of a professional association with uniform national registration requirements; and
2. registered with the Commonwealth Department of Human Services to provide these services.

Please refer to section GN.2.4 in the MBS for more details.

**Interns, registrars and trainees**

Registrars, in an approved placement under section 3GA of the *Health Insurance Act 1973* are eligible to provide services which will attract Medicare benefits.

For eligibility requirements for interns and trainees to access Medicare benefits, please refer to: <https://www.servicesaustralia.gov.au/intern-registrar-and-trainee-eligibility-requirements>

#### Provider numbers

Health practitioners providing services that can be billed under the MBS must have a valid provider number for the location where the services are provided (MBS, section GN.2.5).

#### Supervision

Certain medical services can be billed under the MBS if the service is rendered on behalf of a medical practitioner, where the person is either employed by or acts under the supervision of the medical practitioner. To be able to claim the Medicare benefit the service must be billed in the name of the medical practitioner who must accept full responsibility for the service.

All elements of the service must be performed in accordance with accepted medical practice.

While the supervising medical practitioner need not be present for the entire service, they must have a direct involvement in at least part of the service. Although the supervision requirements will vary according to the service in question, they will, as a general rule, be satisfied where the medical practitioner has:

* established consistent quality assurance procedures for the data acquisition; and
* personally analysed the data and written the report.

There are, however, some medical services that can be billed under the MBS only if the medical practitioner has personally performed the service. Please refer to MBS, section GN.12.30, for a list of these services.

Please refer to sections GN.12.30 and GN.12.31 in the MBS for more details.

#### Maintenance of records

It is the responsibility of practitioners to maintain adequate and contemporaneous records of all services attracting Medicare benefit payment (MBS, section GN.15.39). For the definition of 'practitioners', please refer to the *Health Insurance Act 1973* (section 81).

### Billing procedures

Hospitals may bill, collect and distribute MBS-billed revenue on behalf of and under agreement with health practitioners exercising rights of private practice. Hospitals should have timely and accurate process monitoring mechanisms that facilitate this.

Health practitioners must ensure they have fulfilled the service requirements as specified in the item descriptor have been met and that the services provided are eligible for Medicare benefits to be paid. It is at the health practitioner’s own risk to allow hospital administrators or any other party to claim Medicare benefits utilising their provider number (see <https://www.health.gov.au/health-topics/medicare-compliance/public-hospitals>).

Health practitioners are legally responsible for the claim made under the MBS and repayment for any incorrect billing even though the hospital may have performed the billing on the health practitioners’ behalf and/or received the Medicare benefit (see <https://www.health.gov.au/health-topics/medicare-compliance/how-to-comply-with-your-medicare-obligations>).

The specific billing procedures required by Medicare must be met. Where professional services are bulk-billed, the practitioner accepts the relevant Medicare benefit as full payment for the service and additional fees cannot be charged to the patient (*Health Insurance Act 1973*, section 20A and MBS, section GN.7.17). Please refer to the MBS, section GN.7.17, for exceptions to the above.

**Claims rejected or incorrectly claimed under the MBS**

Where claims are rejected or incorrectly claimed under the MBS, hospitals should investigate and rectify claims. As much as possible, hospitals should prevent any error, fraud, and other irregularities. If they do occur, hospitals must investigate and promptly detect them through a systematic approach. Early notification to Medicare avoids the payment of administrative penalties in addition to refund of the debt (see <https://www.health.gov.au/health-topics/medicare-compliance/debts-and-penalties>).

## Diagnostic imaging and pathology services

These guidelines broadly reference diagnostic imaging and pathology services as components of a public hospital service as described by the NHRA. Principles outlined in this document extend to other diagnostic services (e.g. neurodiagnostics, cardiology and respiratory diagnostic tests and PET-MRI) where these are also components of a public hospital service.

Eligible persons may assign Medicare benefits for public hospital diagnostic imaging and pathology services as a component of a public hospital service or as a separate service provided that on the date of request:

* the eligible person was not a public patient; or
* the service was not related to a public admitted episode or a public non-admitted service event.

Please refer to the NHRA, clause G20, for more details.

A request for any public hospital diagnostic imaging or pathology service must be in written form (including electronic).

### Type of provider

Public hospital diagnostic imaging and pathology services may be provided ‘in-house’ or through a third-party provider who is either contracted or not contracted to the public hospital.

### Request form

**Public hospitals must comply with the requirements stated in the *Health Insurance Regulations 2018* and MBS on the information that must be included in the request form for diagnostic imaging and pathology services.**

* The *Health Insurance Regulations 2018* (sections 32 to 37 and 70) and the MBS (sections IN.0.6, PN.2.1 and PN.2.2) require requests for diagnostic imaging and pathology service comprise certain information. The request must include the date of the request, description of the service requested, details of the requesting health practitioner and any other information required to substantiate the claim.
* To avoid being inappropriately funded by the MBS, the request regardless as to what is required under the *Health Insurance Regulations 2018* must also state if the eligible person was a public or private patient on the date of request.
* A request for any public hospital diagnostic imaging or pathology service must be in written form (including electronic).
* Further details on requesting for diagnostic imaging and pathology services can be accessed at:
  + <https://www.health.gov.au/health-topics/medicare-compliance/public-hospitals>
  + <https://www.servicesaustralia.gov.au/referring-and-requesting-medicare-services>
  + <https://www.health.gov.au/resources/collections/health-professional-guidelines>
* Also refer to the following:
  + Health Insurance (Diagnostic Imaging Services Table) Regulations 2020: <https://www.legislation.gov.au/Series/F2020L00713>
  + Health Insurance (Pathology Services Table) Regulations 2020: <https://www.legislation.gov.au/Series/F2020L00460>

### Request from GP in a private clinic

Where a request is made by a GP in a private clinic that is not associated with a public hospital, this is considered separate and not during an emergency presentation, admitted episode or outpatient appointment in a public hospital. A new patient election point arises in relation to that diagnostic imaging or pathology service and the service may be bulk-billed against the MBS if the following conditions are met:

* the patient has provided informed financial consent and elected to assign their Medicare benefit; and
* evidence of the patient’s election for separate MBS-billed services must be recorded on all occasions.

### Request from emergency, admitted or non-admitted service

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| Diagnostic imaging and pathology services may be MBS billable |
| if the request is provided during an emergency department (ED) presentation:   1. after a clinical decision to admit and patient has elected to be a private inpatient.   if the request is provided during:   1. a private admitted episode or an MBS-billable non-admitted service event. |

Diagnostic imaging and pathology services described under:

* (a) is a component of the private admitted service.
* (b) is a component of the private admitted or MBS-billable non-admitted service.

Therefore, these diagnostic imaging and pathology services are not funded under the NHRA but are eligible for Medicare benefits, regardless of the type of provider. If it is a third-party provider (contracted or not contracted), eligible persons are private patients of the third-party provider and may be billed under MBS and may also incur an out-of-pocket fee.

The Independent Hospital Pricing Authority’s resource linking counting rule using the date the service was provided (which is also a requirement in the Australian Costing Standards) to link unmatched diagnostic imaging and pathology services with the appropriate admitted episode or non-admitted service event is irrelevant as to whether the service being provided is a component of a public hospital service, or as a separate service. The timing of the request will determine whether the service is being provided as a component of a public hospital service or as a separate service and whether it is able to be billed under the MBS.

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| Diagnostic imaging and pathology services are not MBS billable |
| if the request is provided during an emergency department (ED) presentation:   1. before any clinical decision to admit; or 2. after a clinical decision to admit and the patient has elected to be a public inpatient; or 3. and the service is provided after discharge.   if the request is provided during:   1. a public admitted episode or public non-admitted service event. |

Diagnostic imaging and pathology services described under:

* (a) and (c) are a component of the ED service while (b) is a component of the public admitted service.
* (d) is a component of the public admitted or public non-admitted service.

The Commonwealth contributes funding for the cost of these diagnostic imaging and pathology services through the NHRA, hence they must be provided free of charge. This is regardless of the type of provider. If it is a third-party provider (contracted or not contracted), the public hospital is responsible for paying the third-party provider for requested diagnostic imaging and pathology services. Public patients must not be billed to the MBS by the third-party provider.

Case Study 1

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| *Ms S is treated for a fracture on her arm at the emergency department (ED). During her treatment, Ms S mentions to the ED doctor that she is feeling anaemic and that her iron level may be low. The ED doctor then provides a request for a blood test to be taken after discharge.*  Can Ms S’s blood test be claimed under the MBS?  **No.** The request for the blood test was provided during the ED treatment. Regardless of the test being provided after discharge, it is still considered as a component of the ED service and must not be claimed under the MBS, regardless of the type of provider. |

Case Study 2

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| *Mr D has accidentally cut his hand deeply after breaking a glass while washing it. Mr D attends the emergency department (ED). Mr D is asked and provides informed financial consent to be treated as a private inpatient if he needs to be admitted. He is triaged and sent to have his hand X-rayed to ensure there are no fragments of glass embedded in the cut. The X-ray is clear, and Mr D’s hand is stitched and then sent home.*  Can Mr D’s X-ray be claimed under the MBS?  **No.** Even though Mr D has provided informed financial consent to be treated as a private inpatient, he remains a public patient during the ED presentation. There was no clinical decision to admit Mr D and his X-ray was requested during an ED presentation. |

Case Study 3

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| *Ms K attends her outpatient appointment as a public patient with a specialist. Ms K is given a request during her appointment for her to have pathology tests done prior to her next appointment. Ms K returns to the hospital a week prior to her appointment to have her tests performed and is asked if she agrees to have her tests billed to the MBS. Ms K agrees.*  Can Ms K’s pathology tests be claimed under the MBS?  **No.** Regardless of when the test was performed, the request was made during a public outpatient appointment. The request must also have clearly stated that Ms K was receiving services as a public patient. |

### Request from urgent care centre

Requests for diagnostic imaging and pathology services from UCCs by health practitioners employed and/or paid by the hospital to provide the UCC service must not be billed under the MBS because the patients are treated as public patients. This is regardless of the type of provider. If it is a third-party provider (contracted or not contracted), the public hospital is responsible for paying the third-party provider for requested diagnostic imaging and pathology services. Public patients must not be billed to the MBS by the third-party provider.

While requests from health practitioners contracted by the UCC, exercising rights of private practice and not paid by the hospital to provide the UCC service are providing a private service, therefore, the diagnostic imaging and pathology services may be billed under the MBS because the patients are treated as private patients of the health practitioner. This is regardless of the type of provider. If it is a third-party provider (contracted or not contracted), eligible persons are private patients of the third-party provider and may be billed under MBS and may also incur an out-of-pocket fee.

For telehealth consultations, please refer to the MBS and other relevant documents.

# Rights of Private Practice

Rights of Private Practice (RoPP) is a governing body prerogative which is granted to health practitioners upon appointment or application for same.

Employment of any kind by the public hospital is not a pre-requisite to billing under the MBS. Where a practitioner is employed or engaged by the public hospital, section 19(2) of the *Health Insurance Act 1973* requires that the practitioner only provide Medicare services in the course of the practitioner providing services pursuant to their right of private practice. The relevance of employment is to ensure that if professional services are funded by the State or by the public hospital to health practitioners who are either employed or contracted by the hospital, then a Medicare benefit must not be claimed for these services, unless the Minister otherwise directs. The aim of this policy is to prevent professional services from being claimed under Medicare that are already obtaining public funding.

Further, the department notes advice from the Commonwealth Department of Health and Ageing which states that professional services rendered by a practitioner pursuant to his or her right of private practice would be rendered under a contract between the practitioner and the patient, and not by, for, or on behalf of or under an arrangement with the government or statutory authority that has conferred or agreed to the right of private practice. Therefore, practitioners exercising rights of private practice in public hospitals and providing professional services, as defined in the Act, do not constitute a breach of section 19(2) of the Act.

## Referral to a medical specialist exercising a right of private practice

The NHRA (clauses 11, G17 and G19) allows eligible persons to assign Medicare benefits for outpatient services provided at public hospital if the patient has been referred to a named medical specialist exercising a right of private practice. This is provided:

* the public hospital provides the same service for public and private (MBS-billable) patients;
* referral to a named medical specialist is not a prerequisite for access to outpatient services;
* referral pathways have not been controlled to prevent patients from accessing a free public hospital service; and
* the eligible person has provided informed financial consent to be treated as an MBS-billable patient.

A named referral must be to a named medical specialist. This demonstrates that a medical specialist is providing services pursuant to their right of private practice and therefore not in breach of section 19(2) of the *Health Insurance Act 1973*. For the purposes of charging the MBS, the medical specialist providing the service does not need to be the named individual but must be of the same speciality and has a right of private practice. MBS will be charged under the name of medical specialist providing the service.

### Patients attending specialist clinics without a named referral

A patient receiving outpatient services without a named referral is a public patient and funded through the Commonwealth’s contribution to the NHRA. These services should not generate charges under the MBS.

A patient may choose to assign Medicare benefits at subsequent appointments and be referred by an outpatient practitioner who has referral rights for the service, to a named practitioner when it is clinically appropriate to do so. Public hospitals must ensure that they have appropriate policies and protocols to govern this process.

Please refer to the MBS, section GN.6.16, for a summary of referral requirements.

### Providing information to GPs and other referrers

Public hospitals should make information accessible to GPs and other referrers via appropriate means that state the requirements for referring patients for services provided by the public hospital. Where the public hospital offers MBS-billed services the following information should be provided:

* the specialty areas that offer both public and private (MBS-billed) services; and
* the names of medical specialists exercising rights of private practice in each speciality.

## Referrals within a public hospital

Referrals of patients between and within different departments in a public hospital are acceptable for MBS billing if the patient has chosen to be treated as a private (or MBS-billable) patient based on informed financial consent and the practitioner making the referral has referral rights for the service. Please refer to the MBS, section GN.6.16, for details on who can refer. Referrals in this section do not refer to ‘requests’ made for diagnostic imaging and pathology services. These are discussed in Section 3.2.

### Referring patients from emergency department to admitted services

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| Admitted services may be MBS billable |
| when an ED practitioner has made a clinical decision to admit and the eligible person has elected to be a private inpatient, regardless of the patient being physically admitted in the ward. |

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| Admitted services are not MBS billable |
| when an ED practitioner has made a clinical decision to admit and the eligible person has elected to be a public inpatient. |

Patients must elect to be a public or private inpatient via the patient election form before, at the time of, or as soon as possible after admission. Admitted patient election can be for the whole episode of care, commencing from admission. Where admitted patients or their legally authorised representatives, for whatever reason, do not make a valid election, or actual election, these patients will be treated as public patients.

Refer to the NHRA, clauses G14, G18 and G30l.

Case Study 4

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| *Mr D has accidentally cut his hand deeply after breaking a glass while washing it. Mr D attends the emergency department (ED) at 8:15am. Mr D is asked and provides informed financial consent to be treated as a private inpatient if he needs to be admitted. He is triaged and sent to have his hand X-rayed at 8:30am to ensure there are no fragments of glass embedded in the cut. After Mr D has received his X-ray, he is seen by a medical specialist and it is determined that Mr D has severed a nerve and requires surgery. At 9.17am a clinical decision is made to admit Mr D. While waiting in the ED for a bed to become available, Mr D is transferred from the ED to an admitted ward at 9.45am when a bed becomes available.*  When can Mr D’s treatment be claimed under the MBS?  **All treatment provided to Mr D prior to clinical decision to admit at 9.17am, including his X-ray, is provided free of charge as a public patient. All treatment provided to Mr D after 9.17am is provided to Mr D as a private patient.** |

### Referring patients from emergency department to non-admitted services

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| Non-admitted services may be MBS billable |
| for the first outpatient appointment:   1. if an eligible person independently chooses to obtain a named referral from a GP to be treated as an MBS-billable oupatient, following discharge from the ED.   for the subsequent outpatient appointments:   1. if an eligible patient independently chooses to be treated as an MBS-billable outpatient and subject to a named referral. |

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| Non-admitted services are not MBS billable |
| for the first outpatient appointment:   1. if an eligible person is referred from the ED (NHRA, clause G17a); or 2. if an eligible person independently chooses to obtain a referral from a GP but chooses to be treated as a public oupatient, following discharge from the ED.   for the subsequent outpatient appointments:   1. if an eligible patient independently chooses to be treated as a public outpatient. |

Case Study 5

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| *Ms U, an eligible patient, attended the emergency department (ED) and was treated by Dr A. During her treatment at the ED, Dr A advised her that after her discharge from the ED she needs to be seen by a specialist for after-care consultations and refers her as a public outpatient. Prior to her appointment, her friend recommends that she see Dr B, who is working at the same public hospital, and treated her for a similar condition. Ms U makes an appointment with her GP and receives a named referral to see Dr B and advises the public hospital that she has a named referral to see Dr B. Ms U also provides informed financial consent and elects to be treated as an MBS-billable outpatient. Ms U sees Dr B on the date of her scheduled appointment.*  Can Ms U’s outpatient appointment be claimed under the MBS?  **Yes.** Ms U has independently chosen to see Dr B for her outpatient appointments. Provided Dr B has rights of private practice and Ms U provided informed financial consent and elects to be an MBS-billable outpatient prior to the first outpatient appointment, MBS may be billed. |

### Referring patients from admitted to non-admitted services

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| Non-admitted after-care services may be MBS billable |
| if patient is admitted for surgery and the post-operative treatment:   1. is not included in the benefit paid for the admitted service and patient elects to be an MBS-billable outpatient and has a named referral.   if patient is admitted for non-surgery:   1. and elects to be an MBS-billable outpatient and has a named referral. |

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| Non-admitted after-care services are not MBS billable |
| if patient is admitted for surgery and the post-operative treatment:   1. is included in the benefit paid for the admitted service; or 2. is not included in the benefit paid for the admitted service and the patient elects to be a public outpatient.   if patient is admitted for non-surgery:   1. and elects to be a public outpatient. |

**An eligible person admitted as a public patient should be able to access after-care as a non-admitted public patient if it is directly related to the admitted care provided by the hospital (NHRA, clause G16). However, where a public admitted patient independently chooses to be an MBS-billable outpatient, the outpatient appointment can be billed under the MBS, subject to a named referral.**

When an eligible person has elected to have surgery as a private inpatient in a public hospital, each of the operations listed in the MBS, unless otherwise indicated, contains a component for the consequential after care customarily provided. After care is deemed to include all post-operative treatment rendered by health practitioners and is included in the admitted service cost. This means that outpatient appointments related to private inpatient post-operative treatment should not be billed to the MBS. However, these are still reported to the department as MBS‑billable service events.

Case Study 6

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| *Ms V has admitted care (non-surgery) at one campus of a health service as a public patient and is referred to a service at another campus of the same health service for the after-care outpatient appointment.*  Can Ms V’s outpatient appointment be claimed under the MBS?  **No.** As the outpatient appointment is directly related to the admitted care, Ms V should be treated as a public patient for her outpatient appointments unless she independently chooses to consult a practitioner exercising rights of private practice for after-care, elects to be treated as an MBS-billable outpatient, provides informed financial consent and has a valid named referral. |

Case Study 7

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| *Mr W had admitted care (non-surgery) provided at one health service as a private patient. Mr W is referred to another health service for the outpatient appointment.*  Can Mr W’s outpatient appointment be claimed under the MBS?  **Yes.** If Mr W elects to be treated as an MBS-billable outpatient at the other health service, provides informed financial consent and has a valid named referral. |

Case Study 8

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| *Ms X has elected to be treated as a private patient at a health service for elective surgery. Following surgery, Ms X attends two post-operative care outpatient appointments.*  Can Ms X’s post-operative care outpatient appointments be claimed under the MBS?  **No.** The Medicare benefit claimed for the elective surgery includes the post-operative care. The first and subsequent post-operative care appointments are not able to be claimed separately from the MBS because it has already been included in the Medicare benefit paid for surgery. These appointments are still reported to the department as MBS-billable service events. |

Case Study 9

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| *Ms Y has elected to be a public patient and been admitted to a public hospital following a heart surgery. During her admission she noticed a skin rash, which was not directly related to her surgery.*    Can Ms Y’s outpatient appointment for her skin condition be claimed under the MBS?  **Yes. I**f Ms Y elects to be treated as an MBS-billable outpatient for her skin condition, provides informed financial consent and has a valid named referral. |

Case Study 10

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| *Ms Z has been admitted to a hospital after being diagnosed with cancer. She has elected to be a public admitted patient for the whole episode of care. After admission Ms Z is referred to a chemotherapy treatment specialist clinic and a radiation therapy treatment clinic.*  Can Ms Z be treated as an MBS-billable patient at either clinic?  **No.** As the outpatient appointments at both clinics are directly related to the admitted care, Ms Z should be treated as a public patient for the consultations at both the radiation oncology and chemotherapy specialist clinics unless she independently chooses to consult a practitioner exercising rights of private practice for after-care, elects to be treated as an MBS-billable outpatient, provides informed financial consent and has a valid named referral. |

Case Study 11

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| *Mr Y is an MBS-billable outpatient and following the consultation, he is admitted to the hospital for a surgery. He chooses to be a public inpatient. After being discharged, he is provided a valid referral to receive after-care.*  Can the appointments related to Mr Y’s after-care be claimed under the MBS?  **No.** Where the cost of after-care is not included as post-operative treatment in the admitted service, Mr Y should be treated as a public patient for his outpatient after‑care appointments as these are directly related to the admitted care. Mr Y may still elect to be an MBS-billable outpatient if he independently chooses to consult a practitioner exercising rights of private practice for after-care, provides informed financial consent and has a valid named referral. |

Case Study 12

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| *Ms Z is an MBS-billable outpatient for her obstetrics consultations. During her consultations, she is admitted in the hospital for nausea.*  Can Ms Z be admitted as a private patient?  **Yes.** Ms Z can elect to be either a public or a private inpatient on admission. For her subsequent obstetrics consultations, she is still an MBS-billable patient provided her referral is valid. |

### Referring patients from urgent care centres to admitted and non-admitted services

Health practitioners employed and/or paid by the hospital to provide the UCC service, referring patients to admitted and non‑admitted services, operate under the same principles as referrals from emergency department practitioners. Health practitioners contracted by the UCC, exercising rights of private practice and not paid by the hospital to provide the UCC service, are providing a private service and referring patients to admitted and non-admitted services operate under the same principles as a practitioner in a private clinic providing referrals to a public hospital service.

## Valid referrals

When making a claim under the MBS, the referral must be valid. The MBS, section GN.6.16, provides the requirements of a valid referral and the period for which the referral is valid. In the claim form, the practitioner under whom the claim is made must be the person who rendered the services to the patient. If patients are seen by locum tenens, the arrangements for claim are also stated in the MBS, section GN.6.16.

## Remuneration

Public hospitals must grant health practitioners right of private practice (RoPP) for them to provide MBS-billable services in the hospital.

There must be a formal Private Practice Arrangement (PPA) between the practitioner and the public hospital, which clearly states the RoPP and terms of remuneration. These may be offered when a practitioner is predominantly employed to treat public patients. Public hospitals and practitioners must ensure that the arrangements under a private practice model will be compliant with other relevant departmental policies.

Where a practitioner is not predominantly employed to treat public patients, they are not eligible to enter a PPA. In this instance the practitioner should be offered a rental agreement.

Public hospital arrangements with practitioners must be documented in a formal contract and agreed as between the practitioner and public hospital.

### Private practice arrangements

There are different types of PPAs and public hospitals and practitioners should seek their own legal, financial and industrial advice before entering a formal PPA.

These may be used where:

* An employment contract grants RoPP to a practitioner on a full-time or part-time basis to see patients who have provided informed financial consent to be treated as private (or MBS-billable) patients.
* A practitioner who has a facility fee arrangement where the practitioner is employed or contracted by the hospital is not paid a salary but retains all private practice income.
* A Visiting Medical Officer (VMO) who is employed or contracted by the public hospital, providing services to both public patients and private (or MBS-billable) patients.

And provided:

* Private (or MBS-billable) patients are seen during the practitioner’s employed or contracted paid hours of work, as per their agreement with the public hospital.
* The practitioner authorises their employer to act as an agent for the purposes of billing services to Medicare.
* All private practice income rendered in the public hospital is assigned to the practitioner’s employer and agreed share paid to the practitioner.
* The patient is bulk-billed and does not incur any out-of-pocket costs for health care services that they would otherwise have received as a public patient.

In exchange, the public hospital provides support services, infrastructure access and resources to support the treatment of private (or MBS-billable) patients and to address service, professional and community requirements. The practitioner’s remuneration rate may also be adjusted to compensate for the forgone private income.

The practitioner may also be covered by the VMIA Medical Indemnity Master Insurance policy.

**Private practice arrangements should consider:**

* Nature of employment
  + Status (e.g. full-time, fractional)
  + Whether the doctor is predominantly employed to treat public patients.
  + Salary structure (is it all inclusive and covers PPA)
  + Out of hours payment structure
  + PPAs for admitted and non-admitted services. Also consider if the facility fee applies.
* Amount of MBS revenue assigned by the practitioner to the public hospital.
* Whether the practitioner authorises the public hospital to act as an agent for the purpose of claiming services under the MBS.
* Responsibility for the patient record
* Whether the Medical Indemnity Master Insurance Policy (e.g. VMIA) or practitioner’s personal indemnity insurance applies.
* Facility fee arrangement and what does it consist of (e.g. support services, infrastructure access and resources to address service, professional and community requirements).

### Rental agreements

The public hospital may use a rental agreement when:

* The practitioner is not predominantly employed or not employed to treat public patients.
* In circumstances where the practitioner is not employed directly by the hospital but has a contractual relationship with the hospital to provide services to the hospital’s patients.

These may be used where:

* A part-time practitioner is performing services in their own time (i.e. outside their employment rights of PPA and paid time).
* A clinical academic is conducting private practice independently in their own right that is not in connection with their public hospital employment.
* A VMO is providing services that is not in connection with the public hospital and is not being paid by the public hospital for the service.
* Public hospitals contract medical services that have a private component (e.g. private radiology companies).

And provided:

* Any private practice conducted under this model is outside of the employment of the public hospital and is separate from any services rendered in connection with the public hospital.
* The practitioner has entered a commercial relationship with the public hospital to pay for the use of facilities to operate their own standalone private practice.
* Practitioners maintain their own medical indemnity insurance policy that is of an adequate level during these activities.

All private practice income is retained by the practitioner. This includes any out-of-pocket fee the practitioner may choose to charge patients attending their private practice.

The billing for the service can be performed either by the practitioner or the hospital depending on the terms of the rental agreement.

As part of the commercial arrangement with the practitioner, the public hospital may agree to provide in return for payment, several services including but not limited to:

* Billing service;
* Medical Record service;
* Clinical and clerical support staff; and
* Sterilisation/equipment.

The agreement must have a commercial basis for the services used by the private practice and reviewed on an annual basis to account for increases in the cost of provision of health care. Practitioners may provide services in private consulting rooms which may be located at a public hospital (under a tenancy agreement) or outside of the public hospital. Arrangements will be publicly defensible and conducted on a purely commercial basis. Such an agreement should contain the core components expected of any contract with an external party. The commercial arrangement should provide for responsibility for a Medicare shared debt if a refund is owing.

## Medical indemnity

The VMIA Medical Indemnity Master Insurance Policy states that registered health practitioners exercising a right of private practice who remit all or part of the fees earned to the employing public hospital do not bear liability for medical negligence under their own medical insurance policies. Please refer to the VMIA Medical Indemnity Master Insurance Policy for a definition of registered health practitioners and when it applies.

The VMIA Medical Indemnity Master Insurance Policy is updated annually. For further information please refer to: <https://www.vmia.vic.gov.au/insurance/policies-and-cover/medical-indemnity>

# Accessibility of services

## Medicare principles

The decision to allow health practitioners to conduct private practice in a public hospital and bill under MBS should be assessed based on its impact on the objectives stated in the NHRA, clause 8.

## Providing private health services to eligible patients

Public hospitals must consider whether it is beneficial to offer private health services to eligible patients. These may be provided if the public hospital also provides the same service on a public basis (NHRA, clause 11a).

Private patients must not be given preferential treatment and special access to services within a public hospital. Public hospitals must ensure that priority is given to patients with an urgent clinical need. Insurance status or willingness to pay must not result in preferential treatment or access to services within public hospital facilities.

## Establishing public specialist clinics to treat MBS-billable patients

Specialist clinics operated by practitioners who have private practice arrangements with public hospitals are still public clinics regardless of funding sources. The only private clinics are those operated by practitioners who have a rental agreement with the public hospital as mentioned in Section 4.4.2.

**Public hospitals should document the benefits and costs of providing MBS-billed services for each speciality and monitor them annually in terms of compliance and demand.**

Before deciding to establish a public specialist clinic to treat MBS-billable patients, it is best practice for public hospitals to consider the likely benefits and costs of this service delivery and funding arrangement and ensure that services required to meet demand are available and the cost of operating these clinics is revenue neutral. MBS rates in many categories are not designed to fund full practice costs and therefore income generated solely from MBS fees may not cover all costs. Public hospitals will need to undertake local financial analysis to determine if services provided to MBS-billable patients are viable, with particular regard to other private patient funding arrangements. Specialist clinics must not be established or provided by public hospitals to provide preferential access for MBS-billable patients.

Where MBS-billable services are to be provided, services for both public and MBS-billable patients must be available. This can be achieved by providing a dedicated public clinic for MBS-billable patients in parallel to public clinics of the same speciality field; or providing a mixed clinic where services are available within the same clinic for both public and MBS-billable patients.

Specialist clinics for MBS-billable patients are unlikely to be cost-effective if patients fail to attend their appointments or if the clinic is not fully booked. It is recommended that public hospitals consider the impact of patient attendance rates and appointment scheduling in the planning and establishment of these specialist clinics.

It is unlikely that the costs and benefits of providing public clinics for MBS-billable patients will be universally applicable to all public hospitals, but they include:

* Providing patients with a choice of receiving treatment as a public or MBS-billable patient;
* How it will assist with the recruitment and retention of highly skilled health practitioners who may not otherwise practice in a public hospital or in a catchment area;
* 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;
* Variation in the remuneration models under which health practitioners can provide MBS‑billed specialist clinic services, which allows flexibility of working arrangements;
* Human resource and legal costs associated with the negotiation of an arrangement between each health practitioner and the public hospital for the provision of specialist clinic services for private patients; and
* For patients who attend multiple specialist clinics, differences in the operation and physical location of public clinics for public and MBS-billable patients could present some difficulties unless clear information is provided to patients and they are clear about the financial consents they have provided.

Please refer to Appendix 4 for a sample business case for establishing public specialist clinics for MBS-billable patients.

# Patient Consent

Eligible persons attending public hospitals are entitled to be treated as public patients. Eligible persons may elect to be treated as private (or MBS-billable) patients with informed financial consent (written or electronic). Public hospitals must not direct patients or their legally authorised representatives towards making a choice to be treated as a private (or MBS-billable) patient.

## Patient election

The NHRA specify patient election requirements for admitted patients (clauses G14-G16, G30-G32) and for non-admitted patients (clause G19). However public hospitals, as best practice should similarly apply NHRA clauses G15, G30, G32 for non-admitted patients who choose to be treated as an MBS-billable patient to ensure that the patient’s informed financial consent is documented and substantiates billing under the MBS.

The minimum information to be included in the patient election form has been provided in the NHRA for admitted patients. Hospitals are advised to follow, similarly, by providing the information relevant to non-admitted services in the patient election form for non-admitted patients who choose to be treated as an MBS-billable patient. For admitted patients the patient election form should be valid for a maximum of six months (NHRA, clause G31) and for non-admitted patients the patient election form is valid for as long as the period of referral is valid for each episode, or until there is a change in patient election.

For non-admitted patients, please refer to Appendix 2 for a sample of patient election form.

### Emergency department

Eligible persons presenting at a public hospital emergency department are public patients, before any clinical decision to admit (NHRA, clause G18). Therefore, they will receive treatment free of charge and cannot have treatment billed under the MBS.

### Admitted private patients

Admitted patients must elect to be a public or private patient in accordance with the National Standards for Public Hospital Admitted Patient. If it is clinically appropriate, the hospital may provide information about alternative service providers, but must provide treatment at no charge if the patient elects to be a public patient. A service or any part of the same service provided to admitted private patients in public hospitals can be billed under the MBS. Refer to NHRA, clauses A9, A10 and G18.

### Non-admitted MBS-billable patients

Services provided at specialist clinics can be billed under the MBS if the patient has provided informed financial consent (written or electronic) to assign their Medicare benefit for non-admitted services and has a valid referral to a named medical specialist, who is exercising a right of private practice. Refer to NHRA, clause G19.

Public hospitals are not required to physically separate the location of specialist clinics that see both publicly funded and eligible patients who have consented to have their appointment billed under the MBS. However, hospitals should have clearly visible signage in all clinics seeing MBS-billable patients that patients are attending the clinic as a public patient unless they otherwise agree to be an MBS-billable patient. Regardless, signage does not imply that the patient has provided informed financial consent. Sample signage is provided in Appendix 3.

When a patient provides informed financial consent to be treated as an MBS-billable patient, the public hospital cannot prioritise the patient above other patients in relation to the care provided or timeliness of treatment.

**Services involving multiple healthcare providers**

Multiple healthcare provider service events occur when three or more healthcare providers each provide a non-admitted service to a patient either jointly or separately at the same clinic on a given calendar day. MHCP service events are predominantly delivered through MHCP specialist clinics. The service is counted as a single non-admitted service event and flagged as a multiple healthcare provider (MHCP) service event. Where a patient attends multiple clinics on the same day, each visit is counted as a separate service event, provided each service received meets the definition of a service event.

MHCP services are typically public clinics (seeing public patients) but can also be established by public hospitals to allow patients who provided informed financial consent to be treated as MBS-billable patients and have their eligible non-admitted services bulk-billed to the MBS.

The Commonwealth will not fund patient services through the NHRA if the same service, or any part of the service, is billed and therefore funded through the MBS, Pharmaceutical Benefits Scheme (PBS), Private Health Insurance Rebate or any other Commonwealth program (NHRA, clause A9). Therefore, the patient cannot elect to be treated as an MBS-billable patient for part of the MHCP service, including diagnostic imaging and pathology services considered as a component of the service.

### Urgent care centres

Public hospitals must display clear signage and institute appropriate guidelines and procedures to inform patients as to why a fee may be incurred and an estimate of out-of-pocket costs.

## Informed financial consent

Informed financial consent is the provision of cost information to patients, (including any likely out-of-pocket expenses), by the public hospital, about the proposed service.

Hospitals must ensure that eligible persons who have elected to be treated as private (or MBS-billable) patients have done so based on informed financial consent (NHRA, clauses 11b and G15) in written or electronic form.

An example of a informed financial consent form provided as part of the National Safety and Quality Health Service (NSQHS) Standards by the Australian Commission can be accessed at: <https://www.safetyandquality.gov.au/sites/default/files/2019-12/as1810_informed_financial_consent_december_2019_0.pdf>

**Verbal advice**

The NHRA, clauses G34 to G38, on verbal advice provided to patients, specify requirements for admitted patients and not non-admitted patients. However, as best practice, public hospitals should similarly apply NHRA clauses G34 to G38 for non-admitted patients who choose to be treated as an MBS-billable patient.

**Patients’ rights**

Public hospitals must inform the patient of their right to request a private room (for admitted services) and doctor of their choice (where available). This does not constitute directing a patient to a decision. However, informing patients must not be done in a manner which leads the patient to a decision to be either a public or private (or MBS-billable) patient. Hospitals must not direct patients or their legally authorised representatives towards a choice about being treated as a public or private patient (NHRA, clause G37).

The department’s document, *Private patients: Principles for public health services,* provides further clarity by stating that this means that hospitals must not:

* offer any form of inducement including but not limited to vouchers, free TV access, hotel-style dress;
* prioritise the patient above other patients in relation to the care provided or timeliness of treatment; or
* perform any other action, whether verbal or written, that directs a patient towards a choice.

Please refer to the department’s document, *Private patients: Principles for public health services*,for further details.

## Fees charged

Private patients may be charged an amount for public hospital services as determined by the State (NHRA, clause G3).

Further information on fees can be found in the following departmental material:

* Patient fees and charges for public health services: <https://www.health.vic.gov.au/hospitals-and-health-services/patient-fees-and-charges-for-public-health-services>
* Private patients: Principles for public health services: <https://www.health.vic.gov.au/publications/private-patient-principles-for-public-health-services>

### Admitted private patients

Admitted services provided to private patients in public hospitals by health practitioners who are:

* employed by the public hospital must be bulk-billed under the MBS.
* not employed by the public hospital may exceed the MBS schedule fee which might result in an ‘out-of-pocket’ fee payable by the private patient.

### Non-admitted MBS-billable patients

Non-admitted services provided to MBS-billable patients in public hospitals must be bulk-billed under the MBS. Non-admitted public patients may only incur out-of-pocket fees for those services permitted under the NHRA, clause G1.

However, health practitioners who are not employed by the public hospital (under a rental agreement) may charge a fee exceeding the MBS schedule fee which might result in an ‘out-of-pocket’ fee payable by the patient. These health practitioners may be providing services in private consulting rooms, which may be located at a public hospital or outside of the hospital.

### Urgent care centres

The majority of UCCs are nurse-led with medical support provided by on-call GPs. UCCs must not charge the patient for administration and facility.

UCCs operate as a public hospital service. Health practitioners employed and/or paid by the hospital to provide the UCC service must not bill under the MBS because the patients are treated as public patients. However, health practitioners contracted by the UCC, exercising rights of private practice and not paid by the hospital to provide the UCC service are providing a private service and may bill under the MBS because the patients are treated as private patients of the health practitioner.

**Services not billed under the MBS**

Services performed by health practitioners (registered nurse, rural isolated practice endorsed registered nurse (RIPERN), nurse practitioners, GP, GP proceduralists and junior doctors) salaried by the hospital cannot be billed under the MBS. These patients are to be treated as a public patient in the UCC.

If the patient is admitted from the UCC and elects to be a public patient for admission, then the on-call GP cannot bill under the MBS for the services provided at the UCC. The on-call GP is then covered by the VMO arrangement that they have with the hospital for admitted services. This is because the care provided at the UCC and the admitted care are considered part of the same episode of care and the patient cannot be part private and part public for the episode of care.

**Services billed under the MBS**

Nurse practitioners can bill under the MBS if they are contracted to provide private services from the UCC to the practitioner's patients. GPs and GP proceduralists, who are engaged by a hospital to provide on-call non-admitted medical support to an UCC, provide medical services to patients pursuant to a separate arrangement between the practitioner and the patient, and may thus bill under the MBS and may charge a co-payment. Refer to NHRA, clause G21.

**More information**

* Urgent care centres: Models of care toolkit, Rural health urgent care centres: <https://www.health.vic.gov.au/rural-health/urgent-care-in-regional-and-rural-areas>
* Telehealth: <https://www.health.vic.gov.au/rural-health/telehealth>

## Change in patient election

The change in patient election status refers to changes from public to private (or MBS-billable) and vice versa. It does not include compensable patients.

An eligible person may choose to change their patient election status at some later point in time. This is effective from the date of the change onwards and should not be retrospectively backdated to the date of admission (NHRA, clause G30h). It is best practice for hospitals to follow the NHRA, clause G30h, for non-admitted patients as stated for admitted patients.

**Admitted patients**

The NHRA, clauses G30g and G30i, allow admitted patients to change their status from private to public due to unforeseen circumstances.

Admitted patients, however can change their status from public to private under any circumstances, provided it is within the parameters of this document and other documents referred to herein.

For further information, hospitals should refer to the department’s document, *Private patients: Principles for public health services*.

**Non-admitted patients**

In instances where a non-admitted patient has previously consented to be treated as an MBS-billable patient in a public hospital, it is advised that the hospital allow a patient to rescind their consent and have future treatment funded as a public patient and vice versa, provided the change is within the parameters of this document and other documents referred to herein.

# Governance, performance and accountability

The delivery of private practice arrangements in Victorian public hospitals must be effectively managed and monitored to achieve desired outcomes. Public hospitals must:

1. Ensure appropriate and effective guidance is established and sustained. For example meaningful key performance indicators are set and used to measure performance;
2. 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
3. Ensure internal controls are in place to ensure overall business integrity and compliance with policies, directives and frameworks.

## Governance approach

Public hospitals and medical practitioners exercising rights of private practice are jointly responsible for the implementation and operation of services provided to private patients at a local level and should implement a robust governance framework.

Such a framework should ensure the following:

* Compliance with the MBS Billing Policy and these guidelines.
* Supporting the development and implementation of local operational policy.
* Clearly defined objectives and desired outcomes for providing services to private patients, which are regularly measured against key performance indicators and sustainable.
* Robust governance and internal controls are maintained.
* Initiate remedial action where required and/or escalate the matter where appropriate.

## Internal controls

Documented internal controls must be embedded in the operations of management and governance processes that ensure:

1. 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;
2. Error, fraud, and other irregularities are prevented as much as possible and promptly detected through a systematic approach if they do occur;
3. Assets and consumables used in private practice activities are safeguarded from unauthorised use or disposal and are adequately maintained and monitored; and
4. Financial management performance reports are timely, relevant, reliable and accurate.

# Staff Education

Staff performing duties associated with MBS billing and health practitioners exercising a right of private practice within a Victorian public hospital should, as best practice, be supported by an education framework that provides access to training resources that provides them with an understanding of their responsibilities to enable them to successfully perform those duties.

The legislative and regulatory instruments that govern MBS billing are complex and should be well understood prior to engaging in these activities. Both clinical and support staff require information that clearly defines their roles and responsibilities and outlines the correct processes to be undertaken.

All staff involved in MBS billing processes should have a working knowledge of both the MBS billing policy framework and best practice guidelines. To facilitate compliance with these, training materials and educational tools should be provided in different formats to suit the audience.

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

|  |  |
| --- | --- |
| Audience | Training focus |
| Boards  Executives | Understanding of the policy and supporting documents related to MBS billing. |
| CFOs  Directors of medical services  Senior management  Directors of specialist clinics | Comprehensive training on the legislation and agreements 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 cost drivers relevant to private and public patient services. |
| Private practice support and administrative staff  Specialist clinics administration staff | Comprehensive understanding of the MBS and supporting documents, in particular the key requirements.  Comprehensive understanding of data integrity and referral management. |

# Documentation and reporting to the department

To enable the department to monitor compliance with applicable legislation and to meet the department’s obligations under the NHRA, hospitals should report the following information to the department and document the relevant information. The following website provides further details on the department’s reporting criteria: <https://www.health.vic.gov.au/data-reporting/health-data-standards-and-systems>

In addition, health practitioners performing their own administration or public hospitals performing administrative functions on behalf of health practitioners exercising a right of private practice in a specialist clinic must, as a minimum, also document the following:

* referral form
* clinical records - showing that the medical practitioner personally rendered that service to that patient
* the health practitioner’s authorisation to exercise their rights of private practice
* any other documents that the medical practitioner considers may substantiate the Medicare claim

This list is provided by the Commonwealth Department of Health, as a guideline for documents to produce to substantiate a claim. Please refer to the following link for more details: <https://www.health.gov.au/resources/collections/health-professional-guidelines>

**Agency Information Management System (AIMS)**

The S10 Non-Admitted Clinic Activity form collects acute non-admitted aggregate data at the Tier 2 non-admitted clinic category.

All Victorian public hospitals providing acute non-admitted clinical services should report related activity on the S10 form. This includes non-admitted services where the health practitioner bills the MBS for the patient’s treatment. MBS-billed activity is reported as ‘MBS Service events’ in the AIMS S10. It excludes services provided to non-admitted patients by health practitioners on a completely private basis where the medical record is not held by the hospital.

All public hospitals that are in-scope for activity based funding (ABF) should report aggregate activity data via the AIMS. This can be done via the HealthCollect portal at: [www.healthcollect.vic.gov.au](http://www.healthcollect.vic.gov.au).

For further information please refer to the AIMS manual: <https://www.health.vic.gov.au/data-reporting/agency-information-management-system-aims>

**Document patient election (written or electronic)**

All public hospitals should document patient election to be a private patient and any changes to their election. Further details on patient election are provided in Section 6. Appendix 2 provides a sample of private patient election form for non-admitted patients.

**Document signage for public specialist clinics**

Public hospitals should display a clearly visible signage in all clinics seeing private patients that patients are attending the clinic as a public patient unless they elect to be treated as a private patient. Appendix 3 provides a sample of the signage. Signage should not be used to imply patient election to be a private non-admitted patient based on informed financial consent. Patient can only elect to be a private non-admitted patient based on informed financial consent via the patient election form.

**Document business case for MBS-billing specialist clinics**

When establishing and operating MBS-billing specialist clinics, public hospitals should routinely measure, monitor and document, the benefits and costs of these clinics as mentioned in Section 5.3. Appendix 4 provides a sample of the business case.

**Finance return (F1) data collections**

All public hospitals should report their finances (e.g. revenue and expenses) on a monthly basis using the F1, a Microsoft Excel workbook. This can be done via the HealthCollect portal at: [www.healthcollect.vic.gov.au](http://www.healthcollect.vic.gov.au). Please refer to the *Guidelines for completing the F1 (finance return) 2018-19*, accessible at: [www.healthcollect.vic.gov.au](http://www.healthcollect.vic.gov.au)

**Non-Admitted Clinic Management System (NACMS)**

When hospitals register new public clinics with the department, the remuneration model must be specified for clinics treating private patients. This change was implemented in April 2018 to the department’s NACMS. Hospitals are required to review their registered clinics regularly and ensure the MBS remuneration model has been correctly identified for each registered clinic.

Once a clinic has been registered in the NACMS and has a status of pending, hospitals will be able to report service event activity against the clinic on the AIMS S10 form.

All public hospitals classified as an activity based funded health service or small rural health service under the NHRA should register non-admitted clinics with the department. Clinics are registered in the NACMS. This can be done via the HealthCollect portal <[www.healthcollect.vic.gov.au](http://www.healthcollect.vic.gov.au)>.

For further information on registering public clinics for private patients please refer to the NACMS manual: <https://www.health.vic.gov.au/publications/non-admitted-clinic-management-system-nacms-manual-2021-22>

**Victorian Admitted Episodes Dataset (VAED)**

Victorian public hospitals that receive funding for admitted patient services should report demographic, clinical and administrative details for admitted episodes of care. An episode of care is defined as the period of admitted patient care between admission and separation. Separation is when the hospital ceases to be responsible for the patient’s care and the patient is discharged from hospital accommodation.

All public hospitals should report a minimum set of patient-level admitted episode data to the VAED, at least on a monthly basis. This can be done via the Managed File Transfer (MFT) web portal.

For further information please refer to the VAED manual: <https://www.health.vic.gov.au/data-reporting/victorian-admitted-episodes-dataset>

**Victorian Cost Data Collection (VCDC)**

All public hospitals should report patient-level cost information about the services used to deliver care to the VCDC on an annual basis as per the Victorian, *Policy and funding guidelines*. Further information about VCDC can be accessed at: <https://www.health.vic.gov.au/data-reporting/victorian-cost-data-collection-vcdc>

**Victorian Emergency Minimum Dataset (VEMD)**

All public hospitals should submit to the VEMD patient-level demographic, administrative and clinical information for patients presenting to the emergency department, at least twice monthly. This can be done via the Managed File Transfer (MFT) web portal. The VEMD manual can be accessed at: <https://www.health.vic.gov.au/data-reporting/victorian-emergency-minimum-dataset-vemd>

**Victorian Integrated Non-Admitted Health (VINAH) minimum dataset**

VINAH consists of various linked data structures, which reflect aspects of service delivery within a healthcare setting. This information is structured in a consistent manner and periodically submitted by hospitals to the department.

MBS-billed specialist clinic activity is reported with a Contact Account Class of ‘QM – private clinic: MBS funded’ in VINAH.

All public hospitals providing non-admitted services in scope for VINAH should report a minimum data set of patient-level data related to their activities, at least on a monthly basis. At the department, this demographic, administrative and clinical data are compiled into the VINAH. This provides advice on how MBS-billed services are reported.

For further information please refer to the VINAH manual: <https://www.health.vic.gov.au/data-reporting/victorian-integrated-non-admitted-health-vinah-dataset>

# Resources

* Billing Medicare in public hospitals, Commonwealth Department of Health: <https://www.health.gov.au/health-topics/medicare-compliance/public-hospitals>
* News for health practitioners, Commonwealth, Services Australia: <https://www.servicesaustralia.gov.au/news-for-health-professionals>

# Glossary

**Admission** is a process whereby the hospital accepts responsibility for the patient’s care and/or treatment. Admission follows a clinical decision that a patient requires same-day or overnight [or multi-day] care or treatment. An admission may be formal or statistical.

* A formal admission is the administrative process by which a hospital records the commencement of treatment and/or care and/or accommodation of a patient.
* A statistical admission is the administrative process by which a hospital records the commencement of a new episode of care, with a new care type, for a patient within one hospital stay.

(as defined in the VAED)

**Admitted patient** is defined in the National Health Data Dictionary under the data element “Admitted patient care”.

**Clinically relevant service** is defined as one which is generally accepted by the relevant profession as necessary for the appropriate treatment of the patient. (MBS, section GN.1.2 and subsection 3(1) of the *Health Insurance Act 1973*).

**Eligible admitted private patient** means an eligible patient who is admitted and chooses to be treated as a private patient and excludes compensable patients and other patients funded by third parties (as defined in the NHRA).

**Eligible person** means an Australian resident or an eligible overseas representative (as defined in subsection 3(1) of the *Health Insurance Act 1973*), excluding compensable patients.

**Emergency department** is defined in the NHRA as providing emergency services at admission level 3 or above under the Australian College for Emergency Medicine guidelines, or as otherwise recommended by the Independent Hospital Pricing Authority (IHPA) and agreed by the Standing Council on Health.

**Episode of care** is the period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type (as defined in the VAED).

**Episode** is the period during which a patient/client receives services within a defined program and stream (as defined in the VINAH).

**Independently chooses** in relation to a choice made by a patient or their legally authorised representative means the public hospital has not directed patients or their legally authorised representatives towards a choice about being treated as a public or private (or MBS-billable) patient.

**Ineligible person** means any person who is not an eligible person.

**Informed financial consent** is defined in the NHRA as the provision of cost information to patients, (including any likely out-of-pocket expenses), by a doctor or other health service provider, preferably in writing, about a proposed treatment or admission to hospital.

**Medicare Benefits Schedule (MBS)** means the Commonwealth government’s scheme to provide medical benefits to Australians established under part II, IIA, IIB, IIC of the *Health Insurance Act 1973* together with relevant Regulations made under the Act.

**MBS-billable patient** means an eligible patient who has provided informed financial consent to assign their Medicare benefits for public hospital non-admitted services to a health practitioner exercising rights of private practice.

**MBS bulk-billed** means the health practitioner accepts the relevant Medicare benefit as full payment for the service and additional fees cannot be raised against the patient (MBS, section GN.7.17).

**Non-admitted patient services** are defined in the National Health Data Dictionary under the data element “Non-admitted patient service event- care type”.

**Out-of-pocket (gap) payment** means the difference between the fee charged by the practitioner and the amount that can be claimed as a benefit (under the MBS and from a private health insurer).

**Outpatient department** is defined in the NHRA as any part of a hospital (excluding the emergency department) that provides non-admitted patient care.

**Practitioner** means, as defined in subsection 124B of the *Health Insurance Act 1973*:

1. a medical practitioner; or
2. a dental practitioner; or
3. a participating optometrist (other than the Commonwealth, a State, the Australian Capital Territory, the Northern Territory or an authority, being a corporation, established by a law of the Commonwealth, a State or an internal Territory); or
4. an optometrist other than a participating optometrist; or
5. a midwife; or
6. a nurse practitioner; or
7. a chiropractor; or
8. a physiotherapist; or
9. a podiatrist; or
10. an osteopath; or
11. a health professional of a kind determined by the Minister under subsection 124B(7) of the *Health Insurance Act 1973* to be a practitioner for the purposes of Part VB of the Act.

**Private patient**, in relation to a hospital, means a patient of the hospital who is not a public patient (as defined in subsection 3(1) of the *Health Insurance Act 1973).*

**Public hospitals** mean public health services, denominational hospitals and public hospital*s* (as defined by the *Health Services Act 1988*).

**Separation** is the process by which an episode of care for an admitted patient ceases. A patient is separated at the time the hospital ceases to be responsible for the patient’s care and the patient is discharged from hospital accommodation. Hospital waiting areas, transit lounges and discharge lounges are not considered hospital accommodation unless the patient is receiving care or treatment in these areas. A separation may be formal or statistical.

* Formal separation: the administrative process by which a hospital records the cessation of treatment and/or care and/or accommodation of a patient.
* Statistical separation: the administrative process by which a hospital records the cessation of an episode of care for a patient within the one hospital stay.

(as defined in the VAED)

**Specialist**, in relation to a particular specialty, means a medical practitioner in relation to whom there is in force a determination under section 3DB or 3E that the medical practitioner is recognised for the purposes of the *Health Insurance Act 1973* as a specialist in that specialty, or a medical practitioner who is taken to be so recognised under section 3D (as defined in subsections 3(1), 3DB, 3E and 3D of the *Health Insurance Act 1973).*

**Urgent care centres (UCCs)** are defined as rural UCCs that provide emergency and urgent care to people in small rural communities. UCCs are not emergency departments as defined in the NHRA.

**Visiting Medical Officer (VMO)** means a medical practitioner appointed by the hospital board to provide medical services for public hospital patients on an honorary, sessionally paid, or fee for service basis as defined in<https://meteor.aihw.gov.au/content/327170>

# Appendix 1: Extract of the NHRA and the *Health Insurance Act 1973* requirements

|  |  |
| --- | --- |
| NHRA, clause 8 | Under this Addendum, States will provide health and emergency services through the public hospital system, based on the following Medicare principles:   1. eligible persons must be given the choice to receive public hospital services free of charge as public patients; 2. access to public hospital service is to be on the basis of clinical need and within a clinically appropriate period; and 3. arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location. |
| NHRA, clause 11 | States affirm their commitment to the following:   1. providing public patients with access to all services provided to private patients in public hospitals; 2. ensuring that eligible persons who have elected to be treated as private patients have done so on the basis of informed financial consent; 3. providing and funding pharmaceuticals for public and private admitted patients, and for public non-admitted patients in public hospitals (except where Pharmaceutical Reform Arrangements are in place); and 4. maintaining a Public Patients Hospital Charter and an independent complaints body and ensuring that people are aware of how to access these provisions. |
| NHRA, clause A9 | The Commonwealth will also continue to support private health services through the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS) and Private Health Insurance Rebate. Subject to any exceptions specifically made in this Agreement or through variation to this Agreement, the Commonwealth will not fund patient services through this Agreement if the same service, or any part of the same service, is funded through any of these benefit programs or any other Commonwealth program. |
| NHRA, clause A10 | The Parties agree that the following Commonwealth benefits constitute exceptions to the principle outlined at clause A9:   1. MBS payments covered by a determination made by the Commonwealth Health Minister, or a delegate of the Minister, under s19(2) of the *Health Insurance Act 1973*; 2. MBS payments relating to services provided to eligible admitted private patients in public hospitals; 3. PBS benefits dispensed under Pharmaceutical Reform Arrangements agreed between the Commonwealth and the relevant State; and 4. the default bed day rate (or equivalent payment) supported through the private health insurance rebate. |
| NHRA, clause G3 | Private patients, compensable patients and ineligible persons may be charged an amount for public hospital services as determined by the State. |
| NHRA, clause G14 | Election by eligible patients to receive admitted public hospital services as a public or private patient will be exercised in writing before, at the time of, or as soon as possible after admission and must be made in accordance with the minimum standards set out in this Agreement. |
| NHRA, clause G15 | In particular, private patients have a choice of doctor and all patients will make an election based on informed financial consent. |
| NHRA, clause G16 | Where care is directly related to an episode of admitted patient care, it should be provided free of charge as a public hospital service where the patient chooses to be treated as a public patient, regardless of whether it is provided at the hospital or in private rooms. |
| NHRA, clause G17 | Services provided to public patients should not generate charges against the Commonwealth MBS:   1. except where there is a third party payment arrangement with the hospital or the State, emergency department patients cannot be referred to an outpatient department to receive services from a medical specialist exercising a right of private practice under the terms of employment or a contract with a hospital which provides public hospital services; 2. referral pathways must not be controlled so as to deny access to free public hospital services; and 3. referral pathways must not be controlled so that a referral to a named specialist is a prerequisite for access to outpatient services. |
| NHRA, clause G18 | An eligible patient presenting at a public hospital emergency department will be treated as a public patient, before any clinical decision to admit. On admission, the patient will be given the choice to elect to be a public or private patient in accordance with the National Standards for Public Hospital Admitted Patient Election processes (unless a third party has entered into an arrangement with the hospital or the State to pay for such services). If it is clinically appropriate, the hospital may provide information about alternative service providers, but must provide free treatment if the patient chooses to be treated at the hospital as a public patient. However:   1. a choice to receive services from an alternative service provider will not be made until the patient or legal guardian is fully informed of the consequences of that choice; and 2. hospital employees will not direct patients or their legal guardians towards a particular choice. |
| NHRA, clause G19 | An eligible patient presenting at a public hospital outpatient department will be treated free of charge as a public patient unless:   1. there is a third party payment arrangement with the hospital or the State or Territory to pay for such services; or 2. the patient has been referred to a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient. |
| NHRA, clause G20 | Where a patient chooses to be treated as a public patient, components of the public hospital service (such as pathology and diagnostic imaging) will be regarded as a part of the patient’s treatment and will be provided free of charge. |
| NHRA, clause G21 | In those hospitals that rely on GPs for the provision of medical services (normally small rural hospitals), eligible patients may obtain non-admitted patient services as private patients where they request treatment by their own GP, either as part of continuing care or by prior arrangement with the doctor. |
| NHRA, clause G30 | States agree that while admitted patient election forms can be tailored to meet individual State or public hospital needs, as a minimum, all forms will include:   1. a statement that all eligible persons have the choice to be treated as either public or private patients. A private patient is a person who elects to be treated as a private patient and elects to be responsible for paying fees of the type referred to in clause G1 of this Agreement; 2. a private patient may be treated by a doctor of his or her choice and may elect to occupy a bed in a single room. A person may make a valid private patient election in circumstances where only one doctor has private practice rights at the hospital. Further, single rooms are only available in some public hospitals, and cannot be made available if required by other patients for clinical reasons. Any patient who requests and receives single room accommodation must be admitted as a private patient (note: eligible veterans are subject to a separate agreement); 3. a statement that a patient with private health insurance can elect to be treated as a public patient; 4. a clear and unambiguous explanation of the consequences of public patient election. This explanation should include advice that admitted public patients (except for care and accommodation type patients as referred to in clause G2):    1. will not be charged for hospital accommodation, medical and diagnostic services, prostheses and most other relevant services; and    2. are treated by the doctor(s) nominated by the hospital; 5. a clear and unambiguous explanation of the consequences of private patient election. This explanation should include advice that private patients:    1. will be charged at the prevailing hospital rates for hospital accommodation (whether a shared ward or a single room), medical and diagnostic services, prostheses and any other relevant services;    2. may not be fully covered by their private health insurance for the fees charged for their treatment and that they should seek advice from their doctor(s), the hospital and their health fund regarding likely medical, accommodation and other costs and the extent to which these costs are covered; and    3. are able to choose their doctor(s), providing the doctor(s) has private practice rights with the hospital; 6. evidence that the form was completed by the patient or legally authorised representative before, at the time of, or a soon as practicable after, admission. This could be achieved by the witnessing and dating of the properly completed election form by a health employee; 7. a statement that patient election status after admission can only be changed in the event of unforeseen circumstances. Examples of unforeseen circumstances include, but are not limited to, the following:    1. patients who are admitted for a particular procedure but are found to have complications requiring additional procedures;    2. patients whose length of stay has been extended beyond those originally and reasonably planned by an appropriate health care professional; and    3. patients whose social circumstances change while in hospital (for example, loss of job); 8. in situations where a valid election is made, then changed at some later point in time because of unforeseen circumstances, the change in patient status is effective from the date of the change onwards, and should not be retrospectively backdated to the date of admission; 9. it will not normally be sufficient for patients to change their status from private to public, merely because they have inadequate private health insurance cover, unless unforeseen circumstances such as those set out in this Schedule apply; 10. a statement signed by the admitted patient or their legally authorised representative acknowledging that they have been fully informed of the consequences of their election, understand those consequences and have not been directed by a hospital employee to a particular decision; 11. a statement signed by admitted patients or their legally authorised representatives who elect to be private, authorising the hospital to release a copy of their admitted patient election form to their private health insurance fund, if so requested by the fund. Patients should be advised that failure to sign such a statement may result in the refusal of their health fund to provide benefits; and 12. where admitted patients or their legally authorised representatives, for whatever reason, do not make a valid election, or actual election, these patients will be treated as public patients and the hospital will choose the doctor until such time as a valid election is made. When a valid election is made, that election can be considered to be for the whole episode of care, commencing from admission. |
| NHRA, clause G31 | A State or hospital may develop a form suitable for individuals who require multiple or frequent admissions. The form should be for a specified period, not exceeding six months, and nominate the unit where the treatment will be provided. Further, the form should be consistent with the national standards and provide patients with the same information and choices as a single admission election form. |
| NHRA, clause G32 | Any other written material provided to patients that refers to the admitted patient election process must be consistent with the information included in the admitted patient election form. It may be useful to include a cross reference to the admitted patient election form in any such written material. |
| NHRA, clause G34 | Any verbal advice provided to admitted patients or their legally authorised representatives that refers to the admitted patient election process must be consistent with the information provided in the admitted patient election form. |
| NHRA, clause G35 | Admitted patients or their legally authorised representatives should be referred to the admitted patient election form for a written explanation of the consequences of election. |
| NHRA, clause G36 | To the maximum extent practicable, appropriately trained staff should be on hand at the time of election, to answer any questions admitted patients or their legally authorised representatives may have. |
| NHRA, clause G37 | Verbal advice provided to patients by public hospitals or private health insurers on the choice to elect to be treated privately will:   1. be appropriate, robust and best support the consumer to make an informed choice; and 2. refrain from directing the patient to a particular choice. |
| NHRA, clause G38 | Through the provision of translation/interpreting services, hospitals should ensure, where appropriate, that admitted patients, or their legally authorised representatives, from non-English speaking backgrounds are not disadvantaged in the election process. |
| *Health Insurance Act 1973,* section 19(2) | Medicare benefit not payable in respect of certain professional services.  (2) Unless the Minister otherwise directs, a Medicare benefit is not payable in respect of a professional service that has been rendered by, or on behalf of, or under an arrangement with:   * 1. the Commonwealth;   2. a State;   3. a local governing body; or   4. an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory. |

# Appendix 2: Sample of outpatient election form

Name: ………………………………….

Address: ………………………………….

elect for myself/ or on behalf of (patient name)

I understand that:

* this patient election form is valid for as long as the period of referral is valid, or until there is a change in patient election.
* this election can be changed at any time.
* I have been referred to Clinic ………………………………
* I have to be a legally authorised representative if I am electing on behalf of the patient.

……………………………………………………………………………………………………………….

**Medicare Bulk-Billed Patient**

I understand that:

* as a Medicare-eligible patient I am entitled to be treated as a public patient but I am electing to attend this clinic as a Medicare Bulk-Billed patient.
* I have been referred to Dr ………………………………….

Electing to be a Medicare Bulk Billed patient means that:

* I will not be charged out-of-pocket fees for public hospital medical and diagnostic services bulk-billed to Medicare; and
* I can choose my doctor(s) (where available), providing the doctor(s) has private practice rights with the hospital.

Relationship to patient (if applicable): ………………………………….

Signed: ………………………………….Date: ………………………………….

……………………………………………………………………………………………………………….

OR

**Public Patient**

I Elect to be a Public Patient

Relationship to patient (if applicable): ………………………………….

Signed: ………………………………….Date: ………………………………….

……………………………………………………………………………………………………………….

I have been fully informed of the consequences of this election, understand those consequences and have not been directed by a hospital employee towards a choice.

Relationship to patient (if applicable): ………………………………….

Signed: …………………………………. Date: ………………………………….

……………………………………………………………………………………………………………….

**DECLARATION BY HOSPITAL EMPLOYEE AS WITNESS**

I (print name and position) have witnessed the above election.

Signed: …………………………………. Date: ………………………………….

# Appendix 3: Sample of signage for specialist clinics

**Public specialist clinic (seeing public patients only)**

You are attending this clinic as a public patient.

Please present your Medicare card when you arrive for your appointment.

If you have a valid Medicare card, you do not need to pay any money for your consultation.

Please speak to staff if you would like more information.

**Public specialist clinic (seeing private patients)**

You are attending this clinic as a public patient.

Please present your Medicare card when you arrive for your appointment.

If you have a valid Medicare card, you do not need to pay any money for your consultation.

Consultations in this clinic are available to private patients. If you choose to be treated as a private patient, this means your consultation will be bulk-billed under Medicare.

If you would prefer to be treated as a private patient, please notify reception staff on arrival at the clinic. Please sign your Medicare claim form before leaving this clinic.

**Public specialist clinic (seeing private patients only)**

You are attending this clinic as a private patient.

Please present your Medicare card when you arrive for your appointment.

If you have a valid Medicare card, you do not need to pay any money for your consultation.

Please sign your Medicare claim form before leaving this clinic.

If you would prefer to be treated as a public patient, please notify reception staff on arrival at the clinic.

**Visiting Specialist Clinic**

You are attending this clinic as a private patient of a visiting specialist. Please present your Medicare card when you arrive for your appointment.

Please sign your Medicare claim form before leaving this clinic.

# Appendix 4: Sample of business case for specialist clinics

Name of hospital: ………………Name of clinic: ………………Purpose of clinic: ………………

Clinics that are billing under the MBS must document the amount of revenue and cost incurred in setting up and operating the clinic. The table below lists the various sources of revenue and cost but is not limited to this list.

|  |  |  |
| --- | --- | --- |
| Revenue | Expenditure/ Cost | |
|  | Total direct cost | Total indirect cost |
| * Revenue earned through services * Facility fee | * Salaries and Wages – existing and new * On costs – existing and new * Equipment costs – existing and new * Consumable costs * Facility fee * Support services (e.g. indigenous health, interpreter services, social work) * Insurance for staff | * Corporate services * CEO * Planning and innovation * Other indirect costs (e.g. impact on availability of public services, impact on number of patients waiting for a service, impact on access to medicines, availability of staff to provide other services such as procedures or inpatient services) * Costs to patient (e.g. transport costs) |

Examples of corporate services are medical records, medical library, support services (includes contract costs of housekeeping and food supply), telephone, corporate services (includes audits and consulting costs), finance (includes hospital insurance policy), human resources, occupational health, computer services, payroll, procurement and learning and development. Indirect costs related to CEO consist of but are not limited to 150th activities, PR, Philanthropy, board of management and executive costs. Planning and Innovation costs comprise of planning and innovation, engineering and maintenance, power, light, heat and security. Other indirect costs include special functions, cleaning and laundry, Central Sterilization Supply Department (CSSD), indigenous health, interpreter services, social work, clinical quality (infection control), nursing education, access management and medical administration.

To understand the type of workforce present in the clinic which might aid in the allocation of salaries and wages, clinics must document the ratio of public to MBS-billable hours that are completed by each specialist.

|  |  |  |
| --- | --- | --- |
| Specialist’s name: ………………Clinic name: ……………… | | |
|  | Monthly hours | |
|  | Public | MBS-billable |
| Contracted hours |  |  |
| Non-clinical/ theatre |  |  |

Besides the overall financial impact, the business case may also include statement of priorities, patient safety and stakeholders impacted or engaged (e.g. room availability, consumables, pharmacy, nursing support).

**Private specialist clinic (MBS-billed) – business case**

Name of hospital: ……………….. Name of clinic: ………………..

Purpose of clinic: ………………..

Clinics that are billing under MBS must document the amount of revenue and cost incurred in setting up and operating the clinic. The table below lists the various sources of revenue and cost but is not limited to this list.

|  |  |  |
| --- | --- | --- |
| **Revenue** | **Expenditure/ Cost** | |
|  | **Total direct cost** | **Total indirect cost** |
| * Revenue earned through services * Facility fee | * Salaries and Wages – existing * Salaries and Wages – new * On costs – existing * On costs – new * New equipment costs * Existing equipment costs * Pharmacy costs * Consumable costs * Facility fee | * Corporate services * CEO * Planning and innovation * Other indirect costs |

Examples of corporate services are, medical records, medical library, support services (includes contract costs of housekeeping and food supply), telephone, corporate services (includes audits and consulting costs), finance (includes hospital insurance policy), human resources, occupational health, computer services, payroll, procurement and learning and development.

Indirect costs related to CEO consist of but are not limited to 150th activities, PR, Philanthropy, board of management and executive costs.

Planning and Innovation costs comprise of planning and innovation, engineering and maintenance, power light and heat and security.

Other indirect costs include patient transport, special functions, cleaning and laundry, CSSD?, indigenous health, interpreter services, social work, clinical quality (infection control), nursing education, access management and medical administration.

To understand the type of workforce present in the clinic which might aid in the allocation of salaries and wages, clinics must document the ratio of public to private hours that are completed by each specialist.

|  |  |  |
| --- | --- | --- |
| Specialist’s name:  Clinic name: | | |
|  | Monthly hours | |
|  | Public | Private |
| Contracted hours |  |  |
| Non-clinical/ theatre |  |  |