Policy

Directive: compliance is mandatory

Title: Medicare Billing for Private Non-admitted Patients in SA Health Local Health Network Outpatient Clinics

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Summary

This Directive and associated schedules provide the SA Health Policy on Medicare Benefits Schedule (MBS) billing for Local Hospital Network (LHN) specialist outpatient services to ensure consistency in practice across all South Australia LHNs (except for Country Health SA LHN) and that:

- LHNs and medical specialists are aware of and adhere to the requirements of the National Health Reform Agreement and the *Health Insurance Act 1973* as they relate to the provision of outpatient services.
- LHNs have appropriate documentation in place regarding private practice arrangements and, where appropriate, patient election processes relevant to specialist outpatient services.
- patients are aware of their right, where appropriate, to choose whether to be treated as a private or public patient and are well informed of the potential financial impact of their decision.

Keywords

Medicare Billing for Private Non admitted Patients
Specialist outpatient services
Medicare Business Rules
National Health Reform Agreement
Health Insurance Act 1973

Policy history

This policy replaces an existing policy**.**

This Directive and associated schedules supersedes the Privately Referred non Inpatient (PRNI) Directive 2007 and the Medicare Billing and referral for Outpatients Services Fact Sheet 2010.

Applies to

All SA Health Portfolio
All Department of Health Divisions
All Local Health Networks (except for Country Health SA LHN which is out of scope for this Directive)

Staff impact

All LHN Staff, including clinical, management and administration who either provide, manage or support public and private public hospital outpatient and other non admitted services.

PDS reference OCE use only

Version	Date from	Date to	Amendment
1	1/11/2007	1/4/2010	Original version
2	17/11/2011	current	in line with the National Health Reform Agreement 2011

Government of South Australia
SA Health

Medicare Billing for Private Non-admitted Patients in SA Health Local Health Network Outpatient Clinics

1. Purpose/Background

This Directive provides the SA Health Policy on Medicare Benefits Schedule (MBS) billing for Local Hospital Network (LHN) specialist outpatient services and should be read in conjunction with the attached schedule. It has been produced in the context of the National Health Reform Agreement 2011 business rules and legislative requirements under the *Health Insurance Act 1973*.

This Directive provides additional detail around accessing MBS for private outpatient services and supersedes the Directive on Privately Referred Non Inpatient (PRNI) Initiative 2007 and the Medicare Billing and Referrals for Outpatient Services Fact Sheet 2010.

A specialist outpatient service is a consultation or procedure provided by a LHN to a person who is not currently admitted to a public hospital within that LHN (non-admitted patient).

Specialist outpatient clinics enable participating specialists within LHNs to provide professional services to patients in a private capacity. Services include specialist outpatient consultations, procedures and associated diagnostic services such as pathology and radiology.

The purpose of this Directive and attached schedules is to provide clear direction across SA Health that ensures:

- LHNs and medical specialists are aware of and adhere to the requirements of the National Health Reform Agreement 2011 and the *Health Insurance Act 1973* as they relate to the provision of outpatient services.
- LHNs have appropriate documentation in place regarding private practice arrangements and, where appropriate, patient election processes relevant to specialist outpatient services.
- patients are aware of their right, where appropriate, to choose whether to be treated as a private or public patient and are well informed of the potential financial impact of their decision.

It should be noted that professional services rendered by a medical specialist pursuant to their rights of private practice are rendered under a contract between the medical specialist and the patient, and not by, or on behalf of or under an arrangement with the State.

This Directive and attached schedules will ensure consistency in practice across all in scope[1] South Australian LHNs in relation to the application of Medicare Billing for Private Non-admitted Patients in specialist outpatient clinics.

Compliance with this Directive and associated schedules is **mandatory**.

[1] Country Health SA Local Health Network is out of scope for this Directive

2. Scope

This Directive and attached schedules applies to all staff (clinical, administrative and support) who support or provide specialist outpatient services to non-admitted patients in SA Health in scope LHNs. Country Health SA Local Health Network is out of scope for this Directive.

3. Directive Principles

The following overarching principles provide the framework within which medical specialists and LHNs operate in relation to specialist outpatient services and to ensure patients' fair and equitable access to these services:

- Patients will be provided with the choice of being treated as a public or private patient and will be fully informed of the financial and other implications of such choice.
- There will be fair and equitable access for all eligible persons to non-inpatient services on the basis of clinical need, within a clinically appropriate period and regardless of geographic location.
- Billing by a medical specialist providing care through a specialist outpatient service must comply with the provisions of the *Health Insurance Act 1973* and Medicare Benefits Schedule (MBS) and obligations under the National Health Reform Agreement 2011 business rules.

4. Directive Detail

4.1 Informed decision making by patients: choice to be a public or private non-inpatient and informed financial consent

4.1.1 Patients will be provided with the choice to be treated as a public or a private (MBS-billed) non-inpatient in South Australia's public health system.

4.1.2 Eligible persons who have elected to be treated as a private non-inpatient will have done so on the basis of informed financial consent.

4.1.3 Patients will be made fully aware of any financial implications associated with choosing to be treated privately; such as:

- Where the specialist outpatient services provided by a medical specialist in a LHN are bulk-billed against the relevant item number in the MBS, there is no gap and therefore no out of pocket expense to the patient.
- Where the medical specialist chooses to bill up to 100% of the MBS schedule fee, in accordance with their rights of private practice agreements, the patient will be liable for any gap that may need to be paid.

4.1.4 The requirement for election to be a private non-inpatient applies even if the patient does not incur any out of pocket expenses and the full cost of the service is bulk-billed.

4.1.5 Patients who elect to be treated as a private non-inpatient in a LHN specialist outpatient clinic are eligible to receive MBS-billed pathology, diagnostic imaging and procedural services.

4.1.6 LHNs will ensure that patients who have elected to be private non-inpatients for pathology, diagnostic imaging and procedural services (i.e. through a request) have also done so on the basis of informed financial consent.

4.1.7 LHNs will display consistent and clear signage and other information pamphlets and institute appropriate procedures to ensure that patients are able to make an informed decision as to be treated as a public or private non-inpatient. Schedule 2 provides the signage details to be displayed in specialist outpatient service areas. The schedule also details the stamping process required to demonstrate private patient election. In addition to schedule 2 signage requirements, all LHNs need to use the Department of Health resource kit which is available from the Department of Health's Hospital Revenue Services Branch.

4.2 Fair and equitable access to services:

Access

4.2.1 Access to public or private non-inpatient services will be on the basis of clinical need and within a clinically appropriate period.

4.2.2 Arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.

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

- Ensuring that where a specialist medical service is available to private non-inpatients in a LHN, a public specialist outpatient clinic in the same specialty field is also accessible in that LHN; and/or
- Offering patients the choice to be treated publicly (i.e. with no billing against the MBS) in specialist outpatient clinics that undertake MBS-billing.

Referral pathways:

4.2.4 Services provided to public patients should not generate charges against the MBS:

- except where there is a third party payment arrangement, emergency department patients can not be referred to an outpatient department at the hospital to receive services from a medical specialist exercising a right of private practice under the terms of employment of a contract with a LHN which provides public hospital services.
- Referral pathways must not be controlled to deny access to free public hospital services, or to make a referral to a named specialist a prerequisite for access to outpatient services. A patient must be able to receive services free of charge as a public non-inpatient without a named referral.

4.2.5 It is a requirement that patients referred from an emergency department to a LHN specialist outpatient clinic cannot receive services that are billed against the MBS.

Referral to specialist outpatient clinic services

4.2.6 It is a requirement of the MBS rules that professional services (i.e. requirement for a named referral to a named medical specialist in order to access MBS) rendered by a medical specialist in a LHN specialist outpatient clinic cannot be billed against the MBS unless:

- 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.

4.2.7 A written request (not written referral to a named specialist) is required for pathology, diagnostic imaging and many procedural type services by the *Health Insurance Act* and MBS rules in order to access MBS.

4.2.8 Reference should be made to MBS rules for accessing MBS through professional services (written referral to a named specialist) and other specific services (by written request).

Component of outpatient service for the purpose of MBS Billing

4.2.9 If services (including pathology, diagnostic imaging and procedural services) are performed or partly performed during a public or private specialist appointment/occasion of service, that service is a component of that appointment time/occasion of service.

4.2.10 Any service (for example pathology, diagnostic imaging or procedural services) arising from a public or private outpatient appointment time (by written request or referral as required), but provided outside of that appointment time, is not considered to be a component of that outpatient appointment time/ occasion of service. A new patient election point on whether a patient wishes to be treated as a public or private non-inpatient arises for that subsequent occasion of service. If a patient has a public specialist outpatient appointment and a valid private election does not occur for the subsequent service, the patient's previous public election remains.

Aftercare

4.2.11 It is a requirement that where patients have received treatment as a public inpatient, aftercare directly related to that episode of admitted care will be provided free of charge as part of the public hospital service.

4.2.12 Notwithstanding this, where a public patient independently chooses to consult a private medical practitioner for aftercare, then the clinically relevant service provided during this professional attendance will attract Medicare benefits.

4.3 Provision of Medicare Benefits Schedule (MBS) billed specialist outpatient services:

4.3.1. Billing by a medical specialist providing care in a specialist outpatient clinic must comply with the provisions of the *Health Insurance Act 1973* and Medicare Benefits Schedule (MBS) and obligations under the National Health Reform Agreement 2011 business rules.

4.3.2 Compliance with the MBS rules is the legal responsibility of the billing medical specialist whose provider number is used for a Medicare benefit claim. The LHN's role is to provide administrative support services as required by the medical specialist's Rights of Private Practice Agreement for billing purposes.

Note: LHNs and medical specialists that provide MBS-billed specialist clinic services must comply with all relevant sections of the current version of the MBS and any other supporting information issued by Medicare. Some important sections from the MBS are outlined below, however this list is not exhaustive.

Visiting Medical Specialists who do not conduct rights of private practice but perform private services at public hospitals in accordance with the Directive *Visiting Medical Specialists – Private Practice Billing* (May 2010) are also required to comply with the MBS and obligations under the National Health Reform Agreement 2011 business rules.

Service eligibility for Medicare

4.3.3 Medicare benefits are only payable for clinically relevant services that are listed in the MBS (see section G.1.2 of the MBS). A clinically relevant service is defined in the MBS as one which is generally accepted by the relevant profession as necessary for the appropriate treatment of the patient.

Provider eligibility for Medicare

4.3.4 Medical specialists must meet eligibility criteria to be able to provide professional services that will attract Medicare benefits (see section G.2.1 of the MBS). This includes recognition as a specialist or consultant physician as specified under the *Health Insurance Act 1973*.

4.3.5 Medical specialists registered in an approved specialist trainee program as specified under section 3GA of the *Health Insurance Act 1973* can provide limited services that will attract Medicare benefits.

Provider numbers

4.3.6 Medical specialists providing professional services that can be claimed against the Medicare system must have a valid provider number for the location where the services are provided.

4.3.7 A provider number should not be used to claim against the MBS:

- Without expressed permission of the medical specialist; or
- For services that are not rendered by or on behalf of the medical specialist

Valid referral – Professional Services

4.3.8 A valid referral for a professional service must be received to enable a medical specialist to bill specialist outpatient services against the MBS (see section G.6.1 of the MBS).

4.3.9 A valid referral must be:

- Documented in writing;
- Signed and dated by the referring medical specialist;
- Addressed to a named medical specialist; and
- Received on or prior to the patient's first occasion of service.

4.3.10 A reference to a "referral to a professional service" in this section does not refer to written requests made for pathology, diagnostic imaging and specific procedural services as specified in the MBS Rules.

Named referrals

4.3.11 While a referral may be addressed to a named medical specialist, the referral can be used by the patient to see a different medical specialist provided that both medical specialists have equal qualifications in the same discipline, operate in the same clinic and can access the patient's medical record. This arrangement does not however apply to services that are billed against items 132 and 133 of the MBS.

Procedural Items

4.3.12 There is no referral requirement to bill the MBS for procedural items, however a medical specialist (or another appropriately qualified practitioner) will always diagnose the necessity for the procedure during a professional consultation. Where a medical specialist is billing the MBS for a consultation, a referral is required for the professional service. A referral is not required to bill the MBS for the relevant procedure item alone. It is noted that the professional consultation that diagnosed the need for the procedure may be undertaken at a separate time to the procedure. In addition, the professional consultation may be undertaken

by a different medical specialist (or appropriately qualified medical practitioner) to whom performs the procedure. Where a professional consultation does not occur during the same appointment time as the procedure, a referral is not required to bill the MBS for the relevant procedure item. An exception to the above rule is where a procedure item number has an S next to it in the MBS. In those instances, the referring details must be quoted on the account to allow for a benefit to be paid.

Billing procedures

4.3.13 The specific billing procedures required by Medicare Australia must be met. Where services are bulk billed, the medical specialist accepts the relevant Medicare benefit as full payment for the service and additional fees cannot be raised against the patient (see section G.7.1 of the MBS).

Provision of medical services

4.3.14 Medical services that are billed against the MBS must be rendered by, or on behalf of, a medical specialist.

4.3.15 In the case of the latter, section G.12.2 of the MBS specifies that services rendered on behalf of a medical specialist must be billed in the name of the medical specialist who is then required to provide supervision and accept full responsibility for the service.

Supervision

4.3.16 Where professional services are rendered on behalf of medical specialists, it is the responsibility of the medical specialist to provide supervision. The supervising medical specialist need not be present for the entire service however they must have direct involvement in at least part of the service (see section G.12.2 of the MBS).

Maintenance of records

4.3.17 It is the responsibility of medical specialists to maintain adequate and contemporaneous records of all services attracting a Medicare benefit payment (see section G.15.1 of the MBS).

5. Responsibility

CEOs, Managers and medical specialists of in scope[2] LHNs which provide public hospital specialist outpatient clinic services are responsible for implementing the directive and ensuring compliance to the principles and procedures detailed in this Directive.

6. Definitions

Election point: the time in which a new occasion of service is about to commence. At this point in time patients should be given the choice to be treated as a private patient (MBS-billed) or a public patient (not MBS Billed).

Gap: out of pocket expenses to the patient.

LHN: a Local Health Network established under the Health Care Act 2008, except for Country Health SA Local Health Network which is out of scope for this Directive.

[2] Country Health SA Local Health Network is out of scope for this Directive

Medical Specialist: means a medical practitioner who is a SA Health employee conducting private practice. This includes Salaried Medical Officers and Clinical Academics conducting private practice pursuant to a written rights of private practice agreement. It also includes Visiting Medical Specialists who do not conduct rights of private practice but perform private services at public hospitals in accordance with the Directive *Visiting Medical Specialists – Private Practice Billing* (May 2010).

Occasion of service: An occasion of service is each examination, consultation, treatment or other service provided in an individual session to a non-admitted patient intended to be unbroken in time. Each discrete service activity, for example, each test or set of related tests, each consultation, or each treatment, counts as one occasion of service.

For pathology services, each diagnostic test or simultaneous set of related diagnostic tests for the one patient referred to a hospital pathology department consists of one occasion of service.

For radiology services an occasion of service is the examination, consultation, treatment or other services provided within the individual session time.

Outpatient clinic: is where an outpatient service is provided

Outpatient service: in relation to a LHN, means a health service or procedure provided by the LHN to an eligible person other than an inpatient of a LHN hospital.

Professional service as defined in the *Health Insurance Act 1973*:

"(a) service (other than a diagnostic imaging service) to which an item relates, being a clinically relevant service that is rendered by or on behalf of a medical practitioner; or

(b) prescribed medical service to which an item relates, being a clinically relevant service that is rendered by a dental practitioner approved by the Minister in writing for the purposes of this definition; or

(ba)service specified in an item that is expressed to relate to a professional attendance by an accredited dental practitioner, being a clinically relevant service that is rendered by an accredited dental practitioner to a prescribed dental patient; or

(c) a service specified in an item that is expressed to relate to a professional attendance by a participating optometrist, being a clinically relevant service that is rendered by an optometrist, being a participating optometrist or an optometrist acting on behalf of a participating optometrist; or

(d) a pathology service that is rendered by or on behalf of an approved pathology practitioner pursuant to a request made in accordance with subsection 16A(4) by:

(i) a treating practitioner; or

(ii) another approved pathology practitioner who received a request for the service made by the treating practitioner; or

(e) a pathology service (other than a service referred to in paragraph (d)) that is a clinically relevant service rendered by or on behalf of an approved pathology practitioner other than a medical practitioner; or

(f) a diagnostic imaging service that is rendered by or on behalf of a medical practitioner pursuant to a subsection 16B(1) of the *Health Insurance Act 1973* request; or

(g) a diagnostic imaging service (other than a service referred to in paragraph (f)) that is a clinically relevant service rendered by or on behalf of a medical practitioner. Note: See subsection (17) of the *Health Insurance Act 1973* for when a service is taken to be rendered on behalf of a medical practitioner"

Public patient in relation to a LHN, means a patient in respect of whom the LHN provides comprehensive care free of charge, including all necessary medical, nursing and diagnostic services and, if they are available at the hospital, dental and paramedical services, by means of its own staff or by other agreed arrangements.

Private patient in relation to a LHN means a patient who is being treated by a medical specialist conducting private practice who has made the choice to be treated as a private patient of the specialist and the Medicare referral/request requirements have been met.

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

Request – A written request must be signed and dated and contain the name and address or name and provider number in respect of the place of practice of the requesting practitioner. It is not necessary that a written request for a diagnostic imaging service be addressed to a particular provider or that, if the request is addressed to a particular provider, the service must be rendered by that provider. For pathology services the request must conform to specific requirements contained in the MBS; these are already included on the SA Pathology request forms.

Non-referred items/procedures – those procedures for which there is no referral requirement under the MBS in order to bill for that item.

Rights of private practice: Under the Private Practice Agreement 2008 Salaried Medical Specialists are granted limited rights of private practice, enabling them to bill for privately provided medical services. Similar arrangements apply for Clinical Academics.

The terms and conditions for Private Practice are contained in the Department of Health Rights of Private Practice Agreement 2008, and the individual Memorandum of Agreement signed between the medical specialist, the employing authority, and the hospital. The Private Practice Agreements also contain terms and conditions of indemnity provided for services rendered under rights of private practice.

For Medicare eligible outpatient services, the rights of private practice specifies that the maximum amount that can be charged is 100% of the MBS Scheduled Fee or Veterans Affairs Scheduled Fee. Although 100% of the Scheduled Fee may be charged, it is common practice for bulk billing to occur so there is no out of pocket expense to the patient.

Visiting Medical Specialists (VMS) do not exercise rights of private practice in connection with their employment. The provision of private patient services by a VMS are rendered in their independent non-employment capacity and are not governed by rights of private practice agreements. Where a VMS wishes to perform private patient billing on LHN public hospital sites, the VMS must comply with the Directive *Visiting Medical Specialists – Private Practice Billing* (May 2010).

Third party payment arrangement: This relates to non-Medicare patients or compensable patients such as those that may be subject to a Workcover, Motor Accident Commission or other liability claim.

7. Evaluation

Consistent practice and procedures across all in scope SA Health LHNs which provide specialist outpatient services.

8. Risks

Non compliance with accessing MBS in accordance with the *Health Insurance Act 1973*, Medicare Rules and National Health Reform Agreement business rules may result in action from the Commonwealth Government to recover MBS payments for those identified services.

9. Associated Directives or Guidelines

National Health Reform Agreement 2011 Directive
Visiting Medical Specialists –Private Practice Billing (May 2010)

10. References

The following are critical references to ensure compliance with legislation, MBS rules and due regard to the National Health Reform Agreement business rules:

Health Insurance Act 1973

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

The Act can be accessed at the following website:
http://www.austlii.edu.au/au/legis/cth/consol_act/hia1973164/

Medicare Benefits Schedule

The Medicare system was introduced by the Commonwealth Government in 1984 to provide eligible Australian residents with affordable and high quality medical, optometric and Local Health Network care.

The MBS lists the services for which a Commonwealth-funded payment can be claimed against the Medicare system. Each professional service is associated with a unique item number, service description, schedule fee and benefit payable. The types of services in the MBS are reviewed and amended annually.

The MBS can be accessed at the following website:
http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1

National Health Reform Agreement 2011

Agreed by COAG in August 2011, this agreement details provisions for Commonwealth funding contributions to public hospital services and contains the public hospital business rules, unchanged, from the National Healthcare Agreement 2008.

The National Health Reform Agreement can be accessed at the following website:
http://www.federalfinancialrelations.gov.au/

PROCEDURES TO BE IMPLEMENTED FOR SPECIALIST OUTPATIENT SERVICES BILLING BY ALL SA HEALTH LHNS

This schedule reiterates the key requirements for the practical application of this Directive for specialist outpatient MBS billed services performed by medical specialists. This schedule also provides details on the specific procedures required so that consistent practice occurs for all outpatient services across the SA Health system[3].

This schedule will assist in scope South Australian LHNs and medical specialists in the provision of MBS-billed specialist clinic services and the implementation of best practice arrangements in the operation of these clinics.

Medicare billing systems vary across SA Health sites. This schedule details specific MBS billing procedures that shall apply to the various specialist outpatient clinic arrangements that exist within SA Health LHNs. All in scope SA Health LHNs are required to follow the relevant billing procedures that apply to the set-up of their specialist outpatient clinics. The specific procedures have been developed to ensure Medicare billing practices are compliant with MBS rules, the *Health Insurance Act 1973*, and with due consideration to the National Health Reform Agreement 2011.

When billing for private services (including Medicare claiming) it is the responsibility of medical specialists to ensure that they comply with these requirements.

It is the responsibility of the LHN to ensure the billing process meets requirements at all LHN sites where specialist outpatient services are provided.

Reference should always be made to MBS rules generally and for conditions relating to specific item numbers.

1. KEY REQUIREMENTS

1.1 MBS billed specialist outpatient clinic services in public hospitals

Medicare benefits are claimable only for 'clinically relevant' services rendered by an appropriate medical specialist to a private patient. A 'clinically relevant' service is one which is generally accepted by the relevant profession as necessary for the appropriate treatment of the patient.

Based on rights of private practice arrangements, most private non-admitted patients in SA public hospitals are bulk billed to Medicare so there is no out of pocket expense to the patient.

In some cases, the medical specialist may choose not to bulk bill. In these cases the specialist will raise a charge for the full fee, and the patient will claim a benefit from Medicare, resulting in a "gap". Any "gap" arrangements need to be disclosed to the patient before the patient makes the choice to be private.

The amount billed by the medical specialist for a private patient service is based on the MBS. Each item number in the MBS specifies the services covered and in some cases specific requirements for the service provided.

Most MBS item numbers stipulate that 'personal attendance' is required by the billing specialist. Junior medical staff / Registrars do not have rights of private practice in

[3] Country Health SA Local Health Network is out of scope for this Directive.

public hospitals; therefore all consultations that are billed against the MBS must include some face-to-face time between the patient and the billing specialist.

1.2 Patient Choice

To comply with the National Health Reform Agreement 2011 a patient must be provided with the choice of attending as a private patient (Medicare billed) or a free public patient (not Medicare billed). The public services may be provided in a public clinic time slot, or at a different location and patient choice must be available in all circumstances.

This means that where a LHN provides private (Medicare billed) specialist outpatient services, services must also be available for both private (Medicare billed) and public patients within the LHN. Public patients are treated free of charge and may not be billed to Medicare or the patient. They do not necessarily see a medical specialist of choice.

Private patients normally see the specific doctor they are referred to, who may supervise other components of the service for which the patient is referred. Where the specific medical specialist is unavailable, another medical specialist in the same clinic (conducting private practice) may see the patient for and on behalf of the specialist as a private patient provided that both medical specialists have equal qualifications in the same discipline (except for services billed against items 132 and 133 of the MBS).

1.3 Clear and consistent signage and patient information

Clear and consistent signage and other information is required to enable patients to make a choice as to whether they wish to be treated as a public or private patient for specialist outpatient services.

It is a requirement that this signage and information is consistent across all LHNs including the display of Department of Health information pamphlets on Medicare billing arrangements at SA Health.

A further requirement is the use of a stamp on the relevant referral or request form for the purpose of recording that the patient has elected to be a private patient.

The required signage and stamping process to demonstrate private patient election are detailed in schedule 2. Other required material for LHNs are in the Department of Health's resource kit for specialist outpatient clinic services which is available from the Hospital Revenue Services Branch.

1.4 General Specialist Outpatient Service Referral Requirements

As a general rule, Medicare benefits are payable for specialist outpatient services where all of the following conditions are met:

- The patient is referred to a named medical specialist; and
- The treating doctor is a specialist exercising rights of private practice; and
- The patient chooses to be treated as a private patient.

Medicare benefits are not payable for services provided to non-admitted patients referred from an emergency department. This means that patients referred to an outpatient department from an emergency department can only be public patients.

The referring medical practitioner must have undertaken a professional attendance with the patient, turned his or her mind to the patient's need for referral and have communicated relevant information about the patient to the medical specialist or consultant physician.

To enable Medicare billing of specialist outpatient services, all of the following requirements must be met:

- The referral requirements for that service must be met (patient is referred to a named medical specialist for professional services).
- The referral must be in writing.
- The referral must be signed and dated by the referring doctor.
- The referral needs to be a specifically named medical specialist (i.e. “Dear doctor” or “Dear Clinic” referrals are not valid for Medicare billing).
- The referral must be received on or before the service is provided to the patient.
- The referring doctor must have seen the patient, and turned his or her mind to the patient’s need for referral.

Referrals are to be made by another medical practitioner. The general practitioner is regarded as the primary source of referrals. Cross referrals between specialists and/or consultant physicians should usually occur in consultation with the patient’s general practitioner.

Referrals sourced from another medical practitioner working within the hospital are acceptable for Medicare billing (except from the emergency department as already described above).

For example:

- A referral from a hospital Registrar is valid for Medicare billing, if the Registrar has referral rights granted by Medicare Australia.
- A referral from a medical specialist is valid for Medicare billing.
- A referral from the emergency department is not valid for Medicare billing.

Where a non-admitted patient has been seen as a public non-admitted patient by one doctor, the patient may be referred for a separate service or attendance. The patient may elect to be private (and Medicare benefits claimed) for the separate service or attendance.

The MBS provides that referrals have a defined period commencing from the date of first service rendered under that referral.

Referrals from a general practitioner are valid for **12 months** unless a general practitioner refers for a longer or shorter period. For example:

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

Referrals from a medical specialist are valid for 3 months only.

LHNs are required to file written referrals for 18 months from the date of the last service covered by the referral.

Referrals can be required as a condition to access both public and private services to ensure that only appropriate patients are seen by the medical specialist. However, with the exception of dedicated private clinics (see section below), private referrals and Medicare billing cannot be made a prerequisite for access to outpatient services.

2. MBS BILLING PROCEDURES IN SPECIALIST OUTPATIENT SERVICES

2.1 Types of billing practices

There are three main types of Medicare billed specialist outpatient clinics that may exist within LHNs and their specific sites. These are:

A Dedicated private specialist outpatient clinic

B Mixed private and public clinic services:
- B(i) mixed private and public clinic services available at specific clinic times: specific times may be dedicated to seeing public patients of a hospital and other separate times set for private patients;
- B(ii) Mixed private and public clinic services available within the same clinic: patients are seen as either a public or private patient based on patient election.

C Independent private practice located at a LHN site

All outpatient clinics should have clerical policy manuals for the staff working in those clinics so that processes comply with this Directive.

Type A – Dedicated Private Patient Outpatient Clinic

For a fully private clinic to operate, free public services in the same specialty field must be available within the LHN.

The abovementioned Department of Health signage and information should be used. Signage must indicate that the clinic is a private clinic.

Referral requirements for private patients must be complied with as detailed in section 4 above.

The referral form is to be stamped to confirm private patient election has been made. The requirement for election to be a private patient applies whether or not the patient incurs any out of pocket expenses and whether or not the service is bulk-billed.

Private services will usually be bulk billed to Medicare. The patient will be required to sign a Medicare benefit assignment form (referred to as the DB2 or DB4) for bulk billing to occur. This must be signed by the patient after the service is completed.

In some cases, the medical specialist may not bulk bill. In these cases the medical specialist will raise a charge for the full fee, and the patient will claim a benefit from Medicare, resulting in a “gap”. Any “gap” arrangements need to be disclosed to the patient before the patient makes the choice to be private.

Type B – Mixed Public / Private Clinic

This clinic type arrangement means that both public and private patients are seen.

The abovementioned Department of Health signage and information should be used.

Type A billing practices apply for private patients. Particular note should be made to ensure the referral form is stamped to confirm private patient election has been made. Patients choosing to be public patients receive the outpatient service free of charge.

Type B outpatient clinics clerical policy manuals should contain statements to assist clerical staff to reinforce the capacity for an eligible patient to choose to be a public or private patient where appropriate. These statements are outlined in the Department of Health's resources kit which is available from the Department of Health's Hospital Revenue Services Branch.

Type C – Independent private practice located at a hospital site

Medical specialists providing outpatient services under this arrangement have entered into a commercial relationship with the LHN to pay for the use of the facilities to operate their own standalone private practice. These arrangements are outside of medical specialist Rights of Private Practice agreements. Any private practice conducted under this model is outside of employment in SA Health and is completely separate from any services rendered in connection with SA Health employment.

A Type C arrangement can occur where:

- A part time specialist is performing services in their non SA Health employment capacity (i.e. outside their employment rights of private practice agreement and paid FTE).
- A Clinical Academic is conducting private practice independently in their own right that is not in connection with their SA Health employment.
- A Visiting Medical Specialist is performing services in their private non SA Health capacity and is not being remunerated by SA Health for the service.

As part of the commercial arrangement with the specialist(s) the hospital **may** agree to provide in return for payment a number of services including but not limited to:

- Billing service
- Medical Record service
- Clinical and clerical support staff
- Sterilisation/equipment

The use of a site for the private practice can either be through a lease or a license agreement. A lease normally provides the specialists with exclusive use of a set area in the hospital. A license agreement generally provides shared access to part of the hospital.

Type C service arrangements must have a commercial basis for the services used by the private practice. It is not possible to just "allow" space to be used where there is no commercial basis for MBS billing, as this will result in a breach of section 19 of the *Health Insurance Act 1973*.

There must be documentation of the agreement between the parties. Such an agreement should contain the core components expected of any contract with an external party.

Advice should be sought from the Department of Health Hospital Revenue Services branch regarding the utilisation of a standard form legal agreement for provision of services and facilities.

Any Memorandum of Agreement (MoA) entered into with SA Health relates only to employment related Private Practice. The various terms and conditions contained in the SA Health MoA (including earnings cap and indemnity) have no application to non employment related private practice. Assurance should be sought that the specialist has their own indemnity coverage for their medical services.

3. REFERRAL REQUIREMENTS FOR DIAGNOSTIC SERVICES (PATHOLOGY AND RADIOLOGY)

3.1. Requests for Diagnostic Services (Radiology/ Pathology)

Referral to specified provider not required

Under the *Health Insurance Act 1973* and MBS rules it is not necessary that a written request for a diagnostic imaging service be addressed to a particular provider or that, if the request is addressed to a particular provider, the service must be rendered by that provider.

MBS Billing Principles

Where a radiology or pathology service is performed or partly performed during a public appointment time/occasion of service, then that service is considered to be a component of the public appointment time/occasion of service, and must be provided free of charge.

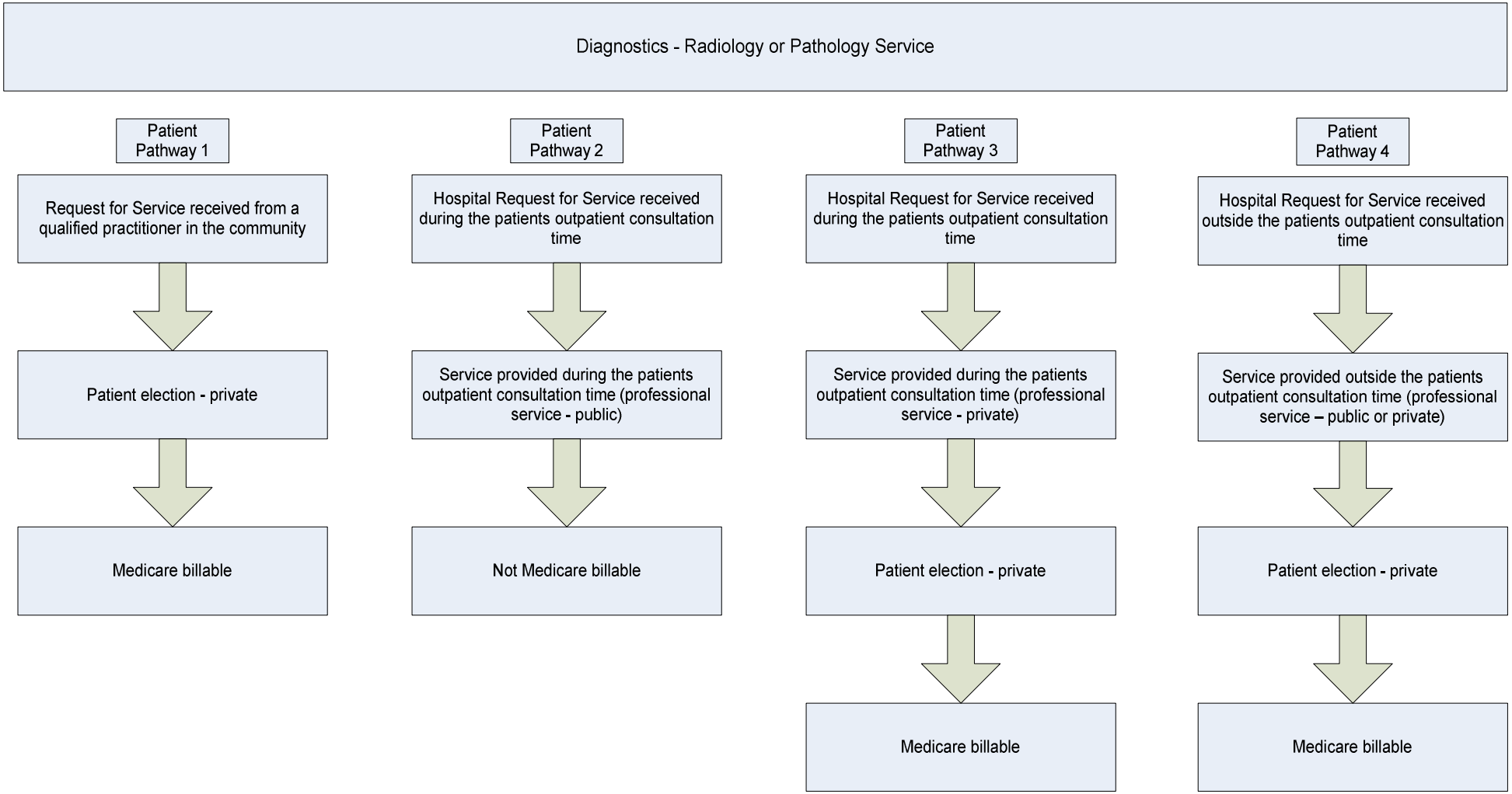
Equally, where a radiology or pathology service is performed or partly performed during a private appointment time/occasion of service, then that service is considered to be a component of the private appointment time/occasion of service, and can be billed against MBS.

Where a radiology or pathology service is provided separately to the appointment time/occasion of service, then this is considered to be a separate service to the appointment. A new patient election point arises in relation to that radiology or pathology service. At this point, a patient can make a choice whether they would like to have the separate service undertaken as a public patient and free of charge, or as a private patient and bulk billed to Medicare.

If a patient has a public outpatient appointment and a valid private election does not occur for the subsequent diagnostic service, the patient's previous public election remains.

At all Radiology and Pathology billing points, clear and consistent signage must be displayed detailing the patient's choice to be treated as a public or private patient.

Patient pathway details are summarised below to clearly define when diagnostic services (radiology and pathology services) can and can not be billed to Medicare.


Diagnostics - Radiology or Pathology Service
Patient Pathway 1
Request for Service received from a qualified practitioner in the community
Patient election - private
Medicare billable
Patient Pathway 2
Hospital Request for Service received during the patients outpatient consultation time
Service provided during the patients outpatient consultation time (professional service - public)
Not Medicare billable
Patient Pathway 3
Hospital Request for Service received during the patients outpatient consultation time
Service provided during the patients outpatient consultation time (professional service - private)
Patient election - private
Medicare billable
Patient Pathway 4
Hospital Request for Service received outside the patients outpatient consultation time
Service provided outside the patients outpatient consultation time (professional service – public or private)
Patient election - private
Medicare billable

3.2 Requests for Procedural Services conducted by Medical Specialists

Procedural services are defined as those which do not require a referral to a named medical specialist under the MBS. Procedural services are accessed via a request. Reference should be made to the MBS to identify the relevant procedural services.

MBS Billing principles

Procedural services attracting MBS items may occur in the following situations.

- The procedural service is requested mainly from a general practitioner in the community:

  The treating medical specialist makes a clinical decision that the procedure can be undertaken at the request of the referring practitioner without performing a consultation.

  The patient does not attend a consultation with the medical specialist prior to the procedure being conducted. The procedure can be billed to Medicare where the patient makes the election to be a private patient for the procedure. The patient must be provided with the choice to be a public or private patient and a stamp is required on the request form to confirm the election has been made.

- The procedural service is carried out by a medical specialist following a private specialist outpatient consultation at the LHN site:

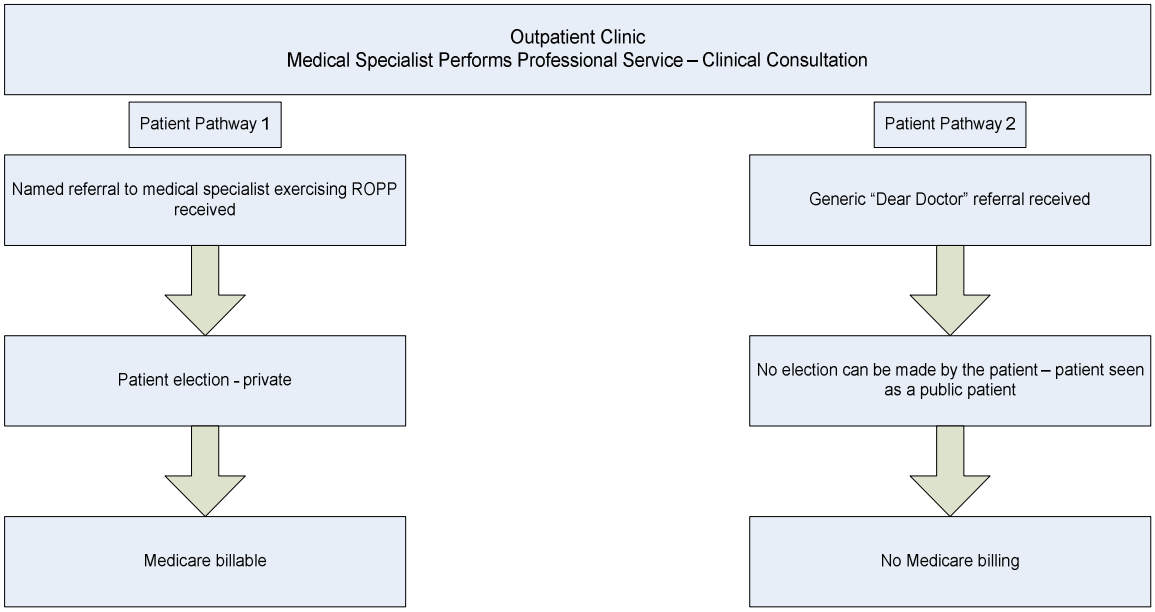
  If the initial consultation that determined the clinical need for the procedure was private (billed to Medicare), and the same medical specialist performs the procedure it can be regarded as private and billed to Medicare. The original stamp confirming the patient's election to be a private patient remains valid for this purpose.

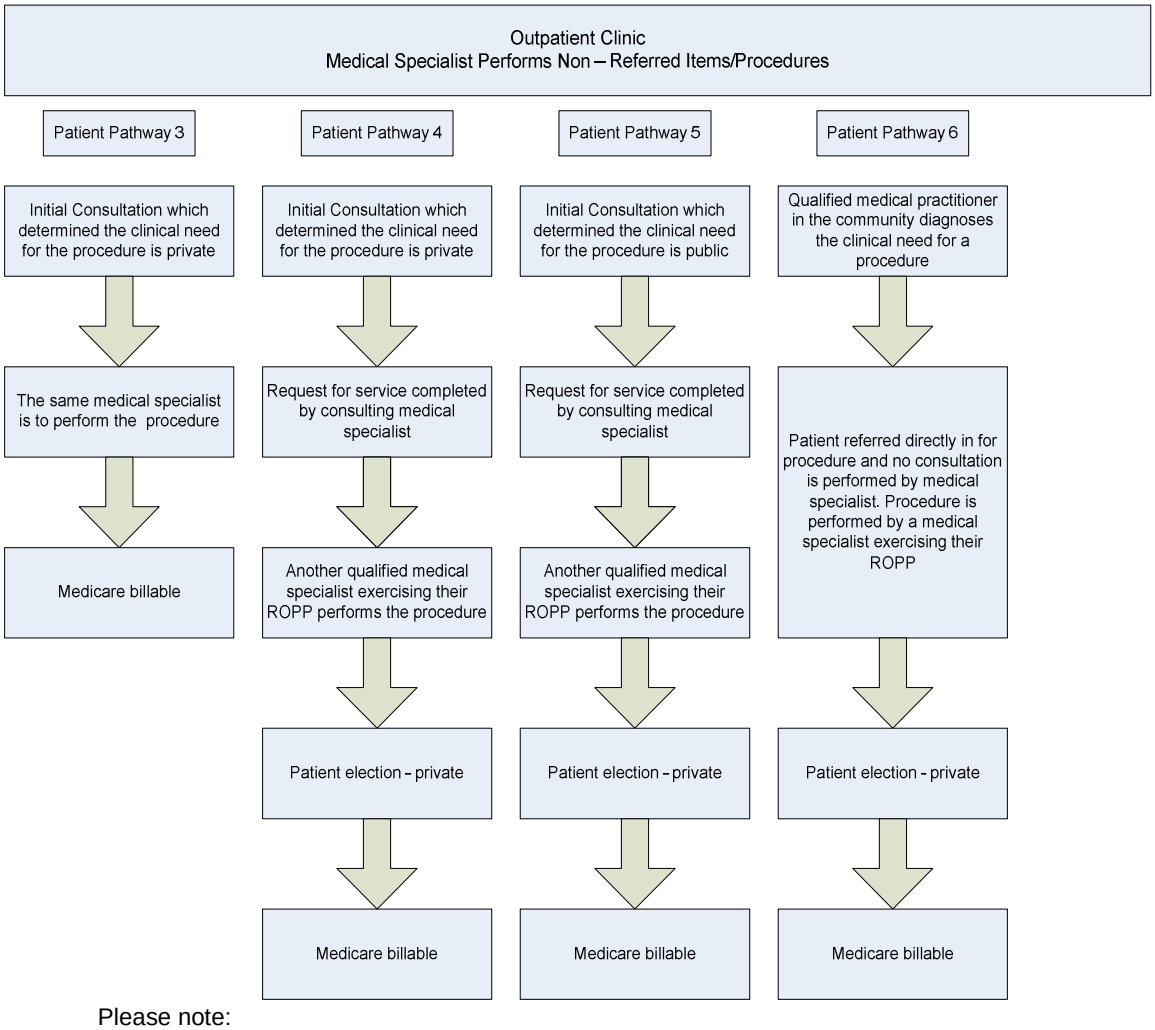
- The procedure is carried out by a public consultation at the hospital:

  If the initial consult that determined the clinical need for the procedure was public, and the same specialist performs the procedure immediately after or as part of the consult appointment time, the procedure is regarded as public and will be performed free of charge.

  In some situations, another suitable qualified consultant will be asked to perform the procedure. If this procedure is undertaken as a separate occasion of service after the consult appointment time, then the patient can be provided with the choice to make an election to be public or private for the subsequent procedure.

  - the initiating medical specialist should request the other medical specialist to perform the service and comply with any applicable MBS rules; and
  - the treating medical specialist must be exercising rights of private practice
  - the patient must be provided with the choice to be a public or private patient, and;
  - the patient chooses to be a private patient for the procedure. This choice should be evidenced by a stamp on the request form indicating a private patient election has occurred.





Please note:

a. Patient pathways detailed above are the most common practiced at MBS billed specialist clinics.
b. Patient pathways 3 - 6 refer to procedures that according to the Medicare Benefit Schedule do not require a named referral for services to be billed to Medicare.
c. Where patient pathway 6 is practiced, the treating medical specialist is consenting to performing the procedure based on the referring doctors' advice and not performing his/her own clinical consultation

3.3 Aftercare

It is a requirement that patients must be able to access non-admitted care free of charge by a LHN following an episode of admitted care as a public patient. However, where a public patient independently chooses to consult a private medical specialist for aftercare, then the clinically relevant service provided during this professional attendance will attract Medicare benefits.

Signage Requirements in Outpatient Clinics

In scope LHNs must use the consistent signage and the use of a stamp to demonstrate private patient election.

The following signs are required to be displayed in all Out Patient clinics, the particular sign based on the type of outpatient clinic provided:

TYPE 1 – Fully Private Clinic – Bulk Billed

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

You will need a valid referral from your doctor to a named specialist.

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

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

TYPE 1 – Fully Private Clinic – Not Bulk Billed

This is a private patient clinic. You will need a valid referral from your doctor to a named specialist.

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

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

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

TYPE 2 – Mixed Private/Public Clinic – Bulk Billed

Public or Medicare Bulk Billed – It's Your Choice

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

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

You will incur **no out of pocket expense**.

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

TYPE 2 – Mixed Private/Public Clinic – Not Bulk Billed

Public or Private – It's Your Choice
You have the choice to be private or a public outpatient.

A private patient can usually see the doctor of choice. You will need a valid referral.

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

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

TYPE 3 – use same signage as model 1

Radiology/ Pathology Signage

Public or Medicare Bulk Billed – It's Your Choice

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

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

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

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

STAMP – use for private patients

Stamp must clearly read - "Private Patient"

To indicate a patient has made a valid election to be treated as a private patient the "Private Patient" stamp must be clearly visible on an appropriate document within the patient's case notes for a consultation as well as on all request forms for diagnostic and procedural services.