GPSA
GENERAL PRACTICE SUPERVISORS AUSTRALIA

FAQ
FREQUENTLY ASKED QUESTIONS

Medicare Compliance

GPs and registrars need to be mindful that just because billings may be accepted by Medicare, they may not necessarily be correct, however it is vital to comply with the requirements of the Medicare Benefits Schedule (MBS).

This resource aims to help you teach your registrar the importance of billing correctly and what to expect, and do, if you receive an MBS audit, or any review request from Medicare.

How can I explain to my registrar the importance of compliance?

The Department of Health (DoH) states: "While most Medicare providers do the right thing, the Department of Health has a role in ensuring that health professionals comply with the requirements of the MBS and other Medicare programs such as the Pharmaceutical Benefits Scheme (PBS) and incentive payment programs. This ensures that Medicare is serving the needs of Australian patients."

What forms of audit could a GP or GP registrar receive?

There are many different audits, and not all audits are administered by the same team or section within the DoH. For this reason, one form of audit does not necessarily lead to another.

Forms of audits a GP or GP registrar could receive include: Review and Act Now Letters; Notification of Investigation; Compliance Audits; Practitioner Review Program (PRP); and Professional Services Review (PSR).

Review and Act Now letters

- Different item numbers across a range of medical specialities.
- Statistical outliers and a large volume of services identified by the DoH.
- Can be part of an awareness campaign but often requires the doctor to perform a self-audit of an attached schedule of services by a specific date.
- Administered by the Provider Benefits Integrity Division.
- **GPs and GP registrars who receive a Review and Act Now letter should seek advice/support from their Medical Defence Organisation (MDO).**

  The doctor should check their medical records accordingly. If the service was incorrectly billed, the doctor needs to complete a voluntary acknowledgement of incorrect payment form and send it back to the DoH with a covering letter explaining why the incorrect item was billed and what they are doing to make sure it doesn't happen again.

  https://www1.health.gov.au/internet/main/publishing.nsf/Content/voluntary-acknowledgement

  If it is difficult to meet the due date (e.g. if the schedule is large or you are moving practice), ask the DoH for an extension of time.

Notification of Investigation

- s.129AC(1) of the Health Insurance Act 1973 – false and misleading statements.
- Can relate to a handful of services and possibly comes about from a patient making a complaint to Medicare.
- Administered by the Provider Benefits Integrity Division.
- **GPs and GP registrars who receive a Notification of Investigation should seek advice/support from their MDO.**

  The doctor should review their medical records to confirm whether the service in the schedule was appropriately billed; write to the DoH to explain the situation; and voluntarily repay incorrect payments.

Compliance Audits

- Compliance audits are similar to Review and Act Now letters.
- An example of a compliance audit regarding nursing home visits: "Incorrect claiming/billing of derived fee items – Based on your claiming of these items, we are concerned that you are incorrectly identifying the number of patients seen on each occasion which may result in you receiving more Medicare benefit that what you are entitled to. If you do not respond to this letter, the HIA allows us to issue a Notice to Produce Documents under section 129AAD".

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- **GPs and GP registrars who receive a Compliance Audit should seek advice/support from their MDO** because often the schedule that is sent with the letter is a sample only. Once the doctor responds to the DoH, the department can expand the audit period. If the item numbers were incorrectly recorded, the doctor can be asked to repay the full amount; they can then re-bill the correct item, provided it is within two years of the service.

Practice Review Program (PRP)

- The process starts with a phone call from a medical adviser from the DoH, scheduling a phone interview.
- This is followed up by a letter confirming the date/time of the phone interview, a list of concerns about your billing profile and a 33-page billing summary and data profile.
- Three possible outcomes:
  1. No further action.
  2. A six-month review period (with possible repayment).
  3. A referral to the delegate.
- Operates under the Compliance Operations Branch.
- **GPs and GP registrars who receive an invitation to participate in a PRP interview should seek <u>urgent</u> advice/support from their MDO**.

Professional Services Review (PSR)

- The PSR's role is:
  "To protect patients and the community from the risks associated with inappropriate practice and to protect the Commonwealth from having to meet the cost of medical/health services provided as a result of inappropriate practice."
- The PSR is an independent statutory agency within the health portfolio and reports directly to the Minister for Health.

What is the role of the MDO beside advising and attending meetings with PSR?

It is likely your MDO can provide advice and assistance through all stages and types of Medicare compliance issues.

How do doctors come to the department's attention for auditing?

Most doctors come to the department's attention because they are statistical outliers.

The nature of statistics is that someone sits at the bottom and someone at the top of the bell curve. The DoH uses computer algorithms which pick up statistical outliers. This means that doctors who sub-specialise within general practice may come to the department's attention because their special area of interest places them above the 90th percentile for a particular item number. That doesn't mean the doctor is necessarily doing anything wrong, but they are more likely to come under scrutiny.

I am the most senior GP principal and seem to have most of the chronic patients and complicated patients and therefore my item numbers are mostly 721, 732 and C or D. Am I being compared to my registrar with almost no experience or other doctors of similar experience and position?

Generally in the first instance you are being compared to your 'peers' (e.g. metro GP), however many doctors sub-specialise in different areas and have different profiles. The main thing is to ensure good documentation, and good understanding of the MBS item descriptor to ensure you are meeting the criteria

Is there a plan for all GPs to be audited in one form or another within the next few years, or is it only if we trigger the system?

We do not know how Medicare plans their reviews.

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How far back do audits go and over what timeframe?

Usually the two previous years. Often the first year is used for comparison only..

What are common GP errors audited by Medicare which registrars should know about?

Item numbers – General Practice

- Consults (Category 1 – Professional attendances)

  ABCD: That is level B (up to 20 minutes), level C (20 to 40 minutes) and level D (more than 40 minutes). If you solve three problems in 18 minutes – it is still a level B.

Mental health

- Explain to your registrar that they can only bill a consult with a mental health item if it is a physical urgent problem, and they will need good documentation to substantiate that.

  E.g. Writing a script for an anti-hypertensive in a mental health consult does not constitute an urgent physical problem.

Chronic disease management (CDM)

- Chronic disease care plans are a big focus of Medicare because a lot of mistakes happen in this area.
- In relation to a TCA 723, ensure you meet the criteria of collaboration with a minimum of two other providers involved in the care of the patient with agreement from them via two-way communication.
- You need to have collaborated with other providers for the TCA before you can bill it.
- E.g. You cannot the next day after a consult, have your nurse set up the physiotherapist or podiatrist appointments/referral and then back date billing of the 723: you can only bill Medicare when the patient is face-to-face, and the item descriptor is completed.
- The only time you can bill the 723 without the patient having seen the all team providers is in the case of using the five rebatable allied health items, but you still must have two-way communication and agreements by that provider for that specific patient.
- If billing a second 732 (for the TCA), on the same day, check to ensure the patient has seen at least two other providers in the preceding period since you last billed either a new plan or the previous review, and include their feedback and review into the plan.

Bulk billing

When bulk billing for a service be aware that you can't make additional charges for that service.

This includes, but isn't limited to:

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

See: https://www.humanservices.gov.au/organisations/health-professionals/subjects/bulk-bill-payments-health-professionals

Items "in association"

Consult items are time and complexity based, so good notes are required to substantiate what you are billing – be careful not to "keep the clock running" if you move from doing a consult to a billed procedure. Medicare may investigate "items in association" if you are doing a lot of procedures with long consults.

Record keeping

- The record must include the name of the patient.
- The record must contain a separate entry for each attendance by the patient for a service.
- Each separate entry for a service must:
  - Include the date on which the service was rendered or initiated.
  - Provide sufficient clinical information to explain the service; and be completed at the time, or as soon as practicable after the service was rendered or initiated.
  - The record must be sufficiently comprehensible to enable another practitioner to effectively undertake the patient's ongoing care in reliance on the record.

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The 80/20 Rule

- A GP or OMP engages in inappropriate practice if they have rendered or initiated 80 or more professional attendance services on each of 20 or more days in a 12-month period (known as a "prescribed pattern of services"). This is commonly referred to as the 80:20 Rule.
- The 80:20 Rule is based on the number of professional attendance services per day, which may not be the same as the number of patients seen in a day. The 80 'services' are as per the list on the website, it is the group A items that are counted: https://www.health.gov.au/resources/publications/prescribed-pattern-of-service-what-you-need-to-know

Is there a penalty payment if one of the items billed was incorrect? Or is just paying the item back enough?

This depends on which part of the compliance program the repayment relates to. See https://www1.health.gov.au/internet/main/publishing.nsf/Content/compliance-audits-and-review

Can we be held as secondary debtor for our registrar if we supervise but do not own the practice?

Registrars bill under their own provider number and have the same compliance requirements as any doctor. See https://www1.health.gov.au/internet/main/publishing.nsf/Content/shared-debt-recovery-scheme-fact-sheet

Who can I speak to if I have questions about the MBS?

Clarification of MBS item numbers and descriptors	
Time sensitive	**Phone:** Department of Health on 132 150 **When:** Monday to Friday, 8.30am to 5pm local time. **Important:** • Take detailed notes of the advice you receive, who provided the advice, and keep it in your medico-legal file for future reference. • Keep up to date with MBS changes and apply to your practice.
Not time sensitive	**Email:** askmbs@health.gov.au **Important:** • Write a clear, and well-worded question. • Show that you have already read the descriptor and include the descriptor's exact wording. *E.g. I have read the item descriptor as per below and I am confused /don't understand.* *Can I do, X, Y and Z? '[Insert descriptor wording here]'* • Keep any advice you receive in your medico- legal file for future reference. • If the question is more clinical than legal and therefore the MBS may not be able to provide clear advice, contact your college for guidance. • Keep up to date with MBS changes and apply to your practice.

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Tips to manage Medicare billing

- Read the MBS – and contact the Department of Health if you need clarification on a particular item.
- If you are concerned, go for the lesser item and encourage your registrar to do the same.
- Don't rely on what others tell you, and don't be pressured into billing services you don't agree with.
- Remember that you are responsible for your provider number.
- Ensure all services, referrals and prescriptions are 'clinically relevant' and can be justified.
- If you sub-specialise, be even more scrupulous in your billing.
- Take time off! Working longer hours and thus higher than average billing in a full year may bring you to the DoH's attention.
- Keep good notes.
- When in doubt, contact your MDO.

Resources

- MBS education for health professionals at https://www.servicesaustralia.gov.au/organisations/health-professionals/subjects/mbs-education-health-professionals
- MDA National articles (also search 'Medicare' in MDA National library):
  - Review of *MBS bulk bill incentive items* at https://www.mdanational.com.au/advice-and-support/library/blogs/2019/07/review-of-mbs-bulk-bill-incentive-items
  - *Billing errors prove costly for doctors* at https://www.mdanational.com.au/advice-and-support/library/blogs/2019/08/billing-errors-prove-costly-for-doctors

Further reading

- GPSA FAQs Managing Medicare Billing at https://gpsupervisorsaustralia.org.au/download/6343/
- GPSA FAQs Shared Debt Recovery Scheme at https://gpsupervisorsaustralia.org.au/download/6352/

Content reviewed by MDA National. If you need any advice and support, contact MDA National's Medico-legal Advisory Service team on 1800 011 255 or email advice@mdanational.com.au

Does this resource need to be updated? Contact GPSA: P: 03 5440 9077, E: admin@gpsa.org.au, W: gpsupervisorsaustralia.org.au
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