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Telehealth Reimbursements

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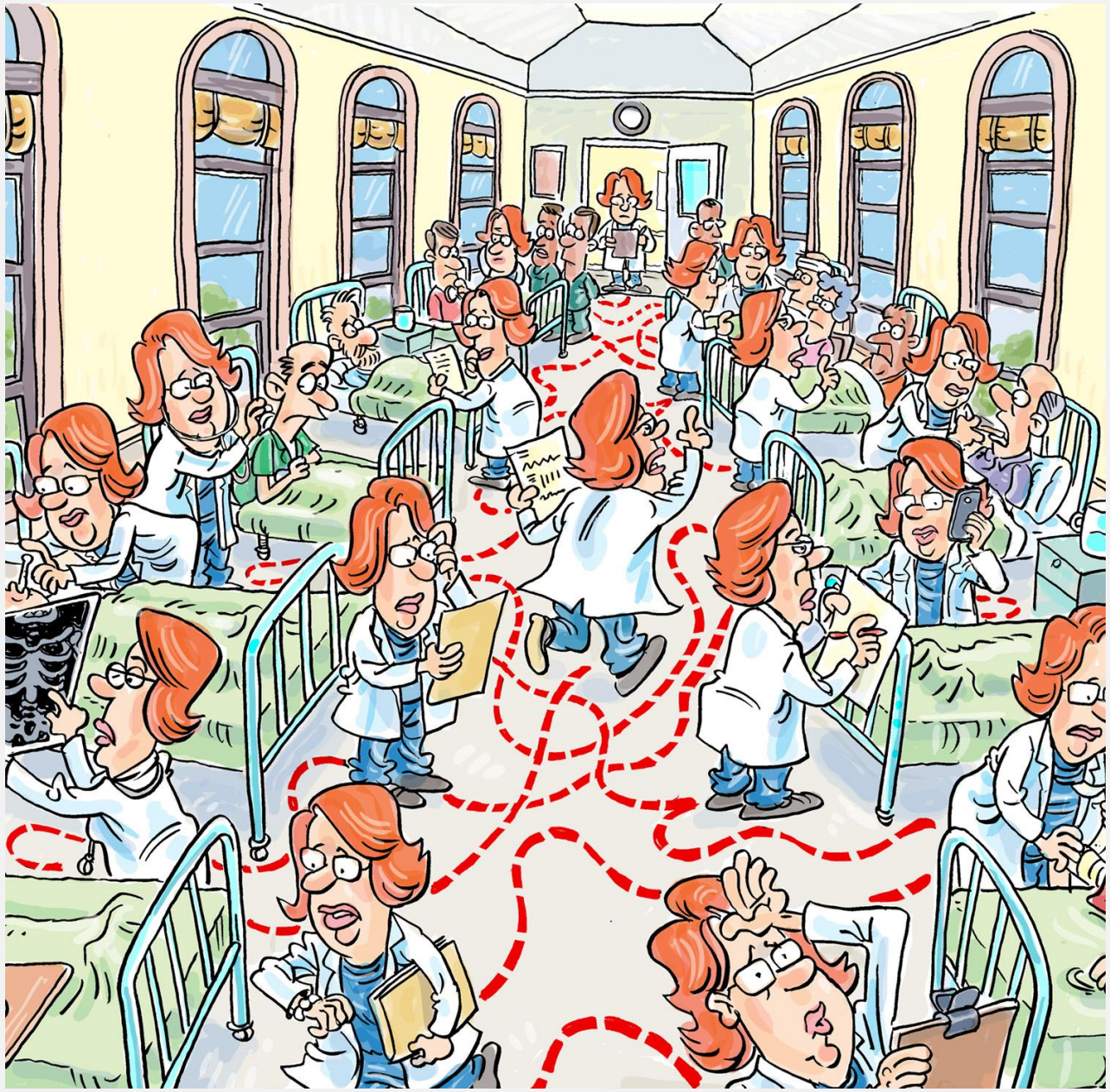

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Telehealth Reimbursements Webinar

What we are going to cover today

- Medicare's legal foundations
- Bulk billing
- What are the telehealth changes?
- The 80/20 and 30/20 rules
- The 12 month rule
- Record keeping requirements
- What does the future hold?
- Take home messages

Telehealth Reimbursements Webinar

What is Medicare?

A quick skip through Medicare's history

A successful referendum on 28 Sept 1946 lead to the insertion of a new clause into the Australian Constitution as follows:

s51(xxiiiA.) The provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorise any form of civil conscription), benefits to students and family allowances.

On 1 July 1975 the Federal Government introduced Medibank (later Medicare) using two separate sections of the Australian Constitution:

1. Section 96 of the Constitution for the States to run public hospitals, and
2. Section 51(xxiiiA) for medical services – to subsidise costs incurred by patients on a fee-for-service basis

60 years of High Court decisions

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3 POINTS OF LAW ARE SETTLED

1. The relationship between a provider of medical services & a patient is a private contract
2. The civil conscription caveat only applies to medical and dental services
3. Both legal and practical compulsion may offend the caveat

Fun Fact ☺

Australasian College of Cosmetic Surgery Limited v Australian Medical Council Limited [2015] FCA 468

"Despite its name, the National Law is not a law of the Commonwealth Parliament, but a law made by the Queensland Parliament and applied by laws made by the parliaments of the other States and the Territories."

Katzmann J
14 May 2015

What does this mean in practice?

Medicare is a patient insurance scheme *not* a provider payment scheme

Rights and Responsibilities

Rights:

- You can charge whatever you like
- Australian patients can choose their providers and cannot be forced into a required relationship with any provider without their consent

Responsibilities:

- All general billing requirements under the *Health Insurance Act 1973* apply to everyone billing to Medicare
- Specifically, you are responsible for your billing and must ensure you only provide 'clinically relevant' services
- Allied health (AH) practitioners and nurse practitioners become providers of 'medical and dental services' through other legal instruments
- Everyone comes within the ambit of the PSR (the Medicare watch dog) and can be found guilty of inappropriate practice

The Golden Rule

If it’s not clinically necessary don’t do it.

If you do it, you must meet ***all*** requirements of ***every*** item number you bill, ***every time*** you bill it.

Bulk Billing – Section 20A Health Insurance Act 1973

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20A Assignment of Medicare benefit

(1) Where a medicare benefit is payable to an eligible person in respect of a professional service rendered to the eligible person or to another eligible person, the first-mentioned eligible person and the person by whom, or on whose behalf, the professional service is rendered (in this subsection referred to as ***the practitioner***) may enter into an agreement, in accordance with the approved form, under which:

(a) the first-mentioned eligible person assigns his or her right to the payment of the medicare benefit to the practitioner; and

(b) the practitioner accepts the assignment in full payment of the medical expenses incurred in respect of the professional service by the first-mentioned eligible person.

Your patient

You

Step 1

Step 2

This means you can bulk bill or patient claim, but not both

High Court of Australia, *Wong v Commonwealth of Australia* [2009] HCA 3, Kirby J at 158:
"Even "bulk billing" is only possible by consent of both parties to that relationship."

- The patient must consent to bulk bill so yes, it is a legal requirement that they sign the DB4 form or press 'YES/OK' on HICAPS…you can throw paper straight in the bin…go figure!
- You cannot charge any additional amount of money when you bulk bill
- Think of it as an EITHER / OR decision:
  - **Either** bulk bill and accept what the government pays
  - **Or** charge the full fee up front and either lodge the claim online for the patient or give them a receipt and let them lodge it to obtain their rebate
  - You cannot do both – remember the Constitution and how it works…
- It does not matter what you may call an additional amount (booking fee, admin fee etc) or if a separate legal entity charges it - it is illegal and may constitute a crime!
- The only exception is certain vaccines

What Medicare and your patients see through MyGov

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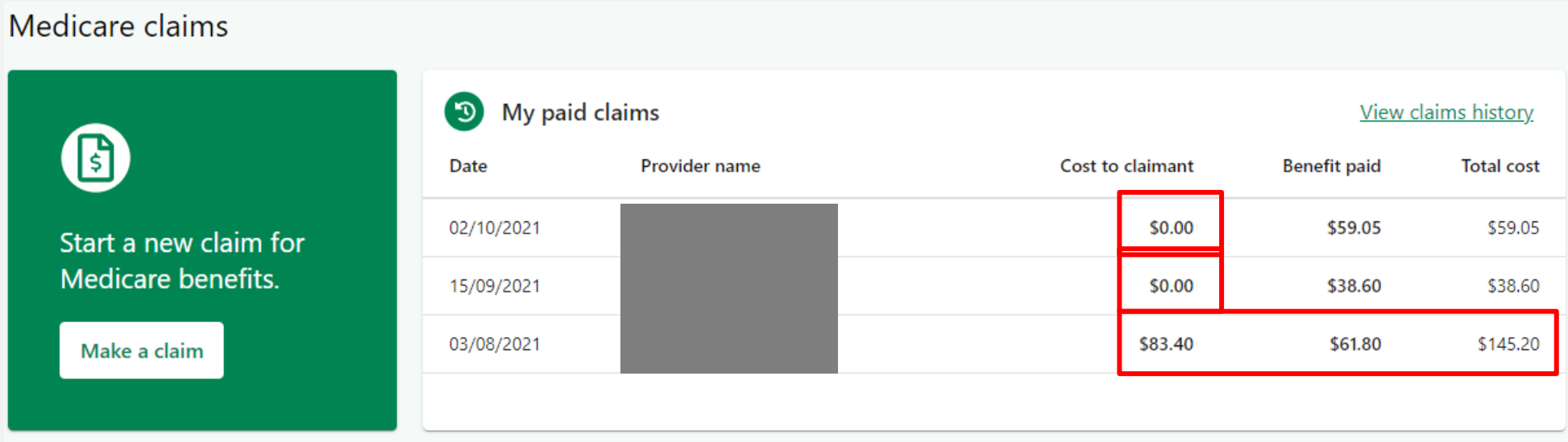

What about patients with PHI?

(Allied health only)

- It is important to understand that Medicare is taxpayers money, whereas private health insurance (PHI) is not.
- There are 2 completely different legislative schemes in operation.
- This means Medicare and the PHIs operate differently.
- So, you CAN charge a gap separate to the amount billed to a patients' PHI using your HICAPS terminal, but you CANNOT do the same when billing to Medicare.
- AND allied health providers *cannot* use the patient's PHI to 'top up' the Medicare bulk bill amount.

9 Effect of election to claim private health insurance for an allied health service

An item in Schedule 2 applies to an allied health service only if a private health insurance benefit has not been claimed for the service.

Which items stayed and which went?

Specialists

- All the old loading items from 2011 were removed permanently
- Patient-end items from 2011 remain for AHW, Practice Nurses and Optometrists only
- Old telepsychiatry items from 2002 were removed
- All phone items were temporarily reinstated to 30 June 2022, but only the lowest paying items will continue to be available by phone from 1 July 2022

GPs

- Most telephone items removed – replaced by video
- One telephone item for a short consult (less than 6 mins) – 91890
- One telephone item for long consult (6 mins or more) – 91891
- One GP long telephone consult for MMM 6-7 - 91894

The 80/20 and 30/20 rules

(https://www.legislation.gov.au/)

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1

Commencement information		
Column 1	**Column 2**	**Column 3**
Provisions	**Commencement**	**Date/Details**
1. The whole of this instrument	1 January 2022.	1 January 2022

8 Circumstances for medical practitioners for prescribed pattern of services

For the purposes of section 82A of the Act, circumstances in which services rendered or initiated by a medical practitioner constitute a ***prescribed pattern of services*** are that:

80/20 → (a) the medical practitioner renders or initiates 80 or more relevant services on each of 20 or more days in a 12 month period; or

30/20 → (b) the medical practitioner renders or initiates 30 or more relevant phone services on each of 20 or more days in a 12 month period.

2

Commencement information		
Column 1	**Column 2**	**Column 3**
Provisions	**Commencement**	**Date/Details**
1. The whole of this instrument	The later of: (a) 20 January 2022; and (b) immediately after this instrument is registered.	20 January 2022 (paragraph (a) applies)

8 Circumstances for medical practitioners for prescribed pattern of services

For the purposes of section 82A of the Act, circumstances in which services rendered or initiated by a medical practitioner constitute a ***prescribed pattern of services*** are that the medical practitioner renders or initiates 80 or more relevant services on each of 20 or more days in a 12 month period.

3

+ Sunset Information

Registered 18 Jan 2022

Tabling History	Date
Tabled HR	08-Feb-2022
Tabled Senate	08-Feb-2022

To be repealed 10 Jun 2022

Repealed by Division 1 of Part 3 of Chapter 3 of the Legislation Act 2003

What is the new '30/20 rule'? (mbsonline.gov.au)

From **1 July 2022**, a new prescribed pattern of service (a '30/20 rule') will apply to telephone attendances provided by consultant physicians and GPs. This was introduced on 1 January 2022, but will now be deferred. Under these new arrangements, a consultant physician or GP who provides 30 or more phone attendances on each of 20 or more days in a 12-month period would be referred to the Professional Services Review.

The 12 month rule for GPs

Health Insurance (Section 3C General Medical Services – Telehealth and Telephone Attendances) Determination 2021

7 Application of items – general

(5) An item in Schedule 1 applies to a service performed by the patient's usual medical practitioner.

NB: Schedule 1 is GP and OMP services

(7) For the purpose of subsection (5):

patient's usual medical practitioner means a medical practitioner (other than a specialist or consultant physician) who:

(a) has provided at least one service to the patient in the past 12 months; or

(b) is located at a medical practice at which at least one service to the patient was provided, or arranged by, in the past 12 months.

For the purpose of this subsection, service means a personal attendance on the patient and excludes telehealth and phone attendances.

Referrals between GPs and AH

Referrals from medical practitioners *do not* have to indicate the number of sessions

- The Allied Health Services Determination 2014 defines various maximum numbers of services.
- Remember, Medicare reimburses clinically relevant services only, so prescribing the number of services would be contrary to this overarching legal requirement.
- There is no prescribed form that medical practitioners must use for any referral, whether it is to an allied health practitioner, or another medical practitioner.
- In the end the decision around whether to accept a referral that *does not* state the number of services, is a risk management issue, rather than a legal issue. You can:
  - Refuse to accept it and request further details, or
  - Accept it and use your clinical judgment as to the number of clinically relevant services
- Referrals that *do* include the number of services, will help you in the event of a Medicare audit.

Record Keeping – Medicare and the Codes

Medicare's record keeping requirement

6 Standards for adequate and contemporaneous records

For the purposes of the definition of ***adequate and contemporaneous records*** in subsection 81(1) of the Act, the standards for a record of the rendering or initiation of services to a patient by a practitioner are that:

(a) the record must include the name of the patient; and

(b) the record must contain a separate entry for each attendance by the patient for a service; and

(c) each separate entry for a service must:

(i) include the date on which the service was rendered or initiated; and

(ii) provide sufficient clinical information to explain the service; and

(iii) be completed at the time, or as soon as practicable after, the service was rendered or initiated; and

(d) the record must be sufficiently comprehensible to enable another practitioner to effectively undertake the patient's ongoing care in reliance on the record.

AH - Reporting to referrers

- ✓ After each course of treatment. If a patient does not complete a course of treatment, after the last service.
- ✓ If the patient comes back later, report again.
- ✓ Anytime there is a significant change in the patient's condition or your treatment.
- ✓ Must be in writing and include details of all assessments and treatments, as well as any recommendations for future treatment.

TOP TIP

Consider recording the start and finish time of each consultation. Together with your appointment book, and the comprehensive records you keep, these details will be invaluable in an audit.

What does the future hold?

3.2. Voluntary patient registration

"To help support a future in which quality, safe MBS telehealth is delivered in the context of a continuity of care relationship between people and their usual doctor and general practice, the Government has invested over $69 million in Services Australia since 2020 to support a future VPR system."

"…the VPR system would open for registration in July 2022 and that MBS telehealth for general practice would become contingent on the patient being registered with the practice from 1 July 2023. The 'usual doctor' requirements for MBS health assessments, chronic disease management plans and medication reviews would also be linked to VPR for registered patients from that date."

https://consultations.health.gov.au/primary-care-mental-health-division/draft-primary-health-care-10-year-plan/

Take home messages

- Medicare is an honour system funded by taxpayers, and the department is aggressively pursuing compliance
- Be careful who you listen to about billing
- The MBS is not the law. It is a departmental interpretation of a very complex statutory scheme. Obtain as much reliable information as you can.
- Free legal information is available here: https://mbsanswers.com.au/
- Remember
  - Medicare itemisation is a precision exercise
  - Satisfy ***all*** requirements of ***every*** 'clinically relevant' MBS item you bill, ***every time*** you bill it
  - Bulk bill *OR* charge upfront full fees – not both
  - Good Records, Good Defence | Poor Records, Poor Defence | No Records, No Defence

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