

# Private practice in the Queensland public health sector guideline

A guide to assist medical practitioners, practice managers and support staff in interpreting the requirements and arrangements of private practice activities in the Queensland public health sector.

February 2014

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# 1. Introduction

This guideline provides information to employees engaged in private practice activities in the public health sector. The guideline also provides relevant information to assist Hospital and Health Services (HHSs) and commercialised business units (CBUs) to implement best practice principals regarding private practice. The guideline has been created in line with the National Healthcare Agreement 2012 between the Australian Government and state and territory governments, and subsequent Queensland Health policy documents.

Queensland Health has implemented the following policy documents relevant to private practice activities delivered in public health facilities:

- *Private practice in the Queensland public health sector health service directive*
- *Private practice in the Queensland public health sector policy*
- *Private practice in the Queensland public health sector implementation standard*
- *Private practice in the Queensland public health sector framework*
- *Private practice in the Queensland public health sector guideline (this document)*

The relationship between the documents is depicted in the diagram below. Individuals will benefit most from reading the guideline in conjunction with either the policy and implementation standard or the health service directive. The guideline provides additional information for practice managers, clinicians and support staff. The policy, implementation standard and health service directive are mandatory, while the framework and guideline are supporting documents.

**Table 1 Relationship of Queensland Health private practice policy documents**

	<b>Department of Health and commercialised business units</b>	<b>Hospital and Health Services</b>
<b>Applicable policy documents</b>	Private practice in the Queensland public health sector policy	Private practice in the Queensland public health sector health service directive
	Private practice in the Queensland public health sector implementation standard	
	Private practice in the Queensland public health sector framework	
	Private practice in the Queensland public health sector guideline	

The guideline further aims to address recommendations from the Queensland Audit Office's first report (2013) to Parliament, titled *Right of private practice in Queensland public hospitals*.

The guideline encases key regulatory requirements typically relating to private practice. However, it is the responsibility of HHSs, CBUs and all employees to ensure they comply with relevant legislative and other regulatory requirements. Each group may need to source further industrial, legal and financial advice to assist with meeting regulatory requirements.

## **2. Private practice in Queensland**

Patients have the right to choose to be treated as either public or private patients. As such, private practice provided by public health services is an important patient care activity. In supporting this right, and where a patient elects to do so, public health services may treat patients privately.

With careful management, private practice may result in additional flow-on benefits.

Effective operation of private practice will achieve:

- quality patient services
- attracting and retaining a quality workforce
- financial sustainability
- optimal resource utilisation (fixed assets and human capital).

## 3. Private (Medicare Benefits Schedule-billed) outpatient clinics

### 3.1 Private specialist outpatient clinics

Private specialist outpatient clinics have been successfully operating within public hospitals across Queensland and Australia for many years. These clinics are an essential part of the continuum of care for patients and provide an important interface between acute and primary care services.

Specialists and consultant clinicians employed through public health services have the opportunity to engage in private practice under the terms of their employment. Private practice engagement enables specialists and consultant clinicians to treat patients in a private capacity in parallel with their public responsibilities, and claim services against the Medicare Benefits Schedule (MBS).

There are numerous reasons why private specialist clinics have been established in public hospitals, including:

- providing patients with a choice to receive treatment as a private patient
- enabling medical practitioners to engage in private practice, which is an important tool in the recruitment and retention of a skilled medical workforce in public hospitals
- co-location of MBS-billed specialist clinics with public hospitals ensures a critical mass of specialist services and can also facilitate a more cost-effective use of high-cost technology and support services
- the ability to provide inpatient and outpatient services, while providing opportunities to broaden the available training programs for junior medical staff.

Patients who choose to access treatment in a private specialist outpatient clinic are responsible for meeting the cost of their care. These patients are provided with a choice of treating clinician, facilitated by way of a named referral (i.e. a referral to an individual doctor as opposed to a specific hospital or clinic). A named referral is also a prerequisite to accessing private patient care under the National Health Reform Agreement, and facilitates the appropriate payment of Medicare benefits for specialist and consultant physician services under the MBS.

Public hospitals are not required to physically separate the location of public and private specialist outpatient clinics. However, it is important that patients are informed as to whether a clinic is public, private or mixed. This is essential for meeting the requirements of the National Health Reform Agreement for ensuring informed financial consent and subsequent election to be treated as a private patient.

It is also important to note that public hospital private specialist outpatient services in Queensland must be provided in accordance with the Queensland Health *Governance of Outpatient Service Policy* and *Outpatient Services Implementation Standard*. This can be viewed online at the Queensland Health policy site.

#### Key requirements of the National Health Reform Agreement—private specialist outpatient clinics:

- Patients are provided with a choice to access care as private patients.
- Access to private specialist outpatient care is by way of named referral where required by MBS (e.g. items 17610–17625 for pre-anaesthetic consultations do not require a named referral).
- Patients cannot be referred to a private specialist outpatient clinic from a public hospital emergency department.
- Private patients are responsible for meeting the cost of their care and must be made aware of the financial consequences of their choice (note in most instances the cost of this care is recovered through the MBS).
- Private patients are given a choice of treating doctor where available.
- Doctors require a private practice arrangement to provide private specialist outpatient services at a public health facility.
- Public patients must be able to access services that are available to patients of private specialist outpatient clinics.

#### Key requirements of the MBS—private specialist outpatient services:

- Patients must be Medicare eligible.
- Specialists and consultant physicians require a valid Medicare provider number (for Medicare benefit purposes) specific to the location of the private specialist outpatient clinic from which the service is provided (the exception to this being services provided by a locum).
- A named referral is required in order to facilitate payment at the correct referred rate.
- Unless otherwise stated in the MBS, whilst assistance may be provided (e.g. by a registrar or house doctor etc.), the payment of Medicare benefit is limited to the actual service provided by the specialist or consultant physician (i.e. they must have physically attended the patient and turned their mind to the treatment of the patient).

Written advice has been provided by Medicare Australia which confirms that a referral made to a specific specialist or consultant physician can be used by another specialist or consultant physician who is working in the same specialty at the same location.

## 3.2 Private telehealth services

Private telehealth services are private specialist outpatient consultations conducted via video conferencing that involve a single specialist, consultant physician or psychiatrist attending to the patient, with the possible participation of another medical practitioner, a participating nurse practitioner, a participating midwife, practice nurse or Aboriginal health worker at the patient end. The decision as to whether the patient requires clinical



support at the patient end during the service should be made in consultation with the referring practitioner.

Telehealth services are subject to the same key requirements of the MBS and the National Health Reform Agreement for services provided in private specialist outpatient clinics. However, there are a number of additional requirements under the MBS that are specific to telehealth services. These are contained in Sections A57 and A58 of the MBS.

Please note, where a specialist or consultant physician provides additional services to a patient on the same day as a telehealth consultation, these services should be lodged to Medicare Australia on a separate claim. This is because the Medicare payment system is programmed to automatically reject additional services claimed by a specialist or consultant physician at the same time as a telehealth service.

### **3.3 Acute primary care clinics**

Acute primary care clinics provide an alternative treatment pathway for primary care patients who would otherwise be treated in emergency departments. The clinics provide one-off (no repeat) primary care type services in a setting distinctive from, and separate to, a facility's emergency department. They may be staffed by external medical practitioners or by senior medical staff engaged in private practice.

Patient access is facilitated through clause G18 of the National Health Reform Agreement which permits public hospitals to provide patients presenting to an emergency department with information on alternative service providers. However, it should be noted that the choice to access such services remains that of the patient, and hospital staff should not direct a patient toward a particular choice.

Acute primary care clinics are not intended to be used as a substitute for general practice and services should be offered on a one-off basis only (i.e. continuing care should be referred back to a community general practitioner). The decision to implement an acute primary care clinic rests with individual HHSs. However the implementation of a clinic must not impact on the viability of local general practice services and/or create additional demand for public hospital services. Therefore, it is imperative that acute primary care clinics should only be implemented after local general practice services have been consulted and have agreed to their implementation and HHSs should implement strict protocols that prevent patients from using the clinics as a substitute for general practice care.

**Key requirements of the National Health Reform Agreement—acute primary care clinic services:**

- Acute primary care clinics must be separate and distinct from a public hospital emergency department
- Where clinically appropriate, patients presenting to a public hospital emergency department may be offered the choice to attend an acute primary care clinic or alternate service provider.
- Patients retain the right to access care in the emergency department.
- Acute primary care clinics provide non-referred services and are not subject to the referral requirements of the National Health Reform Agreement.

## 4. Bulk billed public outpatient services—19(2) arrangements

Section 19(2) of the *Health Insurance Act 1973* enables the Minister for Health and Ageing to direct payment of Medicare benefits for public patient services. This is commonly referred to as a *19(2) exemption*.

A 19(2) exemption is only issued under special circumstances and is restricted to non-referred, non-admitted services that are generally provided in small rural or remote communities. These exemptions are also accompanied by a range of specific funding allocation and reporting requirements.

The following information relates to the provision of public non-admitted patient services under special arrangement with the Australian Government, which enables them to be claimed against the MBS. While these services are not provided in a private capacity (i.e. the doctor is not providing the service under private practice), they have been included in this guideline for completeness due to being eligible to claim against the MBS.

It is important to note that these are public patient services that are claimed against the MBS under a 19(2) exemption. So while the public hospital-employed doctor providing the service requires a valid provider number for MBS benefit purposes, they do not require engagement in private practice.

### 4.1 Council of Australian Governments Section 19(2) exemption

An exemption from Section 19(2) of the *Health Insurance Act 1973* enables Medicare rebates to be claimed for state-remunerated primary health care services—that is public non-admitted, non-referred primary care services. The revenue generated from these initiatives is to be used to enhance primary care services at the sites where the revenue is generated. This exemption is part of a Council of Australian Governments 2006 agreed suite of measures designed to improve primary health care in rural communities of less than 7000 people with an identified general practitioner shortage.

For a site to gain a Council of Australian Governments Section 19(2) exemption a local negotiation and implementation plan must be completed and forwarded to the Australian Government for their review. It is a prerequisite that no local private practitioner will be materially affected by the granting of the exemption.

### 4.2 Rural and Remote Medical Benefits Scheme

The Rural and Remote Medical Benefits Scheme (RRMBS), which has been operating in Queensland since 1997, also grants an exemption from Section 19(2) of the *Health Insurance Act 1973* so that all non-referred, non-admitted primary healthcare services provided from a listed site may be billed against Medicare. The RRMBS was set up by the Australian Government as a method of providing additional funding for states in recognition of the additional expenses incurred by the public hospital system in the

provision of primary healthcare services to Aboriginal and Torres Strait Islander patients. RRMBS sites specifically encompass those communities which have a significant Aboriginal and Torres Strait Islander population and whose members have little or no access to these services through the private sector, either due to affordability or the absence of private sector services (i.e. general practitioners).

Within RRMBS sites, all primary health services (including those provided to non-Aboriginal or Torres Strait Islander patients) may be claimed against Medicare. The direction enabling the Section 19(2) exemption is renewed every three years and currently lists 58 sites that are able to bill for primary healthcare services. All of the revenue generated from this exemption is delivered to Queensland Health and is to be used for the purpose of enhancing primary health care services at the site where it has been generated.

### **4.3 Inala Health Centre General Practice**

The Inala Health Centre General Practice operates under the 19(2) exemption for Inala Health Centre General Practice. As with the Council of Australian Governments and RRMBS exemptions, non-referred, non-admitted public primary healthcare services are able to be billed against Medicare under this exemption.

## 5. Private admitted (inpatient) services

Regardless of whether it is an elective admission or emergency admission, it is a condition of the National Health Reform Agreement that all Medicare eligible patients requiring admitted patient care in public hospitals are to be given the choice to access that care in a public or private patient basis.

An election by an eligible patient to receive admitted public hospital services as a private patient must be made in writing before, at the time of, or as soon as practical after admission. This is achieved by the completion of a patient election form (PEF). The PEF must comply with the minimum standards that are listed in the National Health Reform Agreement at G24: Public Hospital Admitted Patient Election Forms.

When a Medicare eligible patient is admitted to a public hospital via the emergency department, all services provided prior to the decision to admit must be provided on a public patient basis (i.e. free of charge). (National Health Reform Agreement G18)

Key requirements of the National Health Reform Agreement:

- Eligible patients must elect to receive public hospital admitted patient care as either a public or private patient.
- A valid admitted patient election must be made in writing by way of completing a PEF.
- A valid admitted patient election should be made before, at the time of, or as soon as practical after admission.
- Valid admitted patient elections are to be made on the basis of informed financial consent (i.e. the patient is made aware of the costs associated with their choice) and may be reasonably delayed until such time as this has occurred. Some examples of where a valid election may be delayed due to the inability to provide informed financial consent include admissions where the patient is unconscious or until the patient's insurance coverage is confirmed.
- Until such time as a valid election has been made, an admitted patient assumes a default status of public.
- Once a valid election has been made in writing, that election is valid for the entire period of admission (i.e. services provided prior to a private election can be reclassified as private).
- A valid election made in writing can only be changed in the event of unforeseen circumstances (e.g. unforeseen clinical complications that extend the length of stay or procedures required or a change in social circumstances such as job loss). In these situations, the patient's newly elected status of public or private is only valid from the point at which the second or subsequent written election is made (i.e. services provided prior to a change in valid election cannot be reclassified).
- Private admitted patients are provided with a choice of single room where available.
- Any admitted patient who requests and receives a single room (other than for clinical reasons) must be admitted as a private patient.

## 6. Summary of the National Healthcare Agreement 2012

The objective of the *National Healthcare Agreement 2012* is to improve health outcomes for all Australians and to ensure the sustainability of the Australian healthcare system. This agreement defines the objective, outcomes, and performance indicators, and clarifies the roles and responsibilities of the Commonwealth, states and territories in the delivery of services across the health sector. In particular, Section 20 of the *National Healthcare Agreement 2012*, charges states and territories with the responsibility of providing health and emergency services through the public hospital system in accordance with the Medicare principles. The *National Healthcare Agreement 2012* should be read in conjunction with the National Health Reform Agreement.

### Responsibilities of states and territories

Section 20. States and territories will provide health and emergency services through the public hospital system, based on the following Medicare principles:

- (a) eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically provided by hospitals
- (b) access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period
- (c) arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.

## 7. Summary of the National Health Reform Agreement

The objective of the National Health Reform Agreement is to improve health outcomes for all Australians and to ensure the sustainability of the Australian healthcare system. This agreement sets out the architecture of national health reform, which will deliver major structural reforms to establish the foundations of Australia's future health system. In particular, the agreement provides for more sustainable funding arrangements for Australia's health system. The National Health Reform Agreement should be read in conjunction with the *National Healthcare Agreement 2012*.

Schedule G of the National Health Reform Agreement contains the business rules that give effect to the Medicare principles. The following guidance is offered in relation to those rules that specifically relate to private patient services and services that are provided to public patients for which charges may be raised.

Clause G1 reiterates the requirement of public patient services to be provided free of charge. It also summarises the exceptions to this rule by listing those public patient services for which charges may be raised.

- G1. Where an eligible person receives public hospital services as a public patient no charges will be raised, except for the following services provided to non-admitted patients and, in relation to (f) only, to admitted patients, upon separation:
- (a) dental services
  - (b) spectacles and hearing aids
  - (c) surgical supplies
  - (d) prostheses—however, this does not include the following classes of prostheses, which must be provided free of charge:
    - i. artificial limbs
    - ii. prostheses which are surgically implanted, either permanently or temporarily or are directly related to a clinically necessary surgical procedure
  - (e) external breast prostheses funded by the National External Breast Prostheses Reimbursement Program
  - (f) pharmaceuticals at a level consistent with the PBS statutory co-payments
  - (g) aids, appliances and home modifications
  - (h) other services as agreed between the Commonwealth and states.

Clause G2 recognises the right of public hospitals to raise accommodation charges for nursing home type patients.

**G2. States can charge public patients requiring nursing care and accommodation as an end in itself after the 35th day of stay in hospital providing they no longer need hospital level treatment, with the total daily amount charged being no more than 87.5 per cent of the current daily rate of the single aged pension and the maximum daily rate of rental assistance.**

Clause G3 enables public hospitals to raise charges for private patients and patients covered by other third party arrangements.

Clause G4 excludes the payment of benefits under the Pharmaceutical Benefits Scheme (PBS) for private admitted patients, while Clause G5 recognises the bilateral agreements signed under the Pharmaceutical Reform Arrangements and the exemptions that may apply under these.

**G3. Private patients, compensable patients and ineligible persons may be charged an amount for public hospital services as determined by the State. *Note— Rebates are determined by the Australian Government and individual health insurers.***

**G4. Notwithstanding Clause G3, pharmaceutical services to private patients, while they receive services as admitted patients, will be provided free of charge and cannot be claimed against the PBS.**

**G5. States which have signed bilateral agreements for Pharmaceutical Reform Arrangements may charge the PBS for pharmaceuticals for specific categories of patients as provided for in the arrangements.**

Clauses G8 and G9 place an obligation on states and territories to publish a public patients' hospital charter which must be distributed to public hospital service users and carers. The agreement sets a number of minimum standards for the charter, one of which allows public hospitals to offer the choice of private healthcare services.

Clause G14 requires all admitted patients to make a written election to receive admitted patient care as either a public or private patient. In addition, Clause G15 ensures that patients electing to be private have done so on the basis of informed financial consent (i.e. patients must be informed of any known financial costs that may be incurred as a result of this election).

While it is preferable that a patient election occurs prior to, or at the time of admission, there remains significant flexibility within these clauses to enable an election to be reasonably delayed until such time as the patient has been provided with sufficient information by a patient option liaison officer (or equivalent) to enable them to make an informed choice.



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.

G15. In particular, private patients have a choice of doctor and all patients will make an election based on informed financial consent.

Clause G16 relates to patients requiring aftercare services following a public admitted patient episode of care. This clause prevents the raising of charges against the patient or the MBS for aftercare services provided post discharge even if provided in a specialist or consultant physicians own private rooms. However, this clause does not prevent a patient from independently choosing to access aftercare services as a private patient, in which case charges can be raised. This is further supported by Section T.8.4 of the MBS, which includes the following statement on aftercare services for public patients:

All care directly related to a public inpatient's care should be provided free of charge. Where a patient has received inpatient treatment in a hospital as a public patient (as defined in Section 3(1) of the Health Insurance Act), routine and non-routine aftercare directly related to that episode of admitted care will be provided free of charge as part of the public hospital service, regardless of where it is provided, on behalf of the state or territory as required by the National Healthcare Agreement. In this case no Medicare benefit is payable.

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.

Where a public patient independently chooses to consult a private medical practitioner for aftercare following treatment from a public hospital emergency department, then the clinically relevant service provided during this professional attendance will attract Medicare benefits.

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.

Clause G17 prevents charges from being raised for public patient services. It specifically prevents public hospitals from denying access to public outpatient services and from making named referrals a mandatory requirement for accessing those services (i.e. patients without a named referral are entitled to access outpatient services as a public patient). This clause also prevents the referral of emergency department patients to private specialist outpatient clinics.

**G17. Services provided to public patients should not generate charges against the Commonwealth MBS:**

a. 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 engaging in private practice under the terms of employment or a contract with a hospital which provides public hospital services.

b. referral pathways must not be controlled so as to deny access to free public hospital services.

c. referral pathways must not be controlled so that a referral to a named specialist is a prerequisite for access to outpatient services.

Clause G18 of the National Health Reform Agreement identifies the state's responsibilities for the provision of emergency department services. In particular, emergency department services (including diagnostic services) must be provided free of charge (i.e. public) until a decision has been made to admit the patient and the patient then makes an election to be treated as either a public or private admitted patient.

Where clinically appropriate, a patient presenting to an emergency department can be advised of alternative treatment providers. This includes accessing services from a general practice or acute primary care clinic that is co-located in or near the hospital.

**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:**

- (a) 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.
- (b) hospital employees will not direct patients or their legal guardians towards a particular choice.

Clause G19 defaults an outpatient service to being a public occasion of service unless the patient has been referred to a named specialist or consultant physician and they choose to be treated as a private patient. However, unlike admitted patients, there is no legal requirement for this election to be made in writing.

G19. An eligible patient presenting at a public hospital outpatient department will be treated free of charge as a public patient unless:

- a. there is a third party payment arrangement with the hospital or the state or territory to pay for such services.
- b. 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.

Clause G20 precludes charges from being raised for public pathology and diagnostic imaging services.

However, it should be noted that the interpretation applied by the Department of Health in respect to Clause G20, limits the requirement of this clause to those pathology and diagnostic services that are provided during a public patient occasion of service (i.e. within the same appointment of the referring/requesting consultant). Patients who receive pathology and diagnostic services as a separate occasion of service to an outpatient service are offered a choice to receive these as either public or private.

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.

Clause G21 recognises the dependence of some hospitals on local general practitioners for the provision of services. In doing so, it enables charges to be raised by these doctors for services they provide to their own patients whilst undertaking their duties at the hospital.

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.

Clause G22 recognises the payment of Medicare benefits for public patient services provided in accordance with an exemption issued under Section 19(2) of the *Health Insurance Act 1973*.

Clause G23 establishes the need for an admitted patient election process to conform to the national standards set out in the National Health Reform Agreement.

G23. In accordance with this Agreement, public hospital admitted patient election processes for eligible persons should conform to the national standards set out in this schedule.

G22. States which have signed a memorandum of understanding with the Commonwealth for the COAG initiative "Improving Access to Primary Care Services in Rural Areas" may bulk bill the MBS for eligible persons requiring primary health care services who present to approved facilities.

Clause G24 sets out the minimum requirements for patient election forms. These include statements regarding:

- patient choice between public and private patient care
- access to doctor of choice and private room (where clinically appropriate and available) for private patients.
- a valid private patient election may occur even in circumstances where there is only one doctor engaged to provide private practice.
- patients with private health insurance can still elect to be public
- public patients are not charged accommodation fees and are treated by a doctor nominated by the hospital.
- private patients will be responsible for meeting the cost of accommodation, medical services, prostheses and other relevant services and that these may not be fully covered by Medicare and private health insurance.
- patient election status after admission can only be changed in the event of unforeseen circumstances.
- where a valid election is made (i.e. a patient election form has been completed and signed) and then changed at a later point 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.
- 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, at which point that election can be considered to be for the whole episode of care, commencing from admission.

## 8. Summary of the *Health Insurance Act 1973*

The *Health Insurance Act 1973* provides the legal framework for the payment of Medicare benefits. Claims made against the MBS contrary to the *Health Insurance Act 1973* may result in the Australian Government seeking recovery of amounts claimed, and in the case of intentional fraudulent activity, legal prosecution.

### 8.1 Section 19(2) *Health Insurance Act 1973*

Section 19(2) of the *Health Insurance Act 1973* precludes the payment of Medicare benefits for professional services that are provided by, on behalf of, or under arrangement with a state government, unless the Minister for Health and Ageing directs otherwise. This precludes the payment of Medicare benefits for public patient services except in circumstances where the Minister for Health and Ageing has issued a 19(2) exemption. However, when a doctor engages in private practice to treat a private patient, they are providing that service in a private capacity and it is therefore not subject to Section 19(2).

#### Section 19(2) *Health Insurance Act 1973*

Medicare benefits 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:

- (a) the Commonwealth
- (b) a state
- (c) a local governing body
- (d) an authority established by a law of the Commonwealth, a law of the state or a law of an internal territory.

The Australian Government further acknowledges private patient services are provided in public hospitals with consideration to Clauses A6 and A7 of the National Health Reform Agreement. These clauses acknowledge that public hospitals receive revenue through private practice arrangements and will limit the Australian Government's contribution to activity based funding for private patient services with consideration that accounts are rendered to the MBS or other third parties for these services.

### 8.2 Public hospital services and public patients

Section 128C of the *Health Insurance Act 1973* relates to the wrongful claiming for an obstetrics service provided to a public patient or a patient known to be intending to be treated as a public patient. The section is particularly relevant to the administrative processes related to the completion of patient election form for elective admissions.

Section 25A of the Health Insurance Regulations 1975 specifically limits the scope of the provision to obstetrics patients.

Please note that for services provided within emergency departments, until such time as a decision has been made to admit a patient, the patient must be treated as a public patient.

### **Section 128C Health Insurance Act 1973**

#### **Charging of fees for provision of public hospital services to public patients**

(1) A person mentioned in subsection (2) must not, in circumstances set out in the regulations:

(a) Charge a fee for the provision of a public hospital service

(b) Receive any payment or other consideration from anyone in respect of the provision of a public hospital service

If the person knows that the person to whom the service is, or is to be, provided is, or intends to be, a public patient in the hospital.

(2) The persons are as follows:

(a) A medical practitioner

(b) A participating midwife

(c) A participating nurse practitioner

(d) A person acting on behalf of a person mentioned in paragraph (a), (b) or (c).

## Section 25A Health Insurance Regulations 1975

Section 25A - Circumstances where fees etc. cannot be charged for provision of public hospital services to public patients

(1) For section 128C of the Act, the circumstances are where a fee, payment or other consideration (however described) for the provision of an obstetric service:

(a) for a public patient in a public hospital

(b) by a medical practitioner or participating midwife, or a person acting on behalf of the medical practitioner

(i) employed on the staff of the hospital

(ii) performing services under contract to the hospital

(2) In this regulation:

**obstetric service** means a public hospital service:

(a) for attendance at, or associated with, the delivery of a baby

(b) requested or required by a public patient in connection with the delivery of a baby.

### *Example*

The circumstances described by this regulation would include a booking fee or request for payment by a medical practitioner or participating midwife, or a person acting on behalf of the medical practitioner, employed by, or under contract to, a public hospital, for costs or charges of the medical practitioner or participating midwife for performing a public hospital service:

(a) by a tending a public patient in the hospital to deliver a baby

(b) associated with the delivery of a baby for a public patient

(c) requested or required by a public patient in connection with the delivery of a baby.

## 9. Summary of the Medicare Benefits Schedule

The MBS sets out the requirements that must be met for claiming payment for professional services against Medicare. It is important that medical practitioners and billing staff are aware of the general requirements of the MBS and those specific to each item that is being claimed.

The following provides guidance on key information contained in the MBS relevant to private specialist outpatient clinics. A complete copy of the MBS can be viewed at: [www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-benefits-schedule-MBS-1](http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-benefits-schedule-MBS-1)

Section G.1.3 provides key information on Medicare and billing practices

### G.1.3 Medicare benefits and billing practices

#### Key information on Medicare benefits and billing practices

The *Health Insurance Act 1973* stipulates that Medicare benefits are payable for professional services. A professional service is a clinically relevant service which is listed in the MBS. A medical service is clinically relevant if it is generally accepted in the medical profession as necessary for the appropriate treatment of the patient.

Medical practitioners are free to set their fees for their professional service. However, the amount specified in the patient's account must be the amount charged for the service specified. The fee may not include a cost of goods and services which are not part of the MBS service specified on the account.

#### Billing practices contrary to the Act

A non-clinically relevant service must not be included in the charge for a Medicare item. The non-clinically relevant service must be separately listed on the account and not billed to Medicare.

Goods supplied for the patient's home use (such as wheelchairs, oxygen tanks, continence pads) must not be included in the consultation charge. Medicare benefits are limited to services which the medical practitioner provides at the time of the consultation—any other services must be separately listed on the account and must not be billed to Medicare.

Charging all or part of an episode of hospital treatment or a hospital substitute treatment to a non-admitted consultation is prohibited. This would constitute a false or misleading statement on behalf of the medical practitioner and no Medicare benefits would be payable.

An account may not be re-issued to include charges and out-of-pocket expenses excluded in the original account. The account can only be reissued to correct a genuine error.



Section G2.1 outlines Medicare provider eligibility requirements. This is particularly important as medical practitioners engaged in private practice require a valid Medicare provider number in order for their services to be eligible for Medicare benefits. If a medical practitioner is unsure of their eligibility for Medicare purposes they should contact Medicare Australia for clarification.

### **G.2.1 Provider eligibility for Medicare**

To be eligible to provide medical service which will attract Medicare benefits, or to provide services for or on behalf of another practitioner, practitioners must meet one of the following criteria:

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

Any practitioner who does not satisfy the requirements outlined above may still practice medicine but their services will not be eligible for Medicare benefits.

Note: New Zealand citizens entering Australia do so under a temporary entry visa and are regarded as temporary resident doctors.

Note: It is an offence under section 19 CC of the *Health Insurance Act 1973* to provide a service without first informing a patient where a Medicare benefit is not payable for that service (i.e. the service is not listed in the MBS).

Section G2.2 outlines the need to obtain a provider number for each location that a medical practitioner provides services that are claimed against the MBS (i.e. professional services, referrals and/or requests). It also stipulates the need for accounts to contain the medical practitioners name and either the provider number for, or address where, the service was provided.

## G.2.2 Provider numbers

Practitioners eligible to have Medicare benefits payable for their services and/or who for Medicare purposes wish to raise referrals for specialist services and requests for pathology or diagnostic imaging services, may apply *in writing* to Medicare Australia for a Medicare provider number for the locations where these services/referrals/requests will be provided. The form may be downloaded from: [www.medicareaustralia.gov.au](http://www.medicareaustralia.gov.au)

For Medicare purposes, an account/receipt issued by a practitioner must include the practitioner's name and either the provider number for the location where the service was provided or the address where the services were provided.

Medicare provider number information is released in accord with the secrecy provisions of the *Health Insurance Act 1973* (section 130) to authorised external organisations including private health insurers, the Department of Veterans' Affairs and the Commonwealth Department of Health.

When a practitioner ceases to practice at a given location they must inform Medicare promptly. Failure to do so can lead to misdirection of Medicare cheques and Medicare information.

Practitioners at practices participating in the Practice Incentives Program (PIP) should use a provider number linked to that practice. Under PIP, only services rendered by a practitioner whose provider number is linked to the PIP will be considered for PIP payments.

Section G12.1 identifies where specific groups of items undertaken by medical officers employed by Queensland Health engaged in private practice may claim payment from Medicare. It also identifies the range of items that attract a Medicare benefit only when personally performed by a medical practitioner (i.e. the doctor whose provider number the service is claimed against).

In addition, it provides clarification that the requirement of "personal performance" is met whether or not assistance is provided, according to accepted medical standards. This effectively allows the use of registrars to participate in private practice clinics but limits the payment of Medicare benefits to the actual service provided by the specialist or consultant physician claiming the service (i.e. the specialist or consultant physician physically attend the patient and turn his or her mind to the treatment of the patient).

This section also reinforces the need for a public hospital employed clinician to have been engaged in private practice in order to claim Medicare benefits.

### G.12.1. Professional services

Professional services which attract Medicare benefits include medical services rendered by or on behalf of a medical practitioner. The latter include services where a part of the service is performed by a technician employed by or, in accordance with accepted medical practice, acting under the supervision of the medical practitioner.

The Health Insurance Regulations 1975 specify that the following medical services will attract benefits only if they have been personally performed by a medical practitioner on not more than one patient on the one occasion (i.e. two or more patients cannot be attended simultaneously, although patients may be seen consecutively), unless a group session is involved (i.e. Items 170–172). The requirement of 'personal performance' is met whether or not assistance is provided, according to accepted medical standards:

- (a) All Category 1 (Professional Attendances) items (except 170–172, 342–346).
- (b) Each of the following items in Group D1 (Miscellaneous Diagnostic): 11012, 11015, 11018, 11021, 11212, 11304, 11500, 11600, 11627, 11701, 11712, 11724, 11921, 12000, 12003.
- (c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200–13206, 13212–13221, 13703, 13706, 13709, 13750–13760, 13915–13948, 14050, 14053, 14218, 14221 and 14224).
- (d) Item 15600 in Group T2 (Radiation Oncology).
- (e) All Group T3 (Therapeutic Nuclear Medicine) items.
- (f) All Group T4 (Obstetrics) items (except 16400 and 16514).
- (g) All Group T6 (Anaesthetics) items.
- (h) All Group T7 (Regional or Field Nerve Block) items.
- (i) All Group T8 (Operations) items.
- (j) All Group T9 (Assistance at Operations) items.
- (k) All Group T10 (Relative Value Guide for Anaesthetics) items.

For the group psychotherapy and family group therapy services covered by Items 170, 171, 172, 342, 344 and 346, benefits are payable only if the services have been conducted personally by the medical practitioner.

Medicare benefits are not payable for these group items or any of the items listed in (a) – (k) above when the service is rendered by a medical practitioner employed by the proprietor of a hospital (not being a private hospital), except where the practitioner is engaged in private practice, or is performing a medical service outside the hospital. For example, benefits are not paid when a hospital intern or registrar performs a service at the request of a staff specialist or visiting medical officer.

Medicare benefits are only payable for items 12306–12323 when the service is performed by a specialist or consultant physician in the practice of his or her specialty where the patient is referred by another medical practitioner.

Medicare benefits are only payable for items 12306–12323 when the service is performed by a specialist or consultant physician in the practice of his or her specialty where the patient is referred by another medical practitioner.

Section G12.2 outlines the circumstances where Medicare benefits are payable for services rendered on behalf of medical practitioners. In most instances these relate to diagnostic services. It also clarifies that in order for a Medicare benefit to be payable under this section the person providing the service must be employed by, or acting under the supervision of, the medical practitioner making the claim.

#### **G.12.2. Services rendered on behalf of medical practitioners**

Medical services in Categories 2 and 3 not included in G.12.1 and Category 5 (diagnostic imaging) services continue to attract Medicare benefits if the service is rendered by:

- (a) the medical practitioner in whose name the service is being claimed
- (b) a person, other than a medical practitioner, who is employed by a medical practitioner or, in accordance with accepted medical practice, acts under the supervision of a medical practitioner.

See Category 6 notes for guidance for arrangements relating to pathology services.

So that a service rendered by an employee or under the supervision of a medical practitioner may attract a Medicare rebate, the service must be billed in the name of the practitioner who must accept full responsibility for the service. Medicare Australia must be satisfied with the employment and supervision arrangements. 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:

- (a) established consistent quality assurance procedures for the data acquisition
- (b) personally analysed the data and written the report.

Benefits are not payable for these services when a medical practitioner refers patients to self-employed medical or paramedical personnel, such as radiographers and audiologists, who either bill the patient or the practitioner requesting the service.

### Summary of Medicare Benefits Schedule

- Medicare benefits may only be claimed for services rendered to Medicare eligible patients.
- A Medicare provider number is necessary to claim Medicare benefits for professional services rendered.
- Medical practitioners must meet the necessary eligibility requirements to be issued with a provider number.
- A provider number uniquely identifies medical practitioners as a healthcare professional and the location from which they are practicing.
- Medical Practitioners must have a different provider number for every location at which they practice, the exception being locums in some circumstances. It is important to contact the provider eligibility section of Medicare Australia on 132 150 for advice, where a locum situation is likely to occur.
- Private practice services provided by Queensland Health senior medical staff engaging in private practice must be provided by an eligible medical practitioner under arrangement between the medical practitioner and the patient.
- Claims for Medicare benefits regarding professional services rendered must be made on the approved Medicare claim form.
- Claims for professional services rendered may be made for a two year period following the provision of the service.
- Providing false information in order to claim a benefit against Medicare is illegal.
- Using one medical practitioner's provider number to claim a Medicare benefit for services provided by another medical practitioner is providing false information and illegal.
- The claiming of a Medicare benefit for services rendered to a public patient is illegal.

## 10. Indemnity

Due to the specialised nature and circumstance of work in the public health sector, Queensland has separate indemnity policies to cover medical practitioner and health service employees. The policy relevant to medical practitioners is *Indemnity for Queensland Health Medical Practitioners – Human Resources Policy 12*.

Human Resources Policy 12 offers *insurance-like* coverage similar to that offered by a medical defence organisation. Indemnity is provided for claims against medical practitioners who have been engaged to perform duties and functions on patients under the direction of a HHS or CBU and who practice within their scope of duties.

Indemnity may be granted in relation to civil proceedings, inquiries or investigations such as registration boards. Medical practitioners are not entitled to an indemnity for conduct that constitutes wilful neglect as outlined in Human Resources Policy 12.

Where indemnity or legal assistance is granted, the Department of Health, commercialised business unit (CBU) or the relevant HHS is obliged to pay for all reasonable costs including legal professional costs and any awarded damages against the indemnified medical practitioner. The option to seek reimbursement of costs rests within the terms and conditions of the insurance policy purchased by the Department of Health.

Human Resources Policy 12 outlines the indemnity application process, inclusion and exclusions for medical practitioners seeking indemnity or legal assistance.

The Department of Health provides assurance that medical practitioners claiming Medicare benefits through the private practice scheme will not suffer any financial detriment as a result of complying with Queensland Health policy or guidelines relating to private practice where HHSs or CBUs are a financial beneficiary to those claims. In the event that billings are required to be refunded to a third party (i.e. patient, Medicare, health fund) due to incorrect claiming, HHSs or CBUs would be responsible for refunding its portion of retained billings that were incorrectly claimed.

### 10.1 Indemnity cover for private patients

Human Resources Policy 12 extends to cover a medical practitioner who is undertaking clinical management of the private patient, when that medical practitioner is engaged to perform associated clinical services, under an approved Queensland Health arrangement. Human Resources Policy 12 details the extent of indemnity arrangements for medical practitioners who treat private patients.

### 10.2 The Department of Health and Hospital and Health Service insurance arrangements

The Queensland Government self-insures through a Queensland Government treasury managed fund called the Queensland Government Insurance Fund. The Queensland Government Insurance Fund model is similar to a commercial insurance model and

underwrites government insurable risk, manages claims centrally and determines annual insurance premiums.

The Department of Health has purchased the following classes of insurance to cover HHSs or CBUs insurable exposures:

- property
- business interruption
- general liability
- professional indemnity (CBUs only)
- health litigation (i.e. medical indemnity)
- personal accident and illness (volunteers, board members and committee members).

The Department of Health has a centralised insurance team, the Premium Management Group, which was established to provide specialised medical indemnity insurance advice to HHSs, senior management and CBU staff. The Premium Management Group also provides support and advice on a range of indemnity and insurance arrangements including:

- insurance and indemnity claims against Queensland Health and its employees
- insurance premiums and allocation
- insurance and indemnity coverage
- claim risk management.

More information regarding the Premium Management Group, Premium Management Group insurance information guides and Queensland Government Insurance Fund can be found on the Premium Management Group intranet site at:

[http://gheps.health.qld.gov.au/financenetwork/prem\\_mgt\\_group/web\\_pages/homepage.htm](http://gheps.health.qld.gov.au/financenetwork/prem_mgt_group/web_pages/homepage.htm)

## 11. Department of Veterans' Affairs

The Department of Health, along with other states and territories, has a partnering arrangement with the Australian Government, the Repatriation Commission and the Military Rehabilitation and Compensation Commission (collectively acting through the Department of Veterans' Affairs) to support them in their role in arranging the provision of healthcare services for entitled veterans, war widow(er)s and their eligible dependants.

The Commonwealth Repatriation Health Care Scheme provides eligible veterans with a choice of public and private hospitals and the choice of doctor (subject to the doctor having admitting rights to the hospital).

Where eligible veterans present to Queensland public facilities and document their intent (documented in Section A of the patient election form) to access treatment services under the Commonwealth Repatriation Health Care Scheme, these patients are to be treated as private patients.

The Department of Veterans' Affairs (DVA) is a competitive purchaser of health services and the recovery of expenses, including accommodation, is based on an activity driven cost recovery model. The Department of Veterans' Affairs has its own schedule of fees and treating clinicians are able to bill the Department of Veterans' Affairs for services through this schedule. Revenue received from patient billings is allocated in accordance with the medical practitioner's private practice arrangement.

The DVA promotes its system of healthcare for entitled persons and advises entitled persons to present their repatriation cards at Queensland public facilities to access treatment services.

### 11.1 Repatriation cards

Eligibility for hospital treatment is established by confirming that the patient holds a gold card or a valid white repatriation health card.

There are four types of DVA repatriation cards:

- Gold repatriation health card—issued to Australian veterans, their widow(er)s and dependants entitled to treatment for all medical conditions. Department of Veterans' Affairs approval is not required to treat these patients as *DVA-funded* patients.
- White repatriation health card—issued to Australian veterans or mariners and allied veterans entitled for treatment of specific and service-related conditions. Hospital staff must confirm a patient's proposed treatment relates to an accepted disability, by contacting the Department of Veterans' Affairs on 1300 550 457 (metro) or 1800 550 457 (regional) prior to admitting the patient as a *DVA-funded* patient.
- Orange repatriation pharmaceutical benefits card—for pharmaceuticals only and cannot be used to access any medical or other health care treatment.
- Pensioner concession card—does not entitle cardholders to medical or other treatment at the Department of Veterans' Affairs' expense.

The Department of Veterans' Affairs fee schedule can be found at:

[www.dva.gov.au/service\\_providers/doctors/Pages/fee%20schedule.aspx](http://www.dva.gov.au/service_providers/doctors/Pages/fee%20schedule.aspx)



## 12. Motor vehicle accidents

### 12.1 Queensland Compulsory Third Party Scheme

The Motor Accident Insurance Commission is the regulatory authority responsible for the ongoing management of the Queensland Compulsory Third Party Scheme.

Established under the *Motor Accident Insurance Act 1994*, the commission commenced operation on 1 September 1994 as a statutory body reporting to the Treasurer. The chief executive of the commission is the Insurance Commissioner who, in this capacity, is also the nominal defendant.

Compulsory third party insurance premiums include the following levies and administration fees:

- Hospital and emergency services levy—a levy to fund a reasonable proportion of the cost of public hospital and emergency services for people who are injured in motor vehicle accidents, who use such services and who are claimants or potential claimants under the Compulsory Third Party Scheme.
- Nominal defendant levy—a levy to fund the cost of injury claims where a vehicle involved in an accident is either uninsured (unregistered) or cannot be identified.

The Department of Health submits claims to the Motor Accident Insurance Commission on an annual basis in accordance with the funding arrangement endorsed by the Treasurer for cost recovery of treating patients as a result of injuries/illnesses sustained from a Queensland registered motor vehicle. In accordance with the *Motor Accident Insurance Act 1994*, payments made by Motor Accident Insurance Commission cover a reasonable proportion of costs for patients that are deemed not to be at-fault. The current motor vehicle accident funding arrangements are for public patients.

### 12.2 Compulsory Third Party Scheme from other states

In cases where motor vehicle accident patients were injured as a passenger of, or by an at-fault vehicle registered in a state or territory other than Queensland, accounts are raised to the relevant insurer directly.

### 12.3 Treating motor vehicle accident patients privately

In cases where a motor vehicle accident patient requests to be treated privately, prior approval must be obtained from the insurer. If the insurer approves the patient to be treated privately, fees can then be raised to the patient directly and will form part of that patient's compensation claim. Revenue received from private third party patient billings is allocated in accordance with the medical practitioner's private practice arrangement.

## 13. Workers' compensation

### 13.1 Queensland Workers' Compensation

Persons who have sustained a personal injury or disease, as a result of, or in the course of their employment, may be entitled to compensation from an insurer for medical costs and loss of income. Workers of a Queensland based employer are covered by the *Workers' Compensation and Rehabilitation Act 2003*.

The Workers' Compensation Regulator, established under the *Workers' Compensation and Rehabilitation Act 2003*, oversees Queensland's Workers' Compensation Scheme. Under the Queensland scheme, a Queensland employer must hold an accident insurance policy with WorkCover Queensland, unless they are self-insured.

There are currently two billing arrangements for workers compensation in Queensland:

- **WorkCover Queensland**—the largest workers' compensation insurer in Queensland. The Department of Health charges WorkCover Queensland on an annual basis for the cost of treating patients as a result of injuries/illnesses sustained in the course of their employment. Patients are identified as 'WorkCover' patients using specific international classification of disease (ICD) external cause codes and linked with subsequent occasions of services.
- **Self-insured employers**—manage their own workers' compensation claims. Facilities directly raise invoices for both inpatient and outpatient services provided to workers' compensation patients insured by a self-insurer using the Workers' Compensation Hospital Services Calculator and the appropriate Workers' Compensation Table of Costs respectively.

The current workers compensation funding arrangements are for public patients.

#### 13.2 Workers' Compensation from Other States and Commonwealth

In cases where a workers' compensation patient is covered by workers compensation legislation other than Queensland's, accounts will be raised to the relevant insurer directly, in accordance with the Department of Health Fees and Charges Register.

### 13.2 Treating Workers' Compensation patients privately

In cases where a workers compensation patient requests to be treated privately, prior approval must be obtained from the insurer. If the insurer approves the patient to be treated privately fees can then be raised to the patient directly and will form part of that patient's compensation claim. Revenue received from private third party patient billings is allocated in accordance with the medical practitioner's private practice arrangement.

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## **14. Third party compensable patients**

Third party compensable patients are patients who have suffered a personal injury or illness and take common law action against an individual or organisation for negligence causing the injury or illness. The types of injuries usually covered under this category are slips or falls, food poisoning and animal attacks.

Fees are raised directly to the patient and are not payable until the common law action has been settled. Motor vehicle accident and workers' compensation patients are excluded from this category, as money for these patients are recovered through other sources.

## 15. Overseas visitors

Millions of overseas visitors come to Australia each year and during their visit may require hospital treatment for various injuries and medical conditions. Some of these patients are eligible for treatment free of charge as a public patient depending on their Medicare eligibility status and the treatment required. However, services provided to patients who are not eligible for treatment free of charge are not funded under the National Health Reform Agreement and therefore the cost of providing this care needs to be recovered from either the patient or their insurer.

All patients regardless of their ability to pay will be treated on a clinical needs basis.

### 15.1 Reciprocal health care agreements

Patients from countries with a reciprocal health care agreement may be treated free of charge as public patients at public hospitals for essential medical treatment. If they elect to be a private patient, they are considered Medicare ineligible and fees will be raised.

The Australian Government has signed reciprocal health care agreements with the following countries:

- New Zealand (citizens are not issued with Medicare cards but are entitled to public hospital care and PBS drugs and should present their passports before treatment)
- Republic of Ireland (citizens are not issued with Medicare cards but are entitled to public hospital care and PBS drugs and should present their passports before treatment)
- United Kingdom
- The Netherlands
- Sweden
- Slovenia
- Finland
- Norway
- Italy (visitors are only covered for a period of six months)
- Malta (visitors are only covered for a period of six months)
- Belgium.

Visitors from these countries are entitled to essential medical treatment while they are in Australia, comprising public hospital care (as public patients), Medicare benefits and drugs under the PBS. With the exception of residents of New Zealand and the Republic of Ireland, visitors from reciprocal health care agreement countries are covered for non-admitted services provided by private providers.

In order to be eligible for payment of Medicare benefits, visitors from reciprocal health care agreement countries must enrol with Medicare Australia. However, in respect to accessing treatment as a public patient the Australian Government has deemed that a passport is sufficient for accessing public hospital care and PBS drugs.

Residents of New Zealand, United Kingdom, Republic of Ireland, Sweden, Finland or Norway are covered for the length of their stay in Australia.

Visitors from Belgium, The Netherlands or Slovenia need a European health insurance card to enrol in Medicare and are eligible until the expiry date shown on their card, or for the length of their authorised stay in Australia, if that is an earlier date.

Visitors from Malta or Italy who are a resident and citizen of those countries are covered by Medicare for a period of six months from the date of arrival in Australia.

There are also other conditions depending on the type of visa the patient possesses. Regular updates of countries with reciprocal health care agreements are published in the MBS which is published quarterly by the Australian Government Department of Health.

- Reciprocal health care agreements cover treatment as a public admitted or non-admitted patient in a public hospital.
- Reciprocal health care agreements do not cover treatment for private admitted patient services in either a public or private hospital.
- With the exception of residents of New Zealand or the Republic of Ireland, reciprocal health care agreements cover private non-admitted patient services (Note: New Zealanders who reside in Australia are not excluded from receiving private non-admitted patient services).
- In order for private non-admitted services to be bulk billed reciprocal health care agreements patients must be enrolled with Medicare (i.e. they must have a Medicare card/number).
- Reciprocal health care agreements do not cover treatment as a private admitted patient care in a public or private hospital, or any treatment that has been pre-arranged prior to arrival in Australia (i.e. people visiting Australia for the purpose of receiving treatment).

## 15.2 Special arrangements for Papua New Guinea residents

Papua New Guinea does not have a reciprocal healthcare agreement with Australia. However, a treaty concerning sovereignty and maritime boundaries between Australia and Papua New Guinea allows traditional inhabitants from Australia and Papua New Guinea, who reside in the Torres Strait Protected Zone or coastal villages in and adjacent to the Torres Strait, free movement to pursue traditional activities.

The treaty specifically states that health procedures should not prevent free movement and that parties should 'act in a spirit of mutual friendship and good-neighbourliness'.

Facilities in Queensland's far north provide clinical treatment and care to patients from Papua New Guinea due to a variety of reasons, including the serious nature and immediacy of their presenting health needs, the unlikelihood of arranging timely and

appropriate care at a Papua New Guinea health facility and to minimise the risk and spread of communicable diseases.

The terms for the treatment of Papua New Guinea nationals are the result of negotiations between Papua New Guinea and the Australian Government. Therefore, it is recognised that funding for these services is an Australian Government responsibility. As the Australian Government provides the Department of Health with funding to cover the costs in treating these patients, it is not necessary for HHSs in Far North Queensland (from Cape York to Torres Strait) to raise fees at the local level for this group of patients. However, it is important that these HHSs continue to record and classify occasions of service provided to Papua New Guinea nationals as Medicare ineligible and actively monitor and compare the cost of providing care with the level of funding received.

### 15.3 Medicare ineligible patients

For patients without a Medicare card who are not covered under a reciprocal health care agreement, fees and charges are raised for all services provided. In some cases amounts charged can be claimed against the patient's travel insurance, or in the case of overseas students, their overseas student health cover.

- Public ineligible inpatients—charged a *per diem* rate in accordance with the Queensland Health Fees and Charges Register, plus pharmaceutical costs, theatre fees and surgically implanted items where applicable.
- Public ineligible outpatients—charged an occasion of service fee in accordance with the Queensland Health Fees and Charges Register, plus pharmaceutical costs and diagnostic services in accordance with the MBS.
- Private ineligible inpatients—charged a *per diem* rate in accordance with the Queensland Health Fees and Charges Register, in addition to medical service fees (MBS), diagnostic services, pharmaceutical costs, theatre fees, pathology services and surgically implanted prosthesis.
- Private ineligible outpatients—charged an *occasion of service* fee in accordance with the Queensland Health Fees and Charges Register, plus pharmaceutical costs and medical and diagnostic services in accordance with the MBS.
- Ineligible patients with 457 visa—this visa is for skilled workers from outside Australia who have been sponsored and nominated by a business to work in Australia on a temporary basis. People who have been issued with 457 subclass visas on or after 14 September 2009 are required to acquire and maintain appropriate health insurance cover that meets the minimum requirements as specified by the Department of Immigration and Citizenship. Proof of this is a requirement for the issue of the visa. In cases where a patient presents with a 457 visa, staff must ensure the patient is charged for any services at the ineligible rate.

Any revenue received from private ineligible patient billings is allocated in accordance with the medical practitioner's private practice arrangement.

Where a person from a RHCA country chooses to be treated as a private patient, they will be charged as a Medicare ineligible private patient.

## 15.4 Asylum seekers and detainees

- An asylum seeker is a person who has applied for refugee protection and is awaiting a decision on their application.
- The *Australian Migration Act 1955* states that people who are not Australian citizens and do not hold a valid visa may be detained.
- Asylum seekers in community detention reside in the community without escort and have no visas. They are not Medicare eligible, but their healthcare is covered by the Department of Immigration and Border Protection through the International Health and Medical Services (IHMS).
- Asylum seekers that are living in the community (not in detention) and hold Bridging Visas and are eligible for Medicare benefits if the patient has the right to work under their visas. If they are Medicare ineligible, services are billed directly to IHMS.
- Asylum seekers and other detainees in an immigration detention centre are Medicare ineligible. Services provided are billed directly to the IHMS.
- The Federal Government is continually changing asylum seeker requirements in response to recognised needs. The Department of Immigration and Border Protection site needs to be checked regularly for any changes to asylum seeker health care needs. For more information, please visit <http://www.immi.gov.au/media/fact-sheets/>.
- All detainees are not necessarily asylum seekers. Some detainees are non-lawful, non-citizens who have overstayed their visa. The health care services of these detainees should be billed to IHMS.
- A refugee is a person who has been forced to leave their country because they have been persecuted.
- Refugees are Medicare eligible.
- Not every asylum seeker will ultimately become recognised as a refugee, but all refugees were initially asylum seekers.

## **16. Private practice and activity-based funding**

### **16.1 National pricing framework for public hospitals**

The Australian Government has historically provided funding for public hospital services in the form of block funding grants via special purpose payments. Under these former capped funding arrangements, the Australian Government's share of funding for public hospital services in Queensland declined from what was initially around 50 per cent to approximately 35 per cent in 2012.

Under the National Health Reform Agreement the Australian Government has committed to funding 45 per cent of future efficient growth in price and activity from July 2014 (increasing to 50 per cent from July 2017) through activity-based funding arrangements. The funding and activity levels for 2013–14 will be used as the base for determining future growth.

In accordance with Clauses A6, A7 and A41 of the National Health Reform Agreement, acknowledging that some costs for private patients are reimbursed by third parties, the Australian Government will not provide activity-based funding for private non-admitted patients and will provide reduced activity-based funding for private admitted patients.

With reference to these clauses, from July 2014, HHSs and CBUs will need to be selective in respect to the types of private patient services they deliver to ensure that the funding obtained through other sources (activity-based funding and own source revenue combined) is no less than that which would have been provided under activity based funding arrangements for public patient services.



### National Health Reform Agreement and private patients

A6. The Commonwealth will also continue to support private health services through the MBS, the 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.

A7. The parties agree that the following Commonwealth benefits constitute exceptions to the principle outlined at clause A6:

- (a) 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*;
- (b) MBS payments relating to services provided to eligible admitted private patients in public hospitals;
- (c) PBS benefits dispensed under Pharmaceutical Reform Arrangements agreed between the Commonwealth and the relevant State; and
- (d) the default bed day rate (or equivalent payment) supported through the private health insurance rebate.

A41. ABF payments for eligible private patients must utilise the same ABF classification system as for public patients with the cost weights for private patients being calculated by excluding or reducing, as appropriate, the components of the service for that patient which are covered by:

- (a) Commonwealth funding sources other than ABF;
- (b) patient charges including:
  - i. prostheses and
  - ii. accommodation and nursing related components/charge equivalent to the private health insurance default bed day rate (or other equivalent payment).

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## **Appendices—information protocols**

# Appendix 1 Information protocol: bulk billing Medicare

## What is bulk-billing?

*Bulk-billing* is the term applied to the method of billing Medicare for professional services rendered where a patient assigns their right to a Medicare benefit to the practitioner who accepts this as full payment for the medical service.

Billable professional services are listed in the Medicare Benefits Scheme (MBS) and are allocated a unique item number with a schedule fee and Medicare benefit. The benefit payable for professional services listed in the MBS is generally 85 per cent of the schedule fee except in the following circumstances:

- 100 per cent of the schedule fee for services provided by a general practitioner to non-referred, non-admitted patients
- 100 per cent of the schedule fee for services provided on behalf of a general practitioner by a practice nurse or registered Aboriginal health worker
- 75 per cent of the schedule fee for professional services rendered to a patient as part of an episode of admitted hospital treatment (other than public patients)
- 75 per cent of the schedule fee for professional services rendered as part of a privately insured episode of admitted hospital-substitute treatment.

## What services are billable?

The *Health Insurance Act 1973* stipulates that Medicare benefits are payable for professional services. A professional service is a clinically relevant service which is listed in the MBS. A *clinically relevant* service is one which is generally accepted by the relevant profession as necessary for the appropriate treatment of a patient.



## How does a patient assign their rights to a Medicare benefit?

The practitioner enters details relating to the professional service on the assignment form before seeking the patient's signature. The form is then signed and dated by the patient. A copy of the assignment form must be given to the patient.

## What if the Medicare card is not presented?

When a patient who presents without a Medicare card has agreed to be bulk-billed and indicates that they have been issued with a card but are unable to provide the details of their Medicare number, the practitioner may call the Medicare enquiry line on 132 150 to obtain the patient's Medicare number.

If a patient's Medicare number is not available, Medicare can still be bulk-billed if the patient's name, date of birth and current address are included on the claim voucher. The claim may be delayed while additional checking is undertaken by Medicare. If

Medicare eligibility cannot be confirmed, payment for the service provided to the patient will be rejected.

### What if the patient is unable to sign the assignment form?

When a patient is unable to sign, the patient's parent/guardian or other responsible person may complete the form. However, the responsible person must be somebody other than the practitioner or hospital staff. The reason that the patient is unable to sign should also be stated. If a responsible person is unavailable, the patient's signature section should be left blank and an explanation given in the *practitioner's use* section as to why the patient was unable to sign (e.g. *unconscious* or *injured hand*). This note should be signed or initialled by the practitioner.

### Can a bulk-billed patient be charged other fees?

Once a practitioner has agreed to the bulk-billing method and the patient has assigned the benefit, no additional charge can be made for the service. This means that if the practitioner bulk-bills, the patient cannot be charged a booking fee, an administrative fee, a charge for clinical supplies (e.g. bandages) or record keeping fee.

### What details are required for claims submitted to Medicare?

All claims submitted to Medicare must contain the following information:

- practitioner's name, address and/or provider number
- patient's name
- MBS item number and description of the service provided, or a description of the service which is sufficiently detailed to enable the identification of the correct item number
- date the service was provided
- the amount claimed/charged
- in-hospital services must be identified (vouchers must be attached to the in-hospital claim form)
- claims from consultant physicians and specialists must include
  - referral details (name, address and/or provider number of the referring practitioner)
  - date of the referral and the period of referral (preferably in months or *indefinite* if applicable)
- administration of an anaesthetic or assistance at an operation requires the name of the surgeon and the item number relating to the operation
- if a patient is attended on more than one occasion in any day the time each attendance occurred must be recorded on separate vouchers, each signed by the patient.

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## **How are Medicare claims paid?**

Payment of claims is generally made via electronic funds transfer. In order for this to occur, practitioners must provide their relevant bank account details.

## Appendix 2 Information protocol: billing Medicare and patient eligibility

### Who is eligible for Medicare benefits?

Medicare benefits are only payable for professional services provided to Medicare eligible persons.

### What is an eligible person?

An eligible person is a person who resides permanently in Australia and is eligible to claim benefits from Medicare for the cost of professional services rendered by a health practitioner. This includes New Zealand citizens and holders of permanent resident visas. Applicants for permanent residence may also be eligible persons, depending on circumstances. However, eligible persons must enrol with Medicare before they can receive Medicare benefits. Eligible persons who have enrolled with Medicare receive a Medicare card which contains a unique identifier.

### Are all Medicare cards the same?

There are a number of different Medicare cards that may be issued for individuals or families:

- The green Medicare card is issued for people who reside permanently in Australia.
- The blue Medicare card bearing the words *interim card* is for people who have applied for permanent residence.
- Visitors from countries with which Australia has a reciprocal health care agreement receive a card bearing the words *reciprocal health care*.

## Appendix 3 Information protocol: Medicare provider numbers

### What is a provider number?

Provider numbers are unique numbers issued by Medicare Australia to registered health care professionals including medical practitioners, optometrists, dental practitioners and allied health professionals. A Medicare provider number is essential for claiming benefits from Medicare for services rendered. A provider number is also required for issuing a valid referral to a specialist or consultant physician that may be used to claim Medicare benefits for professional services rendered.

Medical practitioners must have a provider number for every location at which they practice. A provider number cannot be transferred from one address to another. If a medical practitioner moves to a new practice location, they must apply for a provider number for that new location.

A provider number does not necessarily mean the medical practitioner can attract Medicare benefits for the services they provide. Before a medical practitioner can attract a Medicare benefit, they must satisfy legislative requirements set out in the *Health Insurance Act 1973*.

It is illegal for a medical practitioner to use another practitioner's provider number or to claim Medicare benefits when working on behalf of another practitioner (including locums). Exceptions to this rule are listed under 2.36.2 (1) and (2) Health Insurance (General Medical Services Table) Regulations 2011.

### Provider eligibility

Section 19 of the *Health Insurance Act 1973* provides that in order for a medical practitioner to be eligible to render professional services that attract Medicare benefits, one of the following conditions must apply:

- The person was a medical practitioner before 1 November 1996 (this does not include a medical practitioner who, on or after 1 November 1996, was undertaking a period of internship or a period of supervised training imposed by a state or territory registration authority; or who was not an Australian citizen or permanent resident on 1 November 1996).
- The person is a recognised specialist or consultant physician or is a general practitioner.
- The person is in an approved placement authorised by the Royal Australian College of General Practitioners, Australian General Practice Training Program, Queensland Country Relieving Doctors Program, specialist college or an approved placement under a program specified under Section 3GA of the *Health Insurance Act 1973*.
- The person is a temporary resident practitioner (including New Zealand citizens) who has been issued with an exemption under Section 19AB of the *Health Insurance Act 1973*, while working in accordance with that exemption.

A service provided by a medical practitioner who does not satisfy one of the above conditions is not eligible for Medicare benefits. Please note that this ineligibility to claim Medicare benefits does not affect the practitioner's ability to prescribe pharmaceutical benefits, refer patients to specialists or consultant physicians, or order pathology or diagnostic imaging services.

## Provider ineligibility

Other circumstances where Medicare benefits are not payable in respect of services rendered by a practitioner who:

- has been fully or partly disqualified relative to relevant services the *Health Insurance Act 1973* (Section 19B provides details of the circumstances in which Medicare benefits are not payable in respect of services rendered by disqualified practitioners)
- is an overseas-trained doctor or former overseas medical student who has not obtained an exemption to Section 19AB of the *Health Insurance Act 1973* and is unable to access Medicare benefits until the requirements of Section 19AB have been met
- is not eligible to provide services which attract Medicare benefits, under Section 19C(c) of the *Health Insurance Act 1973*, it is an offence to render a service without first informing the patient that Medicare benefits are not payable for that service.

## Overseas trained doctors

Since 1997, any doctor who has been trained overseas, or who was not a permanent resident or Australian citizen at the time of undertaking medical training in Australia, is subject to Section 19AB of the *Health Insurance Act 1973*.

Section 19AB restricts access to Medicare provider numbers and requires overseas trained doctors and former overseas medical students to work in a district of workforce shortage, for a minimum period of ten years in order to access the Medicare benefits arrangements. This is referred to as the *ten year moratorium*.

Applications for a Medicare provider number can only be made after the overseas trained doctor has:

- been offered a medical job in Australia
- been granted a visa
- successfully attended the registration interview
- been granted registration
- paid their registration fee.

Applications for exemption of Section 19AB may be made to the Australian Minister for Health.



## Medicare provider number legislation

Sections 19AA, 3GA and 3GC of the *Health Insurance Act 1973* are collectively known as the *Medicare provider number legislation*. The Medicare provider number legislation is reviewed every five years.

This is particularly significant as Section 3GA permits medical practitioners who are subject to Section 19AA to provide professional services that attract Medicare benefits through placements on approved workforce training programs.

Only doctors who are enrolled in a training course or program specified in Schedule 5 of the *Health Insurance Regulations 1975* can provide services for which a Medicare benefit is payable.

## Working in place of another health care professional (locum tenens arrangements)

A locum is a person who temporarily fulfils the duties of another. As mentioned earlier, a healthcare professional must have a provider number for every location at which they practice.

However, in some cases a locum may be able to use one of their existing provider numbers when practising in another location for a short period of time. If this situation is likely to occur in your practice, you should contact the Medicare Provider Eligibility section on 132 150 for advice.

### Key issues

- Medical practitioners must be able to meet the necessary eligibility requirements to be issued with a provider number;
- A provider number uniquely identifies medical practitioners as a health care professional and the location from which they are practicing;
- Medical practitioners must have a different provider number for every location at which they practice, the exception being locums in some circumstances;
- It is important to contact the provider eligibility section of Medicare Australia on 132 150 for advice, where a locum situation is likely to occur.

## Appendix 4 Information protocol: referrals to specialists or consultant physicians

### What is a referral?

Section G.6.1 of the Medicare Benefits Scheme (MBS) describes a referral as '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)'.

Section G.6.1 also indicates that the benefit payable for certain services provided by specialists and consultant physicians is dependent on acceptable evidence that the service has been provided following referral from another practitioner. This effectively means that a referral facilitates the payment of MBS items that require a referral. It should be noted that there are MBS items for *non-referred* consultations that may be claimed in the absence of a patient having a valid referral. However, MBS benefits are paid at a lower rate for these items.

### What is a specialist?

Section 3 of the HIA defines a specialist as:

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 this Act as a specialist in that specialty, or a medical practitioner who is taken to be so recognised under section 3D.

The abovementioned sections of the *Health Insurance Act 1973* provide the details of the specific criteria required for recognition by Medicare Australia as a specialist medical practitioner.

### What is a consultant physician?

Section 3 of the *Health Insurance Act 1973* defines a consultant physician as:

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 this Act as a consultant physician in that specialty.

Sections 3DB and 3E of the *Health Insurance Act 1973* provide details of the specific criteria required for recognition by Medicare Australia as a consultant physician.

Official notification of recognition as a specialist or consultant physician by the Medicare Australia Chief Executive Officer is required prior to the commencement of billing Medicare for professional services rendered as a specialist or consultant physician.

## Who can refer?

The following information is provided under Section G6.1 of the MBS:

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 by dentists or optometrists or participating midwives or participating nurse practitioners

For Medicare benefit purposes, a referral may be made to:

- (i) a recognised specialist:
  - (a) by a registered dental practitioner, where the referral arises from a dental service; or
  - (b) by a registered optometrist where the specialist is an ophthalmologist; or
  - (c) by a participating midwife where the specialist is an obstetrician or a paediatrician, as clinical needs dictate. A referral given by a participating midwife is valid until 12 months after the first service given in accordance with the referral and for 1 pregnancy only or
  - (d) by a participating nurse practitioner to specialists and consultant physicians. A referral given by a participating nurse practitioner is valid until 12 months after the first service given in accordance with the referral.
- (ii) a consultant physician, by an approved dental practitioner (oral surgeon), where the referral arises out of a dental service.

In any other circumstances (i.e. a referral to a consultant physician by a dentist, other than an approved oral surgeon, or an optometrist, or a referral by an optometrist to a specialist other than a specialist ophthalmologist), it is not a valid referral. Any resulting consultant physician or specialist attendances will attract Medicare benefits at un-referred rates.

This does not prevent hospital medical staff (including junior or senior house officers), from referring to either a consultant physician or a specialist. The significant issue is that for a referral to be billable it must meet the requirements of a valid referral detailed in Section G 6.1 of the MBS and the referrer must have a valid provider number.

## What elements are required for a referral to be Medicare billable?

The following details are provided in Section G.6.1 of the MBS, regarding the requirements of a *valid* referral:

Subject to the exceptions in the paragraph below, for a valid "referral" to take place

- (i) the referring practitioner must have undertaken a professional attendance with the patient and turned his or her mind to the patient's need for referral and have communicated relevant information about the patient to

- the specialist or consultant physician (this need not mean an attendance on the occasion of the referral);
- (ii) the instrument of referral must be in writing as a letter or note to a specialist or to a consultant physician and must be signed and dated by the referring practitioner; and
  - (iii) the specialist or consultant physician to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

The exceptions to the requirements in paragraph above are that:

- (a) sub-paragraphs (i), (ii) and (iii) do not apply to:
  - o a pre-anaesthesia consultation by a specialist anaesthetist (items 16710-17625);
- (b) subparagraphs (ii) and (iii) do not apply to
  - o a referral generated during an episode of hospital treatment, for a service provided or arranged by that hospital, where the hospital records provide evidence of a referral (including the referring practitioner's signature); or
  - o an emergency where the referring practitioner or the specialist or the consultant physician was of the opinion that the service be rendered as quickly as possible; and
- (c) subparagraph (iii) does not apply to instances where a written referral was completed by a referring practitioner but was lost, stolen or destroyed.



## Emergency referrals

As previously identified, emergency referrals are an exception to the general rule requiring a written referral. A professional service rendered by a specialist or consultant physician may be billed against Medicare without a written named referral if the referral occurred in an emergency. However, only the initial/emergency consultation is billable without a named referral, for subsequent services rendered during the course of a single treatment a written, named referral must be obtained from a referring practitioner (see Section G.6.1. of the MBS for detail).

## Referrals generated during an admitted patient episode

The following information provided in the MBS indicates that referrals generated during a hospital admission can be made in the form of a notation in the patient's chart. However, such referrals are only valid for the duration of the admission.

Where a referral is generated during an episode of hospital treatment for a service provided or arranged by that hospital, benefits will be payable at the referred rate if the account, receipt or assignment form is endorsed *referral within (name of hospital)* and the patient's hospital records show evidence of the referral. However, in other instances where a medical practitioner within a hospital is involved in referring a patient (e.g. to a specialist or a consultant physician in private rooms) the normal referral arrangements apply, including the requirement for a referral letter or note and its retention by the specialist or the consultant physician billing for the service.

### **What if the referral has been lost, stolen or destroyed?**

Regulation 13 of the Health Insurance Regulations 1975 refers to subsection 19(6) of the Act detailing the particulars required when a referral to a specialist or consultant physician has been lost, stolen or destroyed. These are also detailed in G.6.1. (special circumstances) of the MBS which provide the details required for services provided in these circumstances to be Medicare billable. The account, receipt or assignment form must show:

- the name of the referring medical practitioner
- the practice address or provider number of the referring practitioner (if these are known to the treating consultant physician or specialist)
- the words *lost referral*.

Note that this applies only to the initial attendance/consultation, and a new valid referral must be obtained from the referring practitioner for subsequent attendances to qualify for Medicare benefits.

### **Are referrals from the emergency department billable?**

Referrals for private admitted patient services are billable.

Referrals for private specialist outpatient clinic services are not billable.

Business Rule G17 of the National Health Reform Agreement clearly states:

Services provided to public patients should not generate charges against the Commonwealth Medicare Benefits Schedule:

- (a) 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.

All patients attending an emergency department of a Queensland Health facility are public patients until the decision to admit has been made and the patient then is provided with the opportunity to elect to be admitted as either a public or private patient (see Business Rule G18, National Health Reform Agreement).

## **Can a named referral be the pre-requisite for access to outpatient services?**

Business Rule G17 prohibits the controlling of referral pathways so as to deny access to free public hospital services and the controlling of referral pathways so that a referral to a named specialist is a prerequisite for access to outpatient services. However, patients can be provided with information about private options available, and subsequently choose to access those services.

## **Does the referred patient have to be seen by the named specialist or consultant physician?**

A referral that names a particular specialist or consultant physician may be used to access the services of another specialist or consultant physician, provided that both the specialist or consultant physicians have equal qualifications in the same discipline, operate in the same specialty and can access the patient's medical record.

## **For what period of time is a referral valid?**

The period of time for which a referral to consultant physicians or specialists is valid varies, depending upon whether a specific timeframe is noted on the referral or the type of referring practitioner. Regulation 31 of the Health Insurance Regulations 1975 provides details:

- the referral may be noted to be for a nominated or fixed period
- the referral may specify that it is for an indefinite period
- where no period is specified a referral is valid for a period of twelve months.



## **When does the period of referral validity commence?**

The start time for a period of validity for a referral is from the date that the patient is first seen by the specialist or consultant physician—this is usually the date of their first outpatient appointment or the date of their first consultation in hospital (if an admitted patient).

## **Should referrals be kept for any specific period of time?**

While the actual evidence that a referral exists is the provision of the referral particulars on the specialist or consultant physician's account, the MBS guidelines require the referral to be retained for a period of 18 months from the date the service was provided (that is the patient's first attendance). Should a medical practitioner who is employed by Medicare Australia make a request on behalf of the Medicare Australia chief executive

officer, of a specialist or consultant physician to produce the instrument of referral, the referral must be produced within seven days of the request being made.

### Summary

- A referral is a request to a specialist or consultant physician for investigation, opinion, treatment and/or management of a condition or problem or for the performance of a specific examination(s) or test(s).
- Written referrals are required to access services provided by a specialist or consultant physician medical practitioner.
- Referrals are usually sourced from general practitioners but may be made by other specialists, consultant physicians. Referrals may also be sourced from approved/registered dental practitioners, registered optometrists, nurse practitioners and eligible midwives in specific circumstances.
- Referrals from public hospital emergency departments to specialists/consultant physicians exercising a right of private practice at a public hospital are not billable.
- A named referral cannot be a prerequisite for access to outpatient services.
- The referred patient does not have to be seen by the named specialist or consultant physician. The referral may be used to access the services of another specialist or consultant physician in circumstances where they have the equal qualifications in the same discipline, operate in the same specialty and can access the patient's medical record.
- Referrals are valid for limited periods depending upon the source of the referral (referring agent) and must be retained for a period of 18 months from the date the service was provided (that is the patient's first attendance).

## Appendix 5 Links

### **Medicare Australia—contracts for health professionals**

[www.medicareaustralia.gov.au/provider/contact.jsp](http://www.medicareaustralia.gov.au/provider/contact.jsp)

### **Queensland Health policies**

[www.health.qld.gov.au/ghpolicy/html/index-g.asp](http://www.health.qld.gov.au/ghpolicy/html/index-g.asp)

### **National Health Reform Agreement**

[www.federalfinancialrelations.gov.au/content/npa/health\\_reform/national-agreement.pdf](http://www.federalfinancialrelations.gov.au/content/npa/health_reform/national-agreement.pdf)

### **National Healthcare Agreement**

[www.federalfinancialrelations.gov.au/content/npa/healthcare/national-agreement.pdf](http://www.federalfinancialrelations.gov.au/content/npa/healthcare/national-agreement.pdf)

### **Health Insurance Act 1973 and the Health Insurance Regulations 1975**

[www.comlaw.gov.au/](http://www.comlaw.gov.au/)

### **Department of Health Revenue Strategy and Support Unit**

<http://qheps.health.qld.gov.au/financenetwork/revenue/home-rssu.htm>

### **Fees and Charges Register**

<http://qheps.health.qld.gov.au/financenetwork/revenue/home-rssu.htm>

### **Department of Human Services**

[www.humanservices.gov.au/customer/services/medicare/reciprocal-health-care-agreements](http://www.humanservices.gov.au/customer/services/medicare/reciprocal-health-care-agreements)

### **Australian Taxation Office**

[www.ato.gov.au/](http://www.ato.gov.au/)



## Abbreviations

ABF	Activity based funding
CoAG	Council of Australian Governments
MBS	Medicare Benefits Schedule
NHRA	National Health Reform Agreement
OSR	Own source revenue
PEF	Patient election form
RSSU	Revenue Strategy and Support Unit

## Glossary

Term	Definition
Activity based funding	A system for funding public hospital services provided to individual patients using national classifications, cost weights and efficient prices developed by the Independent Hospital Pricing Authority.
Clinician	An individual who provides diagnosis, or treatment, as a professional: a) medical practitioner b) nurse c) allied health practitioner or Health practitioner not covered by paragraph a), b) or c) (National Health Reform Act 2011).
Commercialised business units (CBUs)	Health Services Support Agency (HSSA) and other commercialised business units employing clinicians that support or engage in private practice activities in the public health sector.
Department of Health	The Department of Health includes employees working in and for: <ul style="list-style-type: none"> <li>• Health Service and Clinical Innovation Division</li> <li>• System Support Services Division</li> <li>• System Policy and Performance Division</li> <li>• Office of the Director-General</li> <li>• Health Services Support Agency</li> <li>• Health Services Information Agency</li> <li>• Queensland Ambulance Service (QAS).</li> </ul>
Granted private practice	A limited right to provide professional services to private patients on the terms of Schedule 3 of the Employment Contract.
Hospital and Health Service (HHS)	A statutory body responsible for the provision of public sector health services for a geographical area which includes one or more health facilities.
Independent Hospital Pricing Authority (IHPA)	The authority established by the Commonwealth legislation in accordance with clause B1 to perform the functions set out in clauses B3 to B8. (National Health Reform Act 2011).
Licensed private practice	An arrangement granted by the HHS or CBU for an individual to undertake private patient activities at a public health facility during unpaid time.
Medical officer/practitioner	A medical practitioner who is registered with the Medical Board of Australia under the Health Practitioner Registration National Law Act 2009.
Medical services	Any of the medical services set out in Schedule 1 of the Health Insurance Act 1973.

<b>Term</b>	<b>Definition</b>
Medicare Benefits Schedule (MBS)	The Commonwealth government's scheme to provide medical benefits to Australians established under part II, IIA, IIB and IIC of the Health Insurance Act 1973 together with relevant regulations made under the act.
Medicare principles	The principles set out in Clause 4 of the National Health Reform Agreement.
National efficient price	<p>The base price(s) which will be determined by the IHPA and applied to those services funded on the basis of activity for the purpose of determining the amount of Commonwealth funding to be provided to public health services. The IHPA may determine that there are different base prices for discrete categories of treatment, for example admitted care, sub-acute care, non-admitted emergency department care and outpatient care.</p> <p>In the event that there are multiple national efficient prices, the IHPA will determine which national efficient price applies.</p>
Pharmaceutical Benefits Scheme (PBS)	The Commonwealth government's scheme to provide subsidised pharmaceuticals to Australians established under part VII of the National Health Act 1953 together with the National Health (Pharmaceutical Benefits) Regulation 1960 made under the National Health Act.
Private patient	A person who could receive treatment free of charge under the National Health Reform Agreement 2011 but who has elected to be treated privately in the public system, or a person who agrees to be a fee paying patient of the medical officer and makes this election on the basis of informed financial consent.
Private practice (retention arrangement)	Private practice performed during employed time where the clinician retains billings after paying applicable Service fees.
Private practice (assignment arrangement)	Private practice performed during employed time where the clinician assigns all billings to the HHS or CBU.
Private practice	<p>Any contractual arrangement between the Department of Health, a HHS or CBU and clinical staff with these features:</p> <ul style="list-style-type: none"> <li>• The medical treatment of a patient who has elected to be a private patient in respect to informed financial consent</li> <li>• Clinical staff treating the private patient uses their Medicare Provider Number to facilitate billing where applicable</li> </ul>
Public patient	In relation to a hospital, means a person in respect of whom the hospital provides comprehensive care, 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 (Health Insurance Act 1973).
Queensland Health	The accumulative body of the Department of Health, CBUs and HHSs.

Term	Definition
Scope of clinical practice	The extent of an individual practitioner's approved clinical practice within a particular organisation based on the individual's credentials, competence, performance and professional suitability and the needs and capability of the organisation to support the practitioner's scope of clinical practice.
Service fees	The fees applicable to granted private practice retention arrangement participants, as specified in the Department of Health Fees and Charges Register

## Document revision and approval history

Version no	Developed/modified by	Approved by	Date
1.0	Revenue Strategy and Support Unit	DG	21.12.2012
2.0	Private Practice Reform Program	Private Practice Governance Board	22.01.2014
3.0	Private Practice Reform Program -- updates to glossary	Private Practice Governance Board	27.02.2014

