Australian Government

Department of Health

Dr Vijay Roach
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Dear Dr Roach

Thank you for your correspondence with the Department of Health on behalf of your members on the issues of correct obstetrician Medicare billing. In providing this advice to you, I have also consulted with relevant policy holders in the Department of Health (Health Workforce Division and Provider Benefits Integrity Division) and the Department of Human Services.

Billing requirements for obstetrics services under the Health Insurance (General Medical Services Table) Regulations 2019

Under 1.2.6 Personal attendance by medical practitioners of the Health Insurance (General Medical Services Table) Regulations 2019, all of Group T4 (Obstetrics) items (except items 16400 and 16514) must be personally performed by the rendering medical practitioner. Further information is provided at explanatory note GN.12.30. Professional services, of the Medicare Benefits Schedule (MBS). A situation where one practitioner has performed the medical service and then billed Medicare under the provider number of another practitioner who has not performed the medical service is not in line with the MBS rules.

Under the *Health Insurance Act 1973*, medical practitioners are legally responsible for services billed to Medicare under the medical practitioner's Medicare provider number and/or name. Additionally, all medical practitioners who choose to privately bill their patients should understand and meet all requirements under the Health Insurance Regulations 2018.

Appropriate billing in cases of obstetrician absence

In addition to the above, the following would constitute appropriate billing meeting the legislative requirements of the MBS in cases where one obstetrician is away and a patient's delivery is performed by another obstetrician, particularly when one obstetrician is required to be 'on call' for another obstetrician.

- A formal locum tenens arrangement is put in place for the duration of time that an obstetrician is away. The birth is billed under the locum tenens provider number. Medicare allows for locum tenens arrangements. However, a practitioner cannot be practising at the same time as their acting locum practitioner at the same practice. If this is the case in the scenario outlined, then this does not meet the policy intention of a locum.

  For further information please see GN.2.6. Locum tenens. The Department of Human Services Medicare provider enquiry line is the best contact for any enquiries regarding locum tenens arrangements.

- The obstetrician attending the birth bills the patient under their provider number. There are a range of existing MBS items which allow for medical practitioners to transfer care of a patient for management of the birth where the attending medical practitioner has not provided antenatal care to the patient (MBS items 16515, 16518, 16520). There are similar items which allow for participating midwives to transfer care to a medical practitioner for management of the birth (MBS items 16527, 16528).

I trust that the above has been of assistance to you and the members of your college.

Yours sincerely

Michael Ryan
A/g Assistant Secretary
MBS Policy and Specialist Services Branch

22 January 2020

Attachments

Attachment A	Medicare Benefits Schedule GN.12.30. Professional services
Attachment B	Medicare Benefits Schedule GN.2.6. Locum tenens

Attachment A

GN.12.30

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 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) Category 1 (Professional Attendances) items except 170-172, 342-346, 820-880, 6029–6042, 6064-6075;

(b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11304, 11600, 11627, 11701, 11712, 11722, 11724, 11728, 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 14245);

(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 exercising their right of 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 - 12322 (Bone Densitometry) when the service is performed by a specialist or consultant physician in the practice of the specialist's or consultant physician's specialty where the patient is referred by another medical practitioner.

Attachment B

GN.2.6

Locum tenens

Where a locum tenens will be in a practice for more than two weeks ***or*** in a practice for less than two weeks but on a regular basis, the locum should apply for a provider number for the relevant location. If the locum will be in a practice for less than two weeks and will not be returning there, they should contact the Department of Human Services (provider liaison - 132 150) to discuss their options (for example, use one of the locum's other provider numbers).

A locum must use the provider number allocated to the location if

(a) they are an approved general practice or specialist trainee with a provider number issued for an approved training placement; or

(b) they are associated with an approved rural placement under Section 3GA of the *Health Insurance Act 1973*; or

(c) they have access to Medicare benefits as a result of the issue of an exemption under section 19AB of the *Health Insurance Act 1973* (i.e. they have access to Medicare benefits at specific practice locations); or

(d) they will be at a practice which is participating in the Practice Incentives Program; or

(e) they are associated with a placement on the MedicarePlus for Other Medical Practitioners (OMPs) program, the After Hours OMPs program, the Rural OMPs program or Outer Metropolitan OMPs program.