Medicare Billing in NSW Public Health Facilities

Summary NSW Health Agencies must endeavour to monitor billing practices throughout their facilities. This requirement will ensure that as a system, NSW Health bills in a manner that is compliant and appropriate. Compliant billing means meeting NSW Health's obligations under the National Health Reform Agreement 2011 and Addendums; the Health Insurance Act 1973 and Regulations; the Private Health Insurance Act 2007 and Rules. This includes NSW Health Policy. Appropriate means raising the correct charges for treatments rendered to chargeable patients who have given their consent.

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Secretary, NSW Health

NSW Health

Policy Directive

Medicare Billing in NSW Public Health Facilities

Policy Statement

NSW Health is committed to ensuring the financial sustainability of the health system through consistent messaging and support for staff involved in Medicare billing throughout NSW Health.

Summary of Policy Requirements

NSW Health Agencies must monitor billing practices throughout their facilities. This requirement will ensure that as a system, NSW Health bills in a manner that is both compliant and appropriate.

Billing compliance means that NSW Health Agencies and health practitioners are adhering to the rules defined by the *Health Insurance Act 1973* [Commonwealth] (underlying legislation for Medicare and the Medicare Benefits Schedule [MBS]); the National Health Reform Agreement and Addendums [NHRA] (intergovernmental agreement) and NSW Health policy.

Appropriate billing means that health practitioners have a Right of Private Practice (RoPP) as a concomitant of their employment/contractual obligations and are exercising that right at the time of billing; meet the descriptor of the MBS item number used and only bill patients with a chargeable financial class, who provided informed financial consent. To assist, NSW Health Agencies must provide up to date information regarding a patient's financial election and any changes that may occur with that election.

By billing compliantly and appropriately, NSW Health Agencies and health practitioners will reduce instances of "double dipping" – that is, being paid twice for the same service via different funding streams; retain income earnt and manage the health system in a financially sustainable manner.

A governance framework is a key component of compliant and appropriate billing. NSW Health Agencies must evaluate, monitor and manage Medicare billing for admitted/non-admitted patient activity.

The setup and management of non-admitted patient clinics undertaking billing must be done with due diligence to maintain the viability of the clinics.

Revision History

Version	Approved By	Amendment Notes
PD2024_035 November-2024	Deputy Secretary, Financial Services and Asset Management & Chief Financial Officer	Added: • Rights of Private Practice and entitlements • Inclusion of other health practitioners • Non-admitted patient consent requirements • Changes in financial election/deferred elections/changes post procedure • Submission and review of MBS item numbers • Governance, performance and accountability requirements. • Definition of “hospital treatment’ (s121-5, *Public Insurance Act 2007*). Removed: • Detailed information on request forms.
GL2021_005 March-2021	Deputy Secretary, Financial Services and Asset Management	Initial Document.

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1. Background

Public hospitals are government funded through both Commonwealth and State/Territory contributions. Medical practitioners employed or otherwise engaged by the hospital can generate an income by raising invoices against private patients where granted a right of private practice (RoPP) by NSW Health. Other practitioners (for example, visiting endorsed midwives, oral health practitioners) may also raise invoices for the treatment of private (chargeable) patients where they have been granted a RoPP by NSW Health.

Medicare affirms that conducting private practice within public hospitals is permissible.

'Under long standing arrangements, it is possible for salaried medical practitioners employed within public hospitals to exercise rights of private practice while working in these hospitals and see their own patients on a private basis, and to bill Medicare in respect of those services' [1, p. 6].

Patients can elect to be treated as public or private in accordance with section 68 of the *Health Services Act 1997* (NSW) and the *National Health Reform Agreement 2011* (NHRA) and Addendums.

An eligible patient is regarded as public unless the patient chooses otherwise or is covered by a third-party arrangement, for example Department of Veterans' Affairs (DVA), workers compensation, motor accident and other compensable.

NSW is committed to the Medicare Principles of equal access to services based on clinical need not patient election status.

Clause 11 and Schedule G of the NHRA permits the billing of private patients in public hospitals provided the following conditions are met:

- Patients must be given the choice to be treated as public or private and this choice must be recorded [2].
- Public patients must be provided with access to all services offered to private patients [2].
- Eligible persons who have elected to be treated as private patients, have done so on the basis of informed financial consent [2].
- Districts/Networks must ensure that referral pathways are not controlled to deny access to free public hospital services or so that a referral to a named specialist is a prerequisite for access to outpatient services [2].

1.1. About this document

This Policy Directive applies when billing Medicare for admitted and non-admitted services provided or controlled by a NSW Health Agency.

The intended audience is medical practitioners practising privately in NSW public health facilities and those administrative staff assisting them. However, other practitioners can also request and refer services that are billable to Medicare. These practitioners can also use this Policy Directive as a guide to ensure that they are billing in a manner that is compliant and

appropriate. Where reference is made to “medical” practitioner, in most instances the requirements described will be applicable.

Treating practitioners who exercise RoPP and administrative staff, including clerical managers and departmental secretaries, must familiarise themselves with this Policy Directive.

Those practitioners who bill through a NSW Health Agency must adhere to this Policy Directive. In this instance, the NSW Health Agency is acting as their billing agent. Staff Specialists must invoice patients using the NSW Health Agency’s billing system consistent with the terms of the *Staff Specialists Determination 2015*.

Clinical Academics, Visiting Medical Officers (VMO), Honorary Medical Officers (HMO) and other treating practitioners with a RoPP are permitted to do their own billing. Where a Clinical Academic or a VMO/HMO elects to do their own billing, the NSW Health Agency is not acting as a billing agent.

1.2. Key definitions

Activity Based Funding (ABF)	ABF is public funding for hospitals. It funds hospitals for the volume and mix of patients treated.
Billing Agent/ **Simplified Billing Agent**	For the purpose of this Policy Directive a billing agent is an entity that bills on behalf of a medical practitioner. It is not the same as a Medicare billing agent which acts on behalf of the patient to claim Medicare benefits/private health insurance benefits.
Chargeable Patient	Any patient who is not a public patient. This includes Department of Veterans’ Affairs, workers compensation, other compensable, motor accident, Medicare Ineligible (Overseas Visitors), privately insured, self-funded and patients who are bulkbilled.
Commonwealth Medicare Benefits Schedule (CMBS) /Medicare Benefits Schedule (MBS)	The Schedule lists all fees associated with a professional service. Each service has been allocated a unique item number, descriptor, schedule fee and Medicare benefit (expressed as percentage of the fee).
Direct Supervision (Therapeutic Procedures)	Means personal and continuous attendance for the duration of the service. This is applicable to item numbers 13015-51318. Excludes the following MBS items: 13209, 16400-16500, 16590-16591, 17610-17690 and 18350-18373 [3].
Eligible Person	An Australian resident, or an eligible overseas representative as defined in the *Health Insurance Act 1973* (Commonwealth).

Medical Practitioner	For the purpose of this Policy Directive a medical practitioner includes Staff Specialists, Clinical Academics, Visting Medical Officers (VMO) and Honorary Medical Officers (HMO).
Medicare Provider Numbers (MPN)	An MPN is a unique identifier issued by Medicare Australia on application from an eligible health professional.
National Health Reform Agreement (2011) and Addendums (2017, 2020-2025)	An intergovernmental agreement between the Commonwealth, and States/Territories outlining the funding mechanism to be used for public hospitals, while seeking to achieve a more connected, sustainable and equitable health system [4].
NSW Health Agency	Public Health Organisations, Statutory Health Corporations, Affiliated Health Organisations, NSW Health Pathology and NSW Ambulance, as defined by the *Health Services Act 1997* (NSW).
Non-admitted/outpatients	This is a healthcare setting [5]. These terms are used interchangeably throughout this Policy Directive.
Personal Attendance	The *Health Insurance Regulations 2018* (Commonwealth) specify that personal attendance items 'apply to a service provided in the course of a personal attendance by a single medical practitioner on a single patient on a single occasion' [6]. This means that the patient must be present and only time spent with the patient counts towards the attendance. For the purposes of telehealth/telephone attendances the Regulations' requirement is modified to 'a service that is an attendance by a single health professional on a single patient' [6].
Post-operative Treatment	Generally referred to as "aftercare." 'Aftercare is deemed to include all post-operative treatment rendered by medical specialists and consultant physicians, and includes all attendances until recovery from the operation, the final check or examination,' (regardless of location) [7]. 'Aftercare need not necessarily be limited to treatment given by the surgeon or to treatment by any one practitioner' [7].

Private Patient	For the purpose of this Policy Directive private patients are eligible persons who can access a Medicare benefit and/or have private health insurance. This cohort is a subset of the broader definition of "chargeable patients".
Public Patient	Where an eligible person elects to be a public patient, no charges are to be raised against the patient or another Commonwealth funding stream. Services are free of charge. Charges can be raised in accordance with the NHRA Schedule G Business Rules *Public patient charges* [2].
Rights of Private Practice (RoPP)	Where NSW Health permits a practitioner to treat chargeable patients in their own private capacity as a concomitant of their appointment. Having RoPP enables a practitioner to supplement their income and gives patients in NSW the choice to be treated privately in a public hospital consistent with the expectations of the NHRA.
Treating Practitioner	For the purpose of this Policy Directive, a treating practitioner includes medical, dental, privately practising endorsed midwives, nurse practitioners, allied health professionals (including oral health practitioners and optometrists) unless expressed otherwise [8].

1.3. Legal and legislative framework

Treating practitioners working in NSW public health facilities must have a RoPP to see and treat chargeable patients. Practitioners wishing to charge patients, must abide by the:

- *Health Insurance Act 1973* (Commonwealth)
- *Private Health Insurance Act 2007* (Commonwealth)
- *Health Insurance Regulations 2018* (Commonwealth); and associated tables (General Medical, Diagnostic Imaging and Pathology Services)
- *Private Health Insurance (Benefit Requirements) Rules 2011* (Commonwealth)
- *Commonwealth Medicare Benefits Schedule* (CMBS/MBS)
- *National Health Reform Agreement 2011* (NHRA) and the *2020-2025 Addendum*
- *Health Services Act 1997* (NSW)
- Department of Health and Aged Care, Services Australia websites.

All relevant NSW Health policy documents are available on the Policy Distribution System webpage.

This Policy Directive is not exhaustive and medical practitioners should continue to liaise with

Services Australia's Medicare program for advice and guidance on Medicare billing in public hospitals.

Specific information on Medicare billing is provided in good faith and every care has been taken in preparing this Policy Directive, including consultation with the Commonwealth Department of Health and Aged Care's (DOHAC) Provider Compliance and Investigation Branch within the Benefits Integrity Division. In the event of technical error, the *Health Insurance Act 1973* (Commonwealth) and associated legislation will prevail.

2. Medicare Billing in NSW public facilities

NSW Health as a signatory to the *National Health Reform Agreement 2011* (NHRA) Addendum 2020-2025 must comply with Schedule A, *Sustainability of funding for public hospital services.* In particular, if the Administrator of the National Health Funding Body identifies instances where it appears that a service has been paid for twice (activity based funding [ABF] and Medicare Benefits Schedule [MBS]/ Pharmaceutical Benefits Scheme [PBS]), clause A11 states that these matters should be referred to the relevant Commonwealth officer to support Commonwealth compliance activities through mechanisms outside the Addendum. The Commonwealth undertakes routine auditing of billing activity to identify and rectify duplicate payments.

2.1. Understanding funding mechanisms

Treating practitioners and administrative staff need to understand the rules governing Medicare billing in public health facilities to avoid any part of a public admitted patient episode or non-admitted service event being paid for twice (such as through ABF and MBS/PBS). This does not imply that a practitioner cannot exercise rights of private practice (RoPP), but it does mean that both the NSW Health Agency and treating practitioner must apply due diligence when billing Medicare.

2.1.1. S19(2) Exempt sites

Under the Commonwealth's exemption initiative *Improving Access to Primary Care in Rural and Remote Areas*, Medicare can be billed for certain professional services at an exempt site provided that the following criteria are met:

- The professional service/s are provided in emergency departments and outpatient clinics.
- The professional service/s are for patients who have not been admitted to the hospital or health facility.
- Non-referred services are provided by state-funded medical practitioners, participating midwives and participating nurses (including nurse practitioners).
- Referred services are provided by state-funded allied health and dental health professionals [9].

2.2. NSW Health Agencies

NSW Health Agencies may, as an agent for the practitioner, bill Medicare for services rendered by the treating practitioner. NSW Health Agencies must ensure that they have consent to bill using the provider number of the treating practitioner for that defined location and the MBS item numbers billed have been chosen by the treating practitioner. It is expected that as their billing agent, NSW Health Agencies will provide treating practitioners with the opportunity to review MBS item numbers, prior to submission to Medicare.

In addition, the NSW Health Agency must provide visibility to the practitioner of all billing occurring under the practitioner's Medicare provider number.

Local processes must be established which take into account variances in billing procedures and billing systems. See section 5 for further details.

2.3. Treating Practitioners

Each treating practitioner granted RoPP has a legal responsibility to comply with the applicable provisions of the *Health Insurance Act 1973* (Commonwealth) [HIA], the MBS, and other relevant regulations or legislative instruments as specified by the Department of Health and Age Care (DOHAC) and Services Australia (formerly the Department of Human Services).

Overseas trained doctors (OTDs) and foreign graduates of an accredited medical school (FGAMS) must have an s19(AB) exemption [*Health Insurance Act 1973* (Commonwealth)] (subject to any conditions) to bill Medicare along with a RoPP in accordance with the conditions of their appointment or other arrangements.

Treating practitioners must advise the NSW Health Agency of the correct Medicare provider number for each location where they exercise RoPP.

2.3.1. Medicare Provider Numbers

A Medicare Provider Number (MPN) is a unique number that is issued to eligible health professionals who apply to participate in the Medicare Program.

An eligible health professional must have an MPN before they can bill, refer or request services that attract a Medicare benefit. If a health practitioner practices at more than one location, changes locations, or is registered in multiple health professions, additional provider numbers are required [10].

Health professionals **cannot** use another professional's MPN under any circumstances. The MPN is linked to the practitioner.

In their capacity as billing agents, NSW Health Agencies **cannot** commence making claims on behalf of a health professional employed or contracted by the NSW Health Agency without written authorisation in the manner specified by Medicare.

2.3.2. Applying for Medicare Provider Numbers (MPN)

Applying for Medicare provider numbers is the responsibility of the eligible treating practitioner. Health professionals who are registered with the Australian Health Practitioner Regulation Agency (AHPRA) or an approved registration body can apply for an MPN.

NSW Health Agencies in the capacity of billing agents, may assist the practitioner to apply.

2.3.3. Refer and Request Only Provider numbers

Nurse practitioners can apply for a provider number for the purposes of referring patients to medical specialists. They can also write requests for certain diagnostic tests that attract a Medicare rebate. Nurse practitioners cannot bill their services to Medicare when employed by NSW Health except at an s19(2) exempt site.

For further information regarding registration or applying for MPNs, eligible health professionals can contact:

Medicare Provider Enquiries

Phone: 132 150

Email: medicare.prov@servicesaustralia.gov.au

2.3.4. Junior Medical Officers

In accordance with section 3.2.4 of NSW Health Policy Directive *Employment Arrangements for Medical Officers in the NSW Public Health Service* (PD2019_027):

> 'Resident medical officers and registrars have no rights of private practice and are not permitted to engage in private practice within the NSW Health hospital or service at which they are employed, or where rotated to a facility or site outside NSW Health, while still employed in the NSW Health Service. Visiting medical officers and staff specialists must not include an assistant's fee in their accounts to private patients where the assistant in question is a resident medical officer or registrar' [11, p. 3].

Junior Medical Officers are recognised as 'Other Medical Practitioners' by Medicare Australia. As such, they can apply for an MPN. However, they are unable to use the MPN within NSW Health facilities to bill Medicare.

An exception to this is where an s19(2) exemption has been provided to permit a General Practitioner (GP) Registrar to be employed by NSW Health in outside practice under the single employer model.

For the avoidance of doubt, the above information does not apply to secondary employment. Such secondary employment must be disclosed to NSW Health consistent with the Code of Conduct (see NSW Health Policy Directive *NSW Health Code of Conduct* [PD2015_049]) and any other applicable policy directive.

2.4. NSW Health Agencies and Treating Practitioners

Both the NSW Health Agency and the treating practitioner must ensure that financial consent has been obtained and where required, a valid referral for Medicare billing purposes. There must also be evidence that the patient chose to be a private patient.

Where a service is not clinically relevant it cannot be billed to Medicare [12].

Medicare benefits cannot be paid for services already funded under a Commonwealth or State arrangement. In other words, the service cannot be paid for twice.

2.5. General Requirements

Medicare billing is permissible for treating practitioners contracted or employed by the NSW Health Agency but only when exercising a right of private practice to ensure separation from NSW Health. This requirement applies to Staff Specialists Levels 1 to 5 equally. General requirements for billing Medicare in public health facilities are:

- The patient must have chosen to be treated as a private patient, be informed of any costs and be eligible for a Medicare benefit.
- The treating practitioner must have a valid referral for Medicare and NHRA purposes prior to the attendance/procedure. Refer to section 3.2 for more information.
- The attendance/procedure must be personally performed (unless otherwise stated in the MBS).
- The treating practitioner must choose the appropriate item number and meet the requirements of the MBS item descriptor.
- The MBS item number must be correctly billed for the service(s) provided.
- The service(s) performed must be eligible under Medicare and not funded by other Government means or a third party (for example, Department of Veterans' Affairs [DVA], motor accident, workers compensation); and
- The attendance or procedure must be documented and/or reported in the patient's health record. It must include the signature (digital or electronic unless paper based) of the practitioner who personally performed the service.

Current public inpatients attending an outpatient clinic at the hospital cannot be billed. These services form part of the admission and are not a distinct event.

The way this information is collected will depend on the setting (admitted or non-admitted).

Where an admitted patient (including Hospital in the Home [HITH]) seeks routine or pre-scheduled care independent of the hospital, this can be billed (Medicare billing in public hospitals - overview) [13]. For example, services sought by patients independent of the hospital whilst on leave (visits to an optometrist, allied health private provider).

2.5.1. Personal Performance

The MBS outlines those medical services where personal performance is required to claim a rebate from Medicare regardless of essential assistance being provided by a doctor in training. These services include:

- all Category 1 – Professional Attendance items except:
  - 170-172, 342-346, 820-880, 6029-6042 and 6064-6075.
- all Group T1 (Miscellaneous Therapeutic) items except:
  - 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13750-13760, 13950, 14050, 14218, 14221 and 14245.
- all Group T4 (Obstetric) items except:

- 16400 and 16514.

- all Group T3, T6, T7, T8, T9 and T10 items
- certain item numbers in Group D1 – Miscellaneous Diagnostic (refer to the MBS GN.12.30).
- Item 15600 in Group T2 (Radiation Oncology).

'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' [14].

Medicare benefits are not payable for these group items or any of the items listed 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' [14].

Professional referred consultation services may only attract Medicare benefits if the service is personally performed by the medical practitioner. That is, where the consultation is face to face, the practitioner must physically attend the patient regardless of essential assistance being provided by a doctor in training. For more information on referred consultation services go to the DOHAC's webpage, Medicare billing in public hospitals.

2.5.2. Specialist Trainee Assistance

Claiming for services utilising a specialist trainee as "personal performance" is permissible so long as those services rendered by the specialist trainee were completed under the direct supervision of the treating practitioner that is, the treating practitioner must be present at all times [8] and two or more patients cannot be attended simultaneously [14]. Appropriate disclosure should be made to the patient on election where specialist trainees may perform services on behalf of the treating practitioner. TN.1.20 (MBS) provides further detail [3].

2.5.3. Professional Services not Requiring Personal Performance

Some medical services in Category 2 *Diagnostic Procedures and Investigations*, Category 3 *Therapeutic Procedures* and Category 5 *Diagnostic Imaging Services*, will attract Medicare benefits if the service is provided either by the medical practitioner or a person who is employed by the practitioner, or in accordance with accepted medical practice, acts under the supervision of a medical practitioner [15].

Category 6 *Pathology* has its own notes for billing arrangements in the MBS please refer directly.

2.5.4. Aftercare (post-operative treatment)

Under the *Health Insurance Act 1973* (Commonwealth), a professional service is deemed to include 'all professional attendances necessary for the purpose of post-operative treatment of the person to whom the professional service is rendered' [8]. This means that 'aftercare is deemed to include all post-operative treatment rendered by practitioners and includes all

professional attendances until recovery from the operation, the final check or examination, regardless of whether the attendances are at the hospital, private rooms, or the patient's home' [7].

In accordance with the MBS, the aftercare period is determined by the medical practitioner and can differ between patients undergoing the same operation or different operations. In other words, it is individualised. A single attendance post-operatively may not be sufficient and further attendances and/or treatment may be required without further cost to the patient.

Video consultations where they are safe and clinically appropriate are subject to the same aftercare rules as face to face consultations, in accordance with relevant professional standards.

2.5.5. Public Patients

'All care directly related to a public inpatient's care must be provided free of charge. Where a patient has received inpatient treatment in a hospital as a public patient...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 NHRA' [7].

'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' [7].

2.5.6. Private Patients

Medicare will not normally pay for any consultations during an aftercare period as the Schedule fee for most operations, procedures, fractures and dislocations listed in the MBS item includes a component of aftercare.

There are some instances where the aftercare component has been excluded from the MBS item and this is clearly indicated in the MBS item description.

If a service is provided during the aftercare phase for a condition not related to the operation, then this can be claimed, provided the account identifies the service as "Not normal aftercare", with a brief explanation of the reason for the additional services.

If a patient was admitted as a private patient in a public hospital, then unless the MBS item descriptor specifically states that the fee does not include aftercare, no Medicare benefits are payable for aftercare.

Where a private patient independently chooses to consult a different private medical practitioner for aftercare, that service will attract Medicare benefits.

Practitioners should familiarise themselves with the full MBS note TN.8.4.

2.6. Telehealth Attendances (not phone attendances)

In accordance with AN.40.1 of the MBS, a telehealth attendance means 'a professional attendance by video conference where the medical practitioner:

- Has the capacity to provide the full service through this means safely and in accordance with relevant professional standards; and

- Is satisfied that it is clinically appropriate to provide the service to the patient; and
- Maintains a visual and audio link with the patient; and
- Is satisfied that the software and hardware used to deliver the service meets the applicable laws for security and privacy' [16].

Note – 'only the time where a visual and audio link is maintained between the patient and the provider can be counted in meeting the relevant item descriptor' [16].

2.7. Figurehead billing

Figurehead billing (using a single provider's name/provider number to bill Medicare) is only permitted under the *Health Insurance Regulations 2018* (Clauses 52, 54, 56) [Commonwealth] for specific services generally provided in the specialties of diagnostic imaging, pathology and radiation oncology, regardless of setting (admitted or non-admitted).

The figurehead takes primary responsibility for claims made under the legislative scheme. The figurehead should establish processes to ensure they are confident the relevant elements to make a Medicare claim have been satisfied by practitioners within the agreed group.

2.8. Assignment of benefits

There are 2 types of assignment of benefit forms: simplified billing form (admitted patients) and the assignment of benefits for bulk billed services (non-admitted patients).

*Treating practitioners are not required to retain a copy of the assignment of benefit form. However, Medicare can still require the practitioner to substantiate a claim by other means. Documents to substantiate a claim include:

- A copy of the referral (where applicable).
- Evidence that the patient chose to be treated as a private patient.
- An extract from the clinical records showing that the treating practitioner personally rendered the service (where applicable).
- A copy or extract of a document that verifies authorisation to exercise RoPP in a public hospital including outpatient services [17].

*As at the date of publication. The Commonwealth Department of Health and Aged Care

3. Rights of Private Practice, Referrals and Requests

Employment of any type by a public health facility does not automatically entitle a treating practitioner to bill patients. The practitioner must have a right of private practice (RoPP) as a condition of their appointment or as part of an overall arrangement.

Private practice arrangements:

- Provides patients with a choice of receiving treatment as public or private patients.

- Provides opportunity for practitioners to supplement their income.
- Acts as a tool for recruitment and retention of a skilled medical workforce for public health facilities.
- Optimises the use of public sector infrastructure ensuring a more cost-effective use of high-cost technology and support services [18].

Treating practitioners when exercising RoPP must comply with applicable NSW Health policy directives and guidelines, contract terms and industrial instruments, including but not limited to (as varied from time to time):

- Staff Specialists – the *Staff Specialists Determination 2015* and NSW Health Policy Directive *Staff Specialist Rights of Private Practice Arrangements* (PD2017_002)
- Visiting Medical Officers – NSW Health Guideline *Standardised Licence Arrangements for VMOs Providing Private Non Admitted Services* (GL2009_008)
- Clinical Academics – NSW Health Policy Directive *Clinical Academics Employed in the NSW Health Service* (PD2019_055)
- NSW Health Guideline *Improving Access to Primary Care in Rural and Remote Areas (s19(2) Exemptions) Initiative* (GL2023_019).

3.1.1. Industrial arrangements for locums

Approved industrial RoPP arrangements remain the same for locums. If employed as a Staff Specialist, they must choose a RoPP scheme level (1-5). If they choose a level 2-5, the Staff Specialist is entitled to drawing rights. Visiting Medical Officers (VMO) are entitled to retain their private practice revenue, subject to any licensing agreement.

3.1.2. Other Treating Practitioners

In the NSW public hospital system, practitioners other than medical practitioners, may also be eligible to exercise RoPP and bill chargeable patients. These practitioners must practice privately in their own time. These practitioners must comply with the following:

- *Section 3C Midwife and Nurse Practitioner Services, Determination 2020*
- NSW Health Policy Directive *Allied Health Professionals' Right of Private Practice in NSW Health Facilities* (PD2015_017)
- NSW Health Policy Directive *Oral Health Practitioners Private Practice Scheme* (PD2018_005)
- NSW Health Policy Directive *Visiting Endorsed Midwife Practice* (PD2023_036).

3.1.3. Facility fees

Facility fees are payable by treating practitioners exercising a RoPP in public facilities. This includes level 2-5 Staff Specialists (admitted/non-admitted) and VMOs exercising RoPP (non-admitted). These fees help to compensate the public health facility for the use of its infrastructure and resources when generating a private practice income.

Facility fees vary depending on the employment type, the speciality and the location where the service is performed (admitted/non-admitted).

3.2. Referrals

A medical practitioner exercising RoPP in a NSW Health Agency can only bill Medicare with a "valid" referral. GN.6.16 of the Medicare Benefits Scheme (MBS) describes the Medicare requirements for a referral to be considered "valid". The *Health Insurance Regulations 2018* (Commonwealth), Part 11, Division 4 also describes the manner of referrals.

A referral from a general practitioner (GP) is usually valid for 12 months (unless stated otherwise) from the date of first service. A referral from a specialist or consultant physician is valid for 3 months from the date of service. A referral written whilst the patient is an admitted patient is valid for3 months or the duration of the admission, whichever is longer.

3.2.1. Format of referrals

In NSW referrals must be:

- Written by a medical practitioner with a RoPP in a public health facility or in external private practice.
- Addressed to a clinician by name who has a RoPP.

Other restrictions include:

- No patient who presents at the emergency department/service, is to be privately referred for treatment of, or examinations relating to, the episode of illness that caused the patient to present to emergency.
- No patient who is attending an outpatient clinic is to be privately referred for treatment of, or examinations relating to the episode of illness which caused them to attend the outpatient clinic unless such referral is specifically agreed to by the patient.
- At the time of the outpatient appointment, the patient must be advised that they are a private patient of the practitioner and as such, will be charged accordingly [19]. This does not necessarily imply that they will be charged an out of pocket fee. The treating practitioner can choose to bulk bill.

If a patient wants to be a private non-admitted patient in the absence of a valid referral, the patient can request a new valid referral from their referring practitioner. Further advice is provided in the Department of Health and Aged Care's (DOHAC) Medicare billing in public hospitals - overview.

If a referral fails to meet all legislative, Commonwealth and State requirements, the referred patient cannot be treated as a private patient at the public health facility.

3.2.2. Other practitioners outside NSW Health

The following practitioners can also refer (with conditions):

- Optometrists may refer a patient to an ophthalmologist [20, pp. 11, pp. Part 11, Div 4 Section 96].

- An approved dental practitioner may refer a patient to a specialist or consultant physician, where the referral arises from a dental service [20, pp. 11, pp. Part 11, Div 4, Section 96].
- A participating midwife may refer a patient to an obstetrician or paediatrician [20, pp. 11, pp. Part 11, Div 4, Section 96].
- A participating nurse practitioner may refer a patient to a specialist or consultant physician [20, pp. 11, pp. Part 11, Div 4, Section 96].

3.2.3. Exceptions

A GP registrar may refer a patient to a specialist or consultant physician. **This referral is valid for Medicare billing purposes**.

NSW Health nurse practitioners (**NPs**) may only use an MBS provider number to facilitate diagnostic requests and specialist referrals to providers **external to NSW Health**. For example, where an NP needs to refer a patient to a private specialist, an external pathology service or medical imaging service that is **not** contractually arranged to provide services for NSW Health.

As NSW Health NPs do not have RoPP, NSW Health Agencies are not to utilise the NP's provider number when a patient is classified as a 'private patient' for Medicare billing purposes.

3.3. Referrals that cannot be used for Medicare billing

The following referrals **cannot** be used for Medicare billing:

- Referrals generated in an emergency department to an outpatient department to receive services from a medical practitioner exercising RoPP.
- Referrals to an outpatient clinic or hospital rather than to a named physician.
- Referrals written by an intern, resident medical officer, career medical officer, non-GP registrar or medical superintendent; and
- Referrals to oneself.

Refer to the askMBS Advisory *Non GP specialist and consultant physician services* paragraph 2.5.

3.3.1. Emergency Departments/Services

Eligible persons presenting to an emergency department or service **cannot** be referred to an outpatient department to receive services from a medical practitioner exercising RoPP under the terms of employment or a contract with a hospital which provides public hospital services [21]. Any requests for diagnostic imaging and pathology services ordered or performed while an eligible person is in the emergency department, prior to the decision to admit, cannot be billed to Medicare. This does not apply to s19(2) exempt sites (see section 2.1.1).

Where a public patient independently chooses to consult a medical practitioner in private practice for aftercare following treatment at a public emergency department, this attendance will attract a Medicare benefit [7].

A patient who is admitted to an Emergency Department Short Stay Unit (EDSSU), can elect to be private or public.

3.3.2. Discharge Summaries/Referrals

On discharge it is expected that patients should have discharge summaries/referrals sent to their general practitioner, where recommendations can be made for the appropriate management of services the patient may require. The discharge summary should also state whether the patient was admitted as public or private [1].

A hospital discharge summary is not designed to be a valid referral. Discharge summaries support the transfer of patients from hospital back to the care of their nominated primary healthcare provider.

3.4. Inappropriate Referral Practices

If a follow-up after discharge is a necessary component of the service and is at the recommendation of the practitioner working at the public hospital, the follow-up treatment can be considered an intrinsic part of the public hospital episode of care and is not expected to be billed to Medicare. The patient attending the follow-up appointment is therefore a public patient.

A public patient should not be sent to a GP just for a referral to a named specialist.

Referrals cannot be backdated and cannot be shared by multiple medical practitioners when billing Medicare.

NSW Health Agencies must ensure that ‘referral pathways are not controlled so as to deny access to free public hospital services. Referral pathways must not be controlled so that a referral to a named specialist is a prerequisite for access to outpatient services’ [2, p. 83].

3.5. Electronic Signatures (askMBS advisory)

‘It is sufficient to indicate on the face of the electronic referral that it has been ‘signed electronically’ by the referrer, provided that the specialist or consultant physician, as the person accepting the referral, consents to this approach. This means that a specialist or consultant physician could accept an electronic referral which simply states that it is “digitally signed by [provider name]”. If a referral is clear in the reasons for the referral and identifies the referring party and is submitted electronically, then there would be no need for a hard copy signature. Examples of electronic signatures include:

- A hard copy document which is signed and then provided electronically’ (for example, scanned document).
- ‘A typed signature block at the end of an email (for example, Yours faithfully, Dr Joan Brown) which has been sent from Dr Brown’s email account.
- Medical software which requires doctors to log on (with a password) in order to generate and securely send a referral to a specialist.

There is no requirement for the software to store or attach a scanned hard copy of the doctor’s signature, provided:

- There is an appropriately reliable method for ensuring that the referral was actually authorised by the named doctor [or practitioner] and
- The practice saves, stores and retains access to electronic referrals so they can be retrieved unaltered (for example where the Department of Health requests a copy)' [22, p. 3].

3.6. Request Forms for private patients

Diagnostic services (pathology/diagnostic imaging) do not require referrals – they are initiated via request forms. Request forms do not need to be addressed to a particular clinician, they do not require a signature and do not expire. The requesting practitioner's name and provider number/practice address must be included on the request.

For a diagnostic service to receive a Medicare rebate, the medical practitioner must be exercising a RoPP or be in private practice when completing diagnostic requests as part of their overall clinical assessment of a private patient (specific performance should be undertaken). Consequently, interns, resident medical officers and registrars are only to submit diagnostic requests for public services, notwithstanding they are considered *Other Medical Practitioners* (OMPs*)* by Medicare Australia. They can write referrals and requests that can attract Medicare benefits when working **outside** the public hospital system.

The Health Insurance Regulations 2018 permits non-admitted patients to take request forms to a provider of their choosing regardless of the branding on the form. Where a patient is treated as a private patient, the requested diagnostic can be billed to Medicare by any provider at any location. The patient is not required to only attend the public hospital's diagnostic/pathology department.

It should be noted that NSW Pathology, NSW public hospital diagnostic imaging departments and other pathology/diagnostic imaging providers engaged by Local Health Districts and Specialty Networks must meet both the requirements of Commonwealth legislation and the National Health Reform Agreement (NHRA) in order to bill Medicare for services rendered at or on behalf of a NSW public hospital.

Eligible persons who present to an emergency department and receive a request form for a diagnostic imaging or pathology service that service cannot be billed to Medicare. This includes standing orders and approved emergency department nursing protocol requests.

Note, E-orders for chargeable services where the patient was/is admitted as a public patient are not billable.

For more information access the MBS Factsheets 2022.

3.7. Substantiating a Claim – services rendered at a public hospital

All health practitioners who provide or initiate a service where a Medicare benefit is payable, must maintain *adequate* and *contemporaneous* records. 'For a Medicare claim to be paid for a patient in a public hospital:

- The patient must give informed financial consent to be treated as a private patient, and

- The consultant physician or specialist must be exercising their right of private practice when the service was rendered [23].

The name or signature (including electronic or digital signature) of the health practitioner performing the service must be included in the documentation. Under Medicare, each billing practitioner must ensure that the requirements specified in the MBS item descriptor have been met and that the services provided are eligible for a Medicare benefit.

Evidence that can be used to substantiate specific treatment include:

- An operation report
- A diagnostic imaging report
- A pathology report
- An excerpt from the patient's clinical record showing the patient's name, the date of the service and sufficient information to indicate that all components of the treatment, procedure or investigation were performed'. [17]

Referrals and requests must be held for 2 years from the date of service and can be used to substantiate a claim if audited.

DOHAC does advise that in most cases, a patient's clinical information will be the only way to confirm that the patient attended a service, had specific treatment, had a valid referral or a valid request form which is why maintaining adequate and contemporaneous records is so important.

For further information access the DOHAC's Practitioner Review Program - *Health professional guidelines*, in particular *Guideline for substantiating personal performance by a consultant physician/specialist in a public hospital*.

3.8. Telehealth

Telehealth can be utilised in facilities subject to the telehealth alternative being safe and clinically appropriate to do so in accordance with relevant professional standards. All MBS telehealth items are stand-alone items and are to be billed instead of face to face MBS items. The telehealth requirements outlined in AN.40.1 must be complied with.

Telehealth cannot be used for hospital inpatients.

4. Patient Choice and Financial Consent/Election

Every eligible person has the right to choose to be a public or private patient in a public hospital. This choice must be based on informed financial consent. A patient can choose to be a public patient regardless of their private health insurance status or valid outpatient referral.

4.1. Requirement for Financial Election

Under the National Health Reform Agreement (NHRA), eligible persons attending a public hospital will be treated as public patients unless they choose to be treated as private (chargeable) patients. Eligible persons presenting at an Emergency Department will be treated as public patients and '…on admission, the patient will be given the choice to elect to be a public or private patient…' [2, p. 83].

Where the care is for the same condition and no change in election status, there is no need for a new election. Where the care is for the same condition, but due to one of the conditions of the NHRA, a patient needs to change election status, (for example, financial hardship), a new election should be obtained.

Where the care is for a new/different condition, for informed financial consent reasons (that is, not presuming the patient wants all care done publicly or privately), a new election should be obtained.

4.2. Emergency Presentations

Eligible persons presenting to an emergency department or service are treated as public patients. All services provided (including diagnostics) are free of charge. No charges are to be raised against the Commonwealth. Any referrals, requests generated in the emergency department cannot be used to bill Medicare. This does not include hospitals with an s19(2) exemption (see section 2.1.1).

4.3. Admitted Patient Consent Requirements

Schedule G of the NHRA states: '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 [2, p. 82].

Patients electing to be private have a choice of doctor and their election must be based on informed financial consent.

If a patient elects to be treated as public, all care directly related to the episode of admitted patient care will be provided free of charge as a public hospital service regardless of whether it is provided at the hospital or in private rooms [2]. The patient will be treated by a doctor nominated by the hospital, which may include a doctor in training (under supervision).

4.4. Non-Admitted Patient Consent Requirements

Consistent with the requirements of G19 of the NHRA, an eligible patient presenting at a public hospital outpatient department will be treated free of charge as a public patient unless the patient has been referred to a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient.

Medical practitioners are required to obtain this election based on informed financial consent. This means the provision of cost information to patients (including any likely out of pocket expenses) by a medical practitioner or other health service provider about a proposed treatment or admission to hospital. This election must be confirmed in writing using the *Outpatient Financial Election Consent* form.

Under the *Competition and Consumer Act 2010* (Commonwealth), medical practitioners must take care not to:

- Mislead patients relating to fees, procedures or outcomes.
- Use misleading advertising relating to fees, procedures or outcomes.
- Act unconscionably by acting in bad faith and deliberately taking advantage of patients who are disadvantaged by:
    - ignorance of important facts that you know but they don't understand
    - financial problems
    - infirmity or age
    - lack of understanding of the nature of the transaction
    - lack of assistance or explanation when these are necessary
    - a special disadvantage that might impair their capacity to judge what is in their best interests, such as English being their second language or situational factors causing a lack of practical alternatives.

For the avoidance of doubt, informed financial consent for patient election is separate to the requirement for consent to medical and healthcare treatment as outlined in NSW Health Policy and Procedure Manual *Consent to Medical and Healthcare Treatment Manual*.

4.4.1. Where financial consent only is required

There are limited services and situations where financial consent only is required in the absence of a referral. This includes:

- Pre-anaesthesia consultation item numbers (17610-17625) when the patient has elected to be a private patient for their upcoming admission.
- Emergencies – applicable to initial attendance only.
- Lost, stolen or destroyed referrals – applicable to initial attendance only.

4.4.2. Where no gap will be charged

In circumstances where the service provided does not generate an out of pocket expense for the patient, upon request by the medical practitioner (or visiting endorsed midwife [VEM]) with rights of private practice, NSW Health administrative staff will facilitate the financial election and consent of patients through the approved form (*Outpatient Financial Election Consent – No Gap*) and support material annexed to this Policy Directive. For Staff Specialists, this process will automatically occur unless advised otherwise.

Questions unable to be answered by administrative staff in the first instance will be directed to the medical practitioner or VEM to discuss with the patient.

If the patient is a public patient, or is unwilling to sign the consent form, the treating practitioner will be informed. In these circumstances, the patient will be seen by a medical practitioner or midwife nominated by the facility.

When billing is undertaken directly by the treating practitioner (where permitted), this process is recommended but not mandatory, as obtaining consent is a matter between the patient and the treating practitioner.

4.4.3. Where there is a gap or fee is unknown

Where fees are unknown or in excess of the Medicare rebate, the treating practitioner will provide the patient with an estimate of the fees to be charged and other relevant information.

The treating practitioner is required to obtain the election and consent of patients via use of the approved form (*Outpatient Financial Election Consent – Gap*) and support material annexed to this Policy Directive. The treating practitioner will also be required to acknowledge a patient's signed election and consent form by way of signature.

If the patient is a public patient or is unwilling to sign the consent form, the treating practitioner must be informed. In these circumstances, the patient will be seen by a treating practitioner nominated by the facility.

Where billing is undertaken directly by the treating practitioner (not permitted for Staff Specialists), this process is recommended but not mandatory, as obtaining consent is a matter between the patient and the doctor.

4.4.4. Approved Forms and support materials

Approved forms and support materials have been developed to cover a patient's private election, including informed financial consent and are annexed to this Policy Directive.

NSW Health Agencies may utilise an electronic version of the consent form so long as the broad considerations are carried across, noting character limitations.

The *Outpatient Financial Election Consent* forms must be retained in accordance with the *Health Records and Information and Privacy Act 2002* (NSW) and NSW Health policy.

4.5. Changes in financial election – admitted patients

Patients can alter their financial election as described in schedule G of the NHRA and NSW Health Policy Directive *Admitted Patient Election Processes* (PD2021_046). In circumstances where a valid election has been made but subsequently changed due to 'unforeseen circumstances' the change in election is effective from the date of the change onwards. Every effort must be made to inform the treating practitioner/s of any change in election status.

4.5.1. Deferred Elections

Where admitted patients or their legally authorised representatives, for whatever reason, do not make a valid election or *actual* election [emphasis added], in NSW Health this is referred to as a deferred election. These patients will be treated as public patients and the hospital will choose the doctor [practitioner] until such time as a valid election is made.

Once a valid election is made, that election can be considered to be for the whole episode of care, commencing from admission. Where the patient elects to be private/chargeable the consent of the treating practitioner is recommended. This is particularly relevant for smaller sites with limited administration coverage.

4.5.2. Changes in financial election post procedure

If a change in financial election occurs post procedure (and therefore a change in the financial classification), the treating practitioner must be informed. A change to a chargeable financial classification should not occur post procedure without the consent of the treating practitioner/s.

If the patient has a deferred election status at the time of the procedure, that patient is deemed to be a public patient until such time that a decision is made. If the patient elects to be a public patient, this decision does not change the financial circumstances of the patient, nor does it impact the treating practitioner. Therefore, consent of the treating practitioner is not required. The change is retrospective.

4.5.3. Changes in financial election – non-admitted patients

A non-admitted patient is a public patient unless the patient elects to be seen as a private patient and has a 'named' referral. If the public patient wishes to be seen in a private capacity, but does not have an appropriate referral, it is acceptable for the hospital to request a named referral. It should be made clear that the request is at the bidding of the patient [13]. This information must be communicated to the treating practitioner.

4.6. Indemnity Coverage

If the NSW Health Agency has yet to discuss/confirm the financial election with the patient or their legally authorised representative (for example, an emergency patient) and a procedure is required, that patient will be treated as a public patient, until such time that a decision is made by the patient or their representative. This extends to where a procedure takes place prior to the medical practitioner being notified of the private election. In these circumstances, the relevant indemnity arrangements which apply to public patients remain until the treating practitioner is notified of the election, or until reasonable attempts to notify the treating practitioner have been made and documented.

Staff Specialists are automatically indemnified through the Treasury Managed Fund (TMF) against liability for claims arising during the course of treating public patients as an employee of NSW Health.

For Visiting Medical Officers (VMO) and Honorary Medical Officers (HMO), they will be indemnified through the TMF against liability for claims arising during the course of treating public patients in circumstances where they have entered into a valid signed contract of liability. TMF indemnity will apply in accordance with the terms of the relevant contract of liability coverage.

4.7. Out of pocket expenses

Staff Specialists cannot charge an out of pocket expense in accordance with NSW Health Policy Directive *Staff Specialists Rights of Private Practice Arrangements* (PD2017_002) and this Policy Directive. Non-admitted patients may only incur out of pocket expenses for those services permitted under Schedule G1 of the NHRA [24]. As contractors, VMOs enter into a financial agreement with their private patients and can charge an agreed amount. This arrangement is between the VMO and the patient, not the hospital. However, it is important

that the VMO advises the hospital that the patient is private to ensure no duplicate payments to the Loal Health District/VMO.

VMOs can also elect to participate in the billing of privately referred non-inpatients and, where the NSW Health Agency is acting as their billing agent, the *Outpatient Financial Election Consent Form* must be used. Treating privately referred non-inpatients is a voluntary arrangement and must be in accord with NSW Health Guideline *Standardised Licence Arrangements for VMOs Providing Private Non Admitted Services* (GL2009_008). Under this Guideline, VMOs are to pay an infrastructure (facility) fee to compensate the NSW Health Agency for the use of its facilities, staff and equipment. Under these arrangements, VMOs can still elect to do their own billing.

5. Submission of Claims

Only the treating practitioner can choose Medicare Benefits Schedule (MBS)/ Australian Medical Association (AMA) item numbers. Where the NSW Health Agency acts as their billing agent it must provide the practitioner with the opportunity to select the appropriate item, and where they so choose, to review those items. In addition, the NSW Health Agency must provide visibility to the practitioner of all billing occurring under the practitioner's Medicare provider number. This extends to Level 1 Staff Specialists.

Where claims have been submitted and rejected by Medicare and/or the private health insurer, the billing system will record the error code and descriptor. This will determine what is needed to resubmit the claim successfully. The treating practitioner should be contacted if the MBS item number is the cause of the issue or where it is a shared responsibility (for example, invalid referral, further information is required to assess the claim etc).

For admitted patient billing, the medical practitioner can use the Clinician Billing Portal (CBP). The CBP permits medical practitioners to enter, amend or delete MBS item numbers prior to submission to Medicare.

For non-admitted patient billing, it is expected that the medical practitioner who is billing in that clinic will be provided with an attendance list of private patients. The practitioner should indicate on the list, the MBS item number(s) for the attendance/treatment provided. It should be initialled and dated prior to returning the list back to the clerk. An example of such a list is provided in Appendix D. Note, this does not preclude the use of electronic/digital lists, MBS item capture for the medical practitioner.

5.1. Reviewing MBS Item Numbers

Where the NSW Health Agency undertakes billing on behalf of the treating practitioner, reports can be requested by the practitioner through the NSW Health Agency's billing system. If an error is identified, the treating practitioner should contact the NSW Health Agency's finance department to rectify the error using the prescribed Medicare form. The frequency of these reports is to be determined at a local level.

The use of appointment booking systems is recommended when providing treating practitioners with the opportunity to review MBS item numbers entered in the booking system prior to submission to Medicare via the billing system. Alternatively, local processes can be

established to provide practitioners with the opportunity to review item numbers prior to entry into the billing system.

For radiology, the NSW Health Agency's Radiology Information Systems & Picture Archiving & Communications System (RIS-PACS) should be used for practitioners to review MBS item numbers prior to submission.

5.2. Private Health Insurance (PHI) Act 2007 section 121-5 – Hospital Treatment

Advice from the Department of Health and Age Care (DOHAC) with regard to s121-5 – hospital treatment states: 'Hospital treatment is defined in Section 121-5 of the PHI Act 2007 and includes any treatment (including goods or services) intended to manage a disease, injury or condition, provided at a hospital (or with the direct involvement of the hospital)' [25].

Where an MBS item is listed on the Type C 'exclusion list' found in the *Private Health Insurance (Benefit Requirements) Rules 2011* it is excluded from the definition of hospital treatment and can therefore be paid at a rate higher than 75 percent.

The practical consequence for staff specialists or visiting practitioners treating privately referred non-inpatients in NSW public hospitals is that where the practitioner performs a Type C procedure (that is, with one of the MBS item numbers listed in Sch 3, cl 8 of the Benefit Rules), on hospital premises or using hospital facilities, and does not issue a certificate that the procedure needed to be performed at the hospital, the procedure will not constitute "hospital treatment" and the practitioner can claim the higher benefit [26].

Where a benefit is greater than 85%, that fee will be paid in accordance with the item's fee as described in the MBS [27].

6. Governance, Performance and Accountability

The delivery of private practice arrangements in NSW public hospitals must be effectively managed and monitored to achieve desired outcomes. NSW Health Agencies must:

- Ensure appropriate and effective governance is established and sustained. Use meaningful key performance indicators as a tool to measure performance.
- Establish a local performance and governance approach that clearly defines objectives and performance expectations with a central point of accountability to ensure that local private practice activities achieve their objectives in a sustainable manner. This is particularly relevant for revenue/finance managers.
- Ensure internal controls are in place to safeguard overall business integrity and compliance with policy directives and Commonwealth legislation or advice.

6.1. Governance Approach

In accordance with their *Service Level Agreements* (SLAs) and *Financial Requirements and Conditions of Subsidy* (COS), NSW Health Agencies must ensure that they manage their sources of revenue in a sustainable manner.

A large component of Own Source Revenue (OSR) is patient fees. The annual and monthly revenue reporting requirements as described in the COS must be complied with. The Chief Executive must ensure that billing practices comply with the laws, policies and other requirements as described by NSW Health and the Commonwealth Government.

Where private practice arrangements are in place, NSW Health Agencies and treating practitioners have separate and joint responsibilities (described in section 1 and section 2). Both parties are responsible for the implementation and operation of services provided to private patients at a local level. A robust governance framework should be implemented.

Such a framework should ensure the following:

- Compliance with this Policy Directive.
- Support the development and implementation of local operational policy for admitted and non-admitted billing.
- Clearly articulate objectives and desired outcomes for providing services to private patients which are regularly measured against key performance indicators (described in the SLA and the COS).
- Ensure that the NSW Health Agency is remunerated for use of its facilities and other resources.
- That services provided to private patients are always available to public patients in accordance with the National Health Reform Agreement's (NHRA) Subclause 11a and Schedule G.
- Initiate remedial action where required and/or escalate as appropriate.

6.2. Performance and Accountability

Documented internal controls must be embedded in the operations of management and governance processes that ensure:

- The activities of private practice are conducted in a manner that facilitates the achievement of the NSW Health Agency's objectives and the delivery of its services in an orderly and efficient manner.
- Routine reports are provided to practitioners exercising rights of private practice (RoPP) detailing Medicare Benefits Schedule (MBS) items billed under their provider numbers.
- Error, fraud and other irregularities are prevented as much as possible and promptly detected through a systematic approach if they occur.
- Assets and consumables used in private practice activities are safeguarded from unauthorised use or disposal and are adequately maintained and monitored.
- Financial management performance reports are timely, relevant, reliable and accurate.
- NSW Health Agencies should use the resources provided by the Ministry of Health including (but not limited to) the revenue portal, clinician billing portal and the Revenue SharePoint.

7. Setup and Management of MBS billable Clinics

Before deciding to establish a specialist clinic to treat privately referred non-inpatients, public hospitals must consider the likely costs and benefits of this service delivery model, the funding arrangement currently in place and the clinic's ability to meet service demands (including growth). Adherence to the Medicare Principles and Commitments at section 68 of the *Health Services Act 1997* (NSW) is required. This includes equal access to services irrespective of patient election status.

Consideration should be given to:

- Outpatient activity levels
- Suitability of the clinic to provide billable services (not every speciality is conducive to Medicare billing (for example, fracture clinics)
- The models of care utilised (for example, multi-disciplinary clinics)
- Associated diagnostics.

MBS rates in many categories are not designed to fund full practice costs and therefore generating income solely from MBS revenue may not cover all costs. The cost associated with public patient activity will also need to be factored in.

NSW Health Agencies will need to undertake local financial analysis to determine whether the operation of MBS billed, non-admitted services is viable, having regard to activity based funding. This analysis should not impinge on the medical practitioner's right of private practice; however, a fully privatised clinic will be impacted if attendance rates or volume is low. A privatised clinic can only be made available if a **comparable service is offered to public patients**. If no alternative is offered, the clinic should be established outside of NSW Health.

Where a separate entity seeks to use NSW Health Agency facilities, a commercial arrangement must be entered into (for example, a lease for the premises or licence agreement). Commercial arrangements which are significant or potentially contentious must be referred to the Ministry of Health (Finance and Workplace Relations) for endorsement to ensure they are consistent with the overall functions of NSW Health.

8. References

[1] Australian Government Department of Health and Aged Care, "Ask MBS Advisories," 28 September 2021. [Online]. Available: https://www.health.gov.au/resources/collections/askmbs-advisories. [Accessed 20 July 2023].

[2] Australian Government - Federal Financial Relations, "Schedule J - Addendum 2020-2025 to the National Health Reform Agreement 2011," 1 July 2020. [Online]. Available: https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/NHRA_2020-25_Addendum.pdf. [Accessed 23 May 2023].

[3] Australian Government Department of Health and Aged Care, "MBS Online Therapeutic Note TN.1.20," 1 July 2024. [Online]. Available: https://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=TN.1.20&qt=noteID&criteria=TN%2E1%2E20. [Accessed 19 September 2024].

[4] R. Huxtable, "Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 - Final Report," 24 October 2023. [Online]. Available: https://www.health.gov.au/resources/publications/nhra-mid-term-review-final-report-october-2023?language=en. [Accessed 15 December 2023].

[5] NSW Government - NSW Health, "NSW Activity Based Funding and Activity Based Management Compendium 2022-23," NSW Health, 2022.

[6] Australian Government Federal Register of Legislation, "Health Insurance (General Medical Services Table) Regulations 2021," 1 July 2024. [Online]. Available: https://www.legislation.gov.au/F2021L00678/latest/text. [Accessed 23 September 2024].

[7] Australian Government Department of Health and Aged Care, "MBS Online - TN.8.4," 1 November 2023. [Online]. Available: https://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=TN.8.4&qt=noteID&criteria=TN%2E8%2E4. [Accessed 24 November 2023].

[8] Australian Government, "Federal Register of Legislation - Health Insurance Act 1973," 16 November 2023. [Online]. Available: https://www.legislation.gov.au/Details/C2023C00435. [Accessed 27 November 2023].

[9] Australian Government, Department of Health and Aged Care, "About the COAG Section 19(2) Exemptions Initiative," 5 August 2024. [Online]. Available: https://www.health.gov.au/our-work/coag-section-192-exemptions-initiative/about. [Accessed 23 September 2024].

[10] Australian Government -Services Australia, "Medicare," 12 October 2023. [Online]. Available: https://www.servicesaustralia.gov.au/medicare-provider-numbers-and-pbs-prescriber-numbers?context=34076. [Accessed 13 December 2023].

[11] NSW Government - NSW Health, "PD2019_027 - Employment Arrangements for Medical Officers in the NSW Public Health Service," 2 July 2019. [Online]. Available: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2019_027.pdf. [Accessed 8 December 2023].

[12] Australian Government Department of Health and Aged Care, "MBS Online Note - GN.6.16," 25 March 2023. [Online]. Available: https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Downloads-230301. [Accessed April 2023].

[13] Australian Government Department of Health and Aged Care, "Medicare billing in public hospitals - Overview," 20 March 2023. [Online]. Available: https://www.health.gov.au/resources/publications/medicare-billing-in-public-hospitals-overview?language=en. [Accessed June 2023].

[14] Australian Government Department of Health and Aged Care, "MBS online Note GN.12.30," 24 November 2023. [Online]. Available: https://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=GN.12.30&qt=noteID&criteria=GN%2E12%2E30. [Accessed 23 November 2023].

[15] Australian Government Department of Health and Aged Care, "MBS Online - Note GN.12.31," 1 November 2023. [Online]. Available: https://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=GN.12.31&qt=noteID&criteria=GN%2E12%2E31. [Accessed 27 November 2023].

[16] Australian Government Department of Health and Aged Care, "MBS Online - Note AN.40.1," 1 November 2023. [Online]. Available: https://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=AN.40.1&qt=noteID&criteria=AN%2E40%2E1. [Accessed 24 November 2023].

[17] Australian Government Department of Health and Aged Care, "Practitioner Review Program - Health professional guidelines," February 2017. [Online]. Available: https://www.health.gov.au/resources/collections/health-professional-guidelines. [Accessed February 2023].

[18] Queensland Department of Health, "Queensland Government Publications portal," April 2019. [Online]. Available: https://www.publications.qld.gov.au/dataset/private-practice/resource/3fab45ba-ed8e-4bb0-8722-ef3d4f85d428. [Accessed 10 July 2023].

[19] NSW Government - NSW Health, "Registered Non-Inpatients in Recognised Hospitals," 27 July 1981. [Online]. Available:

https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2005_501.pdf. [Accessed 4 December 2023].

[20] Australian Government, "Federal Register of Legislation - Health Insurance Regulations 2018," 22 November 2023. [Online]. Available: https://www.legislation.gov.au/Details/F2023C01017/Html/. [Accessed 22 Novemver 2023].

[21] Australian Government Federal Financial Relations, "National Health Reform Agreement 2011," February 2011. [Online]. Available: https://federalfinancialrelations.gov.au/agreements/national-health-reform-agreement. [Accessed 15 May 2023].

[22] Australian Government Department of Health and Aged Care, "Ask MBS Advisories," 28 September 2021. [Online]. Available: https://www.health.gov.au/sites/default/files/documents/2021/09/askmbs-advisory-non-gp-specialist-and-consultant-physician-services-askmbs-advisory-non-gp-specialist-and-consultant-physician-services.pdf. [Accessed 24 November 2023].

[23] Australian Government Department of Health and Aged Care, "Guideline for substantiating personal performance by a consultant physician/specialist in a public hospital," November 2016. [Online]. Available: https://www.health.gov.au/sites/default/files/documents/2022/01/guideline-for-substantiating-personal-performance-by-a-consultant-physician-specialist-in-a-public-hospital.pdf. [Accessed 27 November 2023].

[24] NSW Government - NSW Health, "PD2017_002 - Staff Specialist Rights of Private Practice Arrangements," 13 January 2017. [Online]. Available: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_002.pdf. [Accessed 10 October 2024].

[25] Australian Government Federal Register of Legislation, "Private Health Insurance Act 2007," 1 July 2023. [Online]. Available: https://www.legislation.gov.au/Details/C2023C00107. [Accessed 27 November 2023].

[26] B. C. K Richardson, "Advice on Section 10 of the Health Insurance Act," Sydney, 2022.

[27] Australian Government Department of Health and Aged Care, "MBS Online - Note GN.1.2," 1 November 2023. [Online]. Available: https://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=GN.1.2&qt=noteID&criteria=GN%2E1%2E2. [Accessed 27 November 2023].

[28] Australian Government Department of Health and Aged Care, "MBS Online Note IN.0.6," 1 November 2023. [Online]. Available:

https://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=IN.0.6&qt=noteID&criteria=Exemptions%20for%20R%2Dtype. [Accessed 24 November 2023].

[29] Victorian Government Department of Health, "MBS billing policy framework -Victorian public hospitals," April 2023. [Online]. Available: https://www.health.vic.gov.au/funding-performance-accountability/mbs-billing-policy-framework-victorian-public-hospitals. [Accessed 27 November 2023].

9. Appendices

1. Appendix A: Quick Reference tables
2. Appendix B: Resources
3. Appendix C: Financial Election Forms and Information Sheets
4. Appendix D: Sample Form and List

9.1. Appendix A: Quick Reference tables

Table 1. Emergency Departments/Services

Medicare billing is permitted	Not Permitted	Justification
Where the site is an s19(2) exempt site.	Any site without an exemption.	See NSW Health Guideline *Improving Access to Primary Care in Rural and Remote Areas (s19(2) Exemptions Initiative.* (GL2023_019).

Table 2. Referring patients from Emergency to non-admitted services

Medicare billing is permitted	Not Permitted	Justification
If an eligible patient post discharge from the emergency department (ED) has been referred to an outpatient clinic for the same reason they presented to the ED but *independently chooses to obtain a named referral from their general practitioner (GP) to be treated as a privately referred patient and this election is recorded. ***Not directed by staff towards a particular choice.**	When an eligible public patient has been referred to an outpatient clinic for the same reason they presented to the ED – all services are public and must be provided free of charge. The patient does not independently choose to obtain a named referral from a GP.	NSW Health Policy Directive *Registered Non-Inpatients in Recognised Hospitals* (PD2005_501) states: *No patient who presents at Casualty [Emergency] is to be privately referred for treatment of, or examinations relating to, the episode of illness which caused him/her to present at Casualty [Emergency].* NHRA G17, G18 MBS TN.8.4. Public Patients

Table 3. Referring patients from Emergency to admitted services

Medicare billing is permitted	Not Permitted	Justification
After the physician has made the Decision to Admit (DTA) and the patient elects to be private/chargeable, all services are billable regardless of the location of the patient from this point forward.	After the physician has made the DTA, and the eligible patient elects to be public. All services related to the public admission are free of charge.	NHRA G16, G17a, G18, G20. Department of Health and Aged Care (DOHAC)

Table 4. Eligible patients attending a non-admitted service

Medicare billing is permitted	Not Permitted	Justification
Where an eligible patient has a valid referral for Medicare and National Health Reform Agreement (NHRA) 2011 (NHRA) purposes and chooses to be seen in a private capacity and this choice is recorded. Or where the patient chooses to see another specialist within the same speciality (another named referral is not required).	Where an eligible patient has a referral that is valid for Medicare/NHRA purposes but chooses to be seen as a public patient, or has a referral addressed to the OPD, Junior Medical Officer (JMO), or Dear Dr.	NHRA G19 a & b, G20, DOHAC Overview, Askmbs Advisory - Non-GP Specialist and consultant physician services 2021 para 1.3.

Table 5. Eligible non-admitted patients requiring a non-admitted procedure

Medicare billing is permitted	Not Permitted	Justification
Where an eligible privately referred patient requires a procedure as a result of a consult, the procedure is deemed to also be private unless the patient indicates otherwise.	Where an eligible public patient requires a procedure as a result of a consult, the procedure is deemed to be public unless the patient independently chooses otherwise.	NHRA G19 b DOHAC Overview.

Table 6. Eligible non-admitted patients requiring to be seen by a different specialist/speciality

Medicare billing is permitted	Not Permitted	Justification
Where a private patient requires to be seen by another specialist – the specialist with consent of the patient, (and this is recorded) can write a valid referral to another specialist (cross-specialty referrals). Or when the patient chooses to be seen privately and the clinician can exercise right of private practice (RoPP).	Where a public patient requires a referral to another specialty/specialist, the patient will be public regardless of the validity of the referral (named or not), unless the patient independently chooses otherwise.	DOHAC Overview.

Table 7. Eligible non-admitted patients requiring an admission

Medicare billing is permitted	Not Permitted	Justification
Where a privately referred patient, after attending a clinic requires an elective/emergency admission, the medical practitioner may discuss their options (public/private). Where the patient chooses to be a private patient all components of the admitted episode of care (including pre-admission work ups –tests and diagnostics) will be chargeable.	Where a public patient requires an admission (elective or emergency), all care directly related to an episode of admitted patient care, should be provided free of charge as a public hospital service. This includes any pre-admission test/diagnostics or aftercare arrangements.	NHRA G16, G20, G30 e, f, g, h, I, j, k.

Table 8. Requesting diagnostics (imaging, pathology, other diagnostic services) – Emergency Department/Service

Medicare billing is permitted	Not Permitted	Justification
If the request is written after the DTA, and the patient has elected to be a private inpatient. **And** the request is written by a clinician who is seeing the patient in a private capacity.	If the request was written prior to DTA or the patient had elected to be a public inpatient.	NHRA G17, G18, G20. NSW Health Policy Directive *Employment Arrangements for Medical Officers in the NSW Public Health Service* (PD2019_027)

Table 9. Requesting diagnostics (imaging, pathology, other diagnostic services) – Non-Admitted

Medicare billing is permitted	Not Permitted	Justification
If the request is written by a treating practitioner who is seeing the patient in a private capacity, the patient had a valid referral and the private election was recorded.	If the request was issued by an intern, resident medical officer (RMO), Senior RMO or registrar, or by a doctor who was seeing the patient as a public patient.	NHRA G19, G20. NSW Health Policy Directive *Employment Arrangements for Medical Officers in the NSW Public Health Service* (PD2019_027)

Table 10. Requesting diagnostics (imaging, pathology, other diagnostic services) – Post Discharge

Medicare billing is permitted	Not Permitted	Justification
If the request is written by a treating practitioner seeing the patient in a private capacity and the patient has elected to be private (chargeable).	If the request was issued by an intern, resident medical officer, Senior RMO or registrar, or by a doctor who was seeing the patient as a public patient.	NHRA G19, G20. NSW Health Policy Directive *Employment Arrangements for Medical Officers in the NSW Public Health Service* (PD2019_027)

9.2. Appendix B: Resources

Department of Health and Age Care (DOHAC)

- About Medicare compliance
- Accessing Medicare for health practitioners and industry
- AskMBS Advisories
- Case Studies
- How to comply with Medicare Obligations
- Jurisdictional Guidance on when to claim 75/85/100% benefits under Medicare for health professionals – December 2021
- MBS Factsheets
- Medicare billing in public hospitals - Overview and FAQs
- Our Medicare compliance activities
- Practitioner Review Program – Health Professional Guidelines
- About the COAG Section 19(2) Exemptions Initiative

Federal Financial Arrangements

- National Health Reform Agreement 2011 and Addendum 2020-25

Services Australia

- Health Professionals webpage
- Health Professionals Education Resources – MBS

Australian Commission on Safety and Quality in Health Care (ACSQHC)

- AS18/10: Informed Financial Consent

Australian Medical Association (AMA)

- Informed Financial Consent

9.3. Appendix C: Financial Election Forms and Information Sheets

9.3.1. Outpatient Financial Election Consent– No Gap Form

NSW Health

Facility:

OUTPATIENT FINANCIAL ELECTION CONSENT - No Gap
Please complete prior to your first appointment

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR020245

PERSONAL DETAILS

Title: | Family Name: | Given Name:
Previous Family Name: | Date of Birth: | Sex:
Home Address:
Suburb: | State: | Postcode:
Phone Number: | Work/Mobile Number:

Are you Aboriginal or Torres Strait Islander origin?

☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - both ☐ Neither ☐ Unknown

TREATING CLINICIAN NAME: **OUTPATIENT CLINIC NAME:**

Outpatient Financial Consent

I choose to be treated as a private (Medicare funded) patient in the hospital's Outpatient Department.

As a private patient, I understand that Medicare funding will cover the full cost of this service, including treatments, tests and procedures, until my referral ends.

I understand that the doctor/s who provide/s the services will bulk bill Medicare for all consultations, treatments, tests and procedures provided by the hospital. I will not be required to pay any out of pocket charges for those services.

Where a test or procedure is provided by an external provider, there may be out of pocket charges above the Medicare rebate. The provider should discuss with you any out of pocket charges.

As a private (Medicare funded) patient I agree to be treated by the doctor named on this consent form who may not be the doctor named on the referral.

Patient Name: .....

Patient/Authorised Representative Signature: ..... *Date:* .....

Authorised Representative Name: .....

Relationship: .....

INTERPRETER Was an interpreter used to help the patient or their legally authorised representative to understand the information required for this form? Yes ☐ If yes, please complete the following:

Interpreter: ..... PRINT NAME ..... SIGNATURE ..... /..../20..... DATE ..... : ..... TIME ..... Emp ID/Prov No.

NH700722 300823

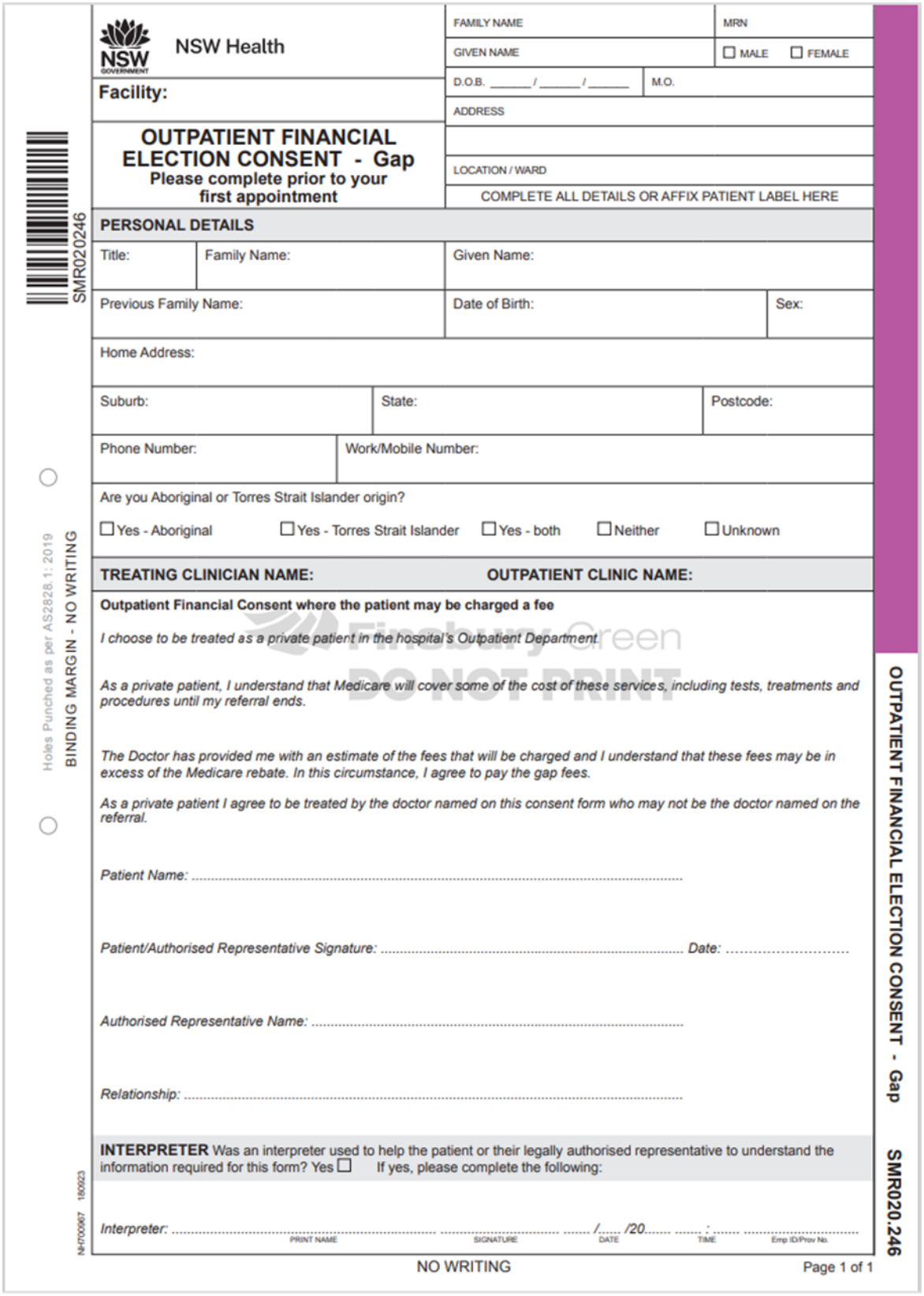
Holes Punched as per AS2828.1: 2019 BINDING MARGIN - NO WRITING

OUTPATIENT FINANCIAL ELECTION CONSENT - No Gap SMR020.245

NO WRITING

Page 1 of 1

9.3.2. Outpatient Financial Election Consent – Gap Form



NSW Health

Facility:

OUTPATIENT FINANCIAL ELECTION CONSENT - Gap
Please complete prior to your first appointment

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR020246

PERSONAL DETAILS

Title: | Family Name: | Given Name:
Previous Family Name: | Date of Birth: | Sex:
Home Address:
Suburb: | State: | Postcode:
Phone Number: | Work/Mobile Number:

Are you Aboriginal or Torres Strait Islander origin?

☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - both ☐ Neither ☐ Unknown

TREATING CLINICIAN NAME: **OUTPATIENT CLINIC NAME:**

Outpatient Financial Consent where the patient may be charged a fee

I choose to be treated as a private patient in the hospital's Outpatient Department.

As a private patient, I understand that Medicare will cover some of the cost of these services, including tests, treatments and procedures until my referral ends.

The Doctor has provided me with an estimate of the fees that will be charged and I understand that these fees may be in excess of the Medicare rebate. In this circumstance, I agree to pay the gap fees.

As a private patient I agree to be treated by the doctor named on this consent form who may not be the doctor named on the referral.

Patient Name: .....

Patient/Authorised Representative Signature: ..... *Date:* .....

Authorised Representative Name: .....

Relationship: .....

INTERPRETER Was an interpreter used to help the patient or their legally authorised representative to understand the information required for this form? Yes ☐ If yes, please complete the following:

Interpreter: ..... PRINT NAME ..... SIGNATURE ..... /..... /20..... DATE ..... : ..... TIME ..... Emp ID/Prov No.

NO WRITING

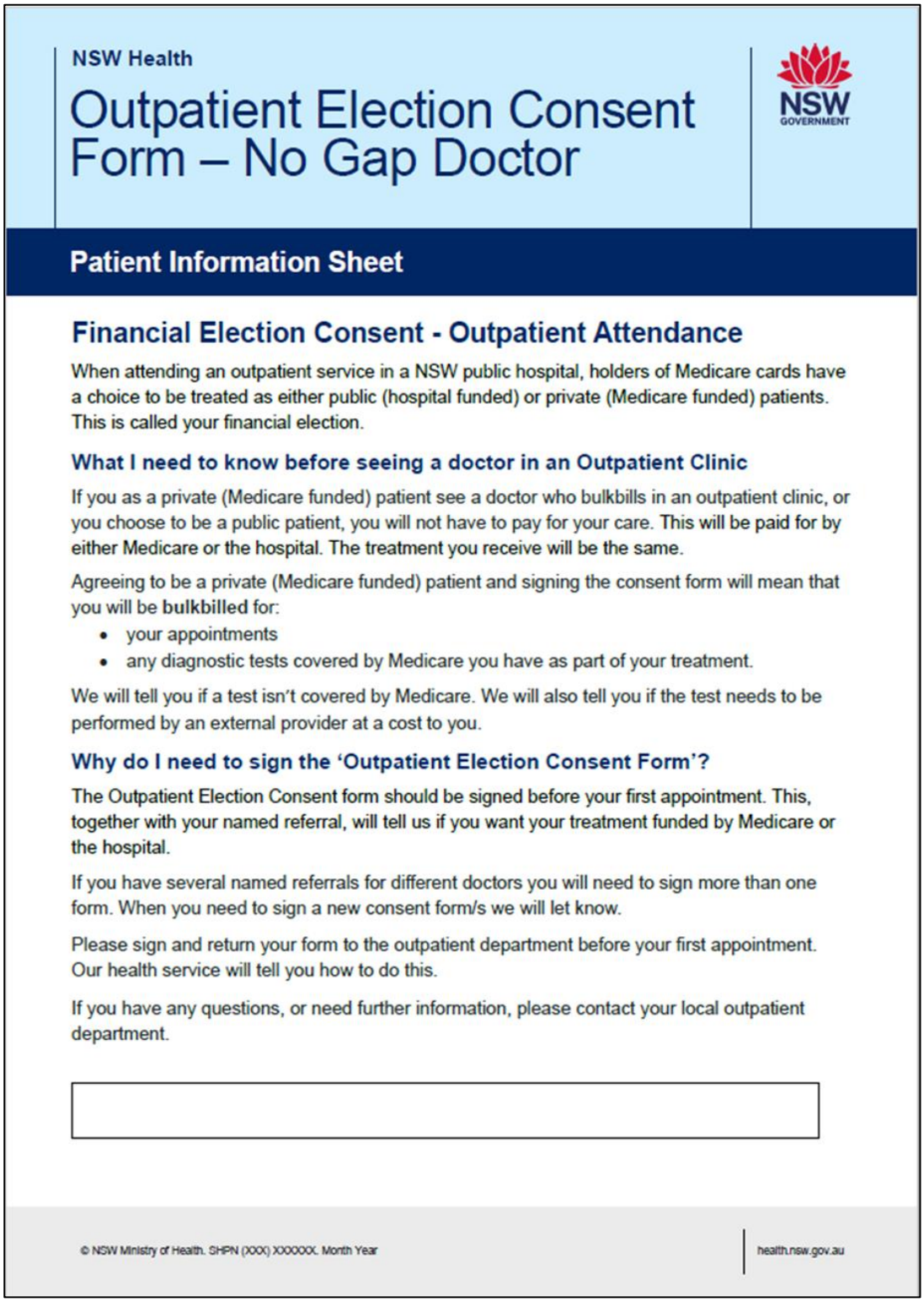
Page 1 of 1

Holes Punched as per AS2828.1: 2019
BINDING MARGIN - NO WRITING

OUTPATIENT FINANCIAL ELECTION CONSENT - Gap SMR020.246

N4700967 180923

9.3.3. Final Information Sheet: Outpatient Election Consent Form – No Gap Doctor



NSW Health

Outpatient Election Consent Form – No Gap Doctor

Patient Information Sheet

Financial Election Consent - Outpatient Attendance

When attending an outpatient service in a NSW public hospital, holders of Medicare cards have a choice to be treated as either public (hospital funded) or private (Medicare funded) patients. This is called your financial election.

What I need to know before seeing a doctor in an Outpatient Clinic

If you as a private (Medicare funded) patient see a doctor who bulkbills in an outpatient clinic, or you choose to be a public patient, you will not have to pay for your care. This will be paid for by either Medicare or the hospital. The treatment you receive will be the same.

Agreeing to be a private (Medicare funded) patient and signing the consent form will mean that you will be **bulkbilled** for:

- your appointments
- any diagnostic tests covered by Medicare you have as part of your treatment.

We will tell you if a test isn't covered by Medicare. We will also tell you if the test needs to be performed by an external provider at a cost to you.

Why do I need to sign the 'Outpatient Election Consent Form'?

The Outpatient Election Consent form should be signed before your first appointment. This, together with your named referral, will tell us if you want your treatment funded by Medicare or the hospital.

If you have several named referrals for different doctors you will need to sign more than one form. When you need to sign a new consent form/s we will let know.

Please sign and return your form to the outpatient department before your first appointment. Our health service will tell you how to do this.

If you have any questions, or need further information, please contact your local outpatient department.

health.nsw.gov.au

9.3.4. Final Information Sheet: Outpatient Election Consent Form – Gap Payment Doctor

NSW Health

Outpatient Election Consent Form – Gap Payment Doctor

Patient Information Sheet

Financial Election Consent – Outpatient Attendance

When attending an outpatient service in a NSW public hospital, holders of Medicare cards have a choice to be treated as either public (hospital funded) or private (Medicare funded) patients. This is called your financial election.

What I need to know before seeing a doctor in an Outpatient Clinic

If you as a private (Medicare funded) patient have a named referral to see a doctor in an outpatient clinic, you will have to pay for your care if the doctor doesn't bulkbill. We will tell you if need to pay before seeing the doctor. **Please check with our staff to confirm.**

Agreeing to be a private (Medicare funded) patient and signing the consent form will mean that the doctor you are seeing will charge Medicare and you for:

- your appointments
- any diagnostic tests covered by Medicare you have as part of your treatment.

We will tell you if a test isn't covered by Medicare. We will also tell you if the test needs to be performed by an external provider at a cost to you.

Why do I need to sign the 'Outpatient Election Consent Form'?

The Outpatient Election Consent form should be signed before your first appointment. This, together with your named referral, will tell us if you want your treatment funded by Medicare or the hospital.

If you have several named referrals to different doctors you will need to sign more than one form. When you need to sign a new consent form/s we will let know.

Please sign and return your form to the outpatient department before your first appointment. Our health service will tell you how to do this.

If you have any questions, or need further information, please contact your local outpatient department.

health.nsw.gov.au

9.4. Appendix D: Sample Form and List

9.4.1. Sample Form (can be digital)

Surgical
Outpatient Appointment
Outcome Form
Version: 2021_1

Patient sticker (with barcode) include F/C

SURGICAL OUTPATIENTS

APPOINTMENT DATE:	TIME SEEN:	CLINIC:

FINANCIAL ELECTION STATUS: PUBLIC ☐ PRIVATE ☐ COMPENSABLE ☐ MEDICARE INELGIBLE ☐

1. PATIENT CARE PROVIDED TODAY BY: *(tick all that apply)*

☐ Consultant/VMO	☐ 1 ☐ 2 RN General	☐ 1 ☐ 2 Physio/Plaster Rm	☐ Interpreter
☐ 1 ☐ 2 Registrar	☐ 1 ☐ 2 RN Surgical	☐ 1 ☐ 2 OT	☐ GP
☐ 1 ☐ 2 Resident	☐ 1 ☐ 2 Enrolled Nurse	☐ Orthoptist	☐ Other (specify)
☐ Fellow			

2. BILLING CODES:

104	105	6011	6007	6016	110	116	119	23	36	36812	36812	36833	11919	75855	91822	91833	other

3. OUTCOME OF TODAY'S APPOINTMENT – MUST BE COMPLETED *(tick one)*

☐ Seen & Discharged from Clinic	☐ Admitted from clinic
☐ Seen & Discharged from Clinic- PRN review ok if required Patient can request another appt within 12mths without requiring new referral	☐ Did not wait
☐ Placed on Waiting List/RFA	☐ Did Not Attend/Answer (phone consult/Telehealth)
☐ **FOLLOW UP APPOINTMENT REQUIRED (complete below)**	☐ Other (No admin action required)

4. FOLLOW UP APPOINTMENT DETAILS

Follow up timeframe

SPECIFIC TIMEFRAME REQUIRED

Days	Weeks	Months	Date

OR APPOINTMENT DATE RANGE

☐ 2- 4 weeks	☐ 4- 8 weeks	☐ 8- 12 weeks
☐ 3-6 months	☐ 6-9 months	☐ 9-12 months

Follow up with

Delivery mode

☐ Face-To-Face ☐ Phone ☐ Dressing ☐ Procedure: 30m / 1 hr

☐ **Telehealth:**

Telehealth Location	Clinical Support Patient End
☐ Patient Preference	☐ Nil Required
☐ Health Facility	☐ Doctor/GP
☐ GP Surgery	☐ Physio/OT
☐ Other	☐ Other

☐ CCC Approved

Required for appt

☐ X-Ray ☐ MRI ☐ CT ☐ NCS ☐ USS ☐ Bloods ☐ PET ☐ VFT ☐ ☐ Audio

☐ **Request given to patient** ☐ **Request attached to outcome form** ☐ **Request submitted electronically**

Admin use: ☐ No form provided ☐ Scanned ☐ Sent to TH ☐ Sent to pt ☐ Sent to Radiology/Diagnostics

5. ADDITIONAL COMMENTS/ INSTRUCTIONS (if required)

6. PRINT Name (Primary Clinician)	SIGNATURE (Primary Clinician)	Designation eg. Registrar, RN, VMO	Time Consult Completed

Admin Use ☐ Outcome / Also Seen stats in PAS ☐ Telehealth Request Template Sent ☐ Follow up Clinic Appt made ☐ Letter/s sent

9.4.2. Sample List (can be digital)

Clinic: xxxxx Date: ----------

LIST OF PATIENTS – Private

MRN/AUID	Name	Appt/Visit Type	Patient Category F/C	Referred to Clinician	AMA/MBS Item No.
1324566	Smith	New	E.G., NAC.01 (Non-admitted: MBS/PBS Claim Privately Referred)	Dr Alan James	
1285314	Taggertt	F/up	E.G., NAC.08 (Non-admitted: DVA – Direct DVA Claim)	Dr Roger Ranjit	
5598133	Singh	New	E.G., NAC.02 (Non-admitted: Charge OSHC)	Dr Alan James	
2456987	Tappett	New	E.G., NAL (Non-admitted: Compensable – Lifetime Care & Support)	Dr Srinivasan	

Name of Clinician ---------- Signature: ----------