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| MBS billing policy framework  Victorian public hospitals |
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# Policy framework

There is a long history across Australia of billing under the Medicare Benefits Schedule (MBS) for services provided to private patients in public hospitals. Eligible persons attending public hospitals are entitled to be treated as public patients. If the public hospital also provides the same services on a private basis, a patient may choose to be treated as a private patient.

To enable the department to monitor compliance with applicable legislation and to meet the department’s obligations under the National Health Reform Agreement (NHRA), hospitals and health practitioners must be able to substantiate their MBS claims to the department during an audit.

It is mandatory that public hospitals in Victoria comply with the requirements stated in this document.

# Purpose

The objectives of this document are to state the requirements that apply to Victorian public hospitals billing under the MBS on behalf of health practitioners exercising a right of private practice and to provide Victorian public hospitals with clarity on the Department of Health and Human Service’s expectations when billing under the MBS.

# Scope

This policy applies to all Victorian public hospitals and health practitioners who are exercising a right of private practice within a Victorian public hospital. The services provided refer to all health services provided at a Victorian public hospital urgent care centre, inpatient, outpatient and diagnostic imaging and pathology departments.

# Definitions

**Eligible person** means an Australian resident or an eligible overseas representative (as defined in subsection 3(1) of the *Health Insurance Act 1973*), excluding compensable patients.

**Ineligible person** means any person who is not an eligible person.

**Medicare Benefits Schedule (MBS)** means the Commonwealth government’s scheme to provide medical benefits to Australians established under part II, IIA, IIB, IIC of the *Health Insurance Act 1973* together with relevant Regulations made under the Act.

**Out-of-pocket (gap) payment** means the difference between the fee charged by the practitioner and the amount that can be claimed as a benefit (under the MBS and from a private health insurer).

**Practitioner** means, as defined in subsection 124B of the *Health Insurance Act 1973*:

1. a medical practitioner; or
2. a dental practitioner; or
3. a participating optometrist (other than the Commonwealth, a State, the Australian Capital Territory, the Northern Territory or an authority, being a corporation, established by a law of the Commonwealth, a State or an internal Territory); or
4. an optometrist other than a participating optometrist; or
5. a midwife; or
6. a nurse practitioner; or
7. a chiropractor; or
8. a physiotherapist; or
9. a podiatrist; or
10. an osteopath; or
11. a health professional of a kind determined by the Minister under subsection 124B(7) of the *Health Insurance Act 1973* to be a practitioner for the purposes of Part VB of the Act.

**Private patient**, in relation to a hospital, means a patient of the hospital who is not a public patient (as defined in subsection 3(1) of the *Health Insurance Act 1973).*

**Eligible admitted private patient** means an eligible patient who is admitted and chooses to be treated as a private patient, and excludes compensable patients and other patients funded by third parties (as defined in the NHRA).

**Public hospitals** mean public health services, denominational hospitals and public hospital*s* (as defined by the *Health Services Act 1988*).

**Specialist**, in relation to a particular specialty, means a medical practitioner in relation to whom there is in force a determination under section 3DB or 3E that the medical practitioner is recognised for the purposes of the *Health Insurance Act 1973* as a specialist in that specialty, or a medical practitioner who is taken to be so recognised under section 3D (as defined in subsections 3(1), 3DB, 3E and 3D of the *Health Insurance Act 1973).*

# Requirements

## Compliance with Commonwealth and Victorian policies, legislations and agreements

If a public hospital provides the same services on both a public and private basis, eligible persons have the choice to be treated as a public or private patient, except at an emergency department where all eligible persons are treated as public patients. Public hospitals must ensure that any election to be treated as a private patient is exercised in accordance with the NHRA and any future National Health Agreement which replaces the NHRA and is agreed to by the Victorian government.

It is mandatory for public hospitals in Victoria that bill under the MBS to comply with the requirements stated in *Health Insurance Act 1973*, the MBS, any additional requirements stated in the NHRA or future National Health Agreements agreed to by the Victorian government, and other relevant Commonwealth and Victorian government documents.

Public hospital diagnostic imaging and pathology services requested during an emergency department presentation, a public admitted episode, or a public outpatient appointment must not be billed under the MBS. For the purposes of the NHRA, these are considered components of that public hospital service and regarded as part of the patient’s treatment and not as separate episodes of care.

## Rights of Private Practice

Rights of Private Practice (RoPP) are a governing body prerogative which is granted to practitioners upon appointment or application for same. Employment of any kind by the public hospital is not a pre-requisite to billing under the MBS. Where a practitioner is employed or engaged by a public hospital, section 19(2) of the *Health Insurance Act 1973* requires that the practitioner only provide Medicare services in the course of the practitioner providing services pursuant to their right of private practice.

For a public hospital to bill MBS on behalf of a practitioner, the public hospital must have granted the practitioner a right to provide services to private patients in one of two ways – as employed practitioners exercising a right of private practice, or as contracted practitioners who have been granted access to treat private patients at the public hospital. In the case of the latter, there must be a formal access agreement between the practitioner and the public hospital, which clearly specifies the rules around Medicare billing.

### Referral to a medical specialist exercising a right of private practice

The *Health Insurance Regulations 2018* and MBS do not require referrals to be made out to a certain practitioner for billing to occur. However, for MBS billing to occur for services provided to private patients attending public hospital outpatient appointments:

* **The NHRA** **requires that the patient must have a named referral** to a medical specialist exercising a right of private practice and the patient must have elected to be treated as a private patient. The referral to a named specialist must not be a prerequisite for access to public hospital outpatient services.
* If a referral is not to a named medical specialist when the patient presents to a public outpatient department, the patient must receive the relevant service as a public patient. If, at that appointment, the patient provides informed consent to receive ongoing services as a private patient, a practitioner may provide a referral to a named practitioner when it is clinically appropriate to do so. Hospitals must ensure that they have appropriate policies and protocols in place to govern this process. Please refer to the MBS, section GN.6.16, for a summary of referral requirements.

## Accessibility of services

Public hospitals granting rights of private practice to practitioners must ensure that public patients have access to all services provided to private patients in public hospitals. Public patients must receive services free of charge (i.e. no billing against the MBS or to the patient), within a clinically appropriate period of time and based on clinical need. Services must not be provided exclusively to private patients in a public hospital. Private patients must not be given preferential treatment or special access to services within public hospitals.

Public hospitals may provide non-employed health practitioners access to a public hospital facility to conduct their private practice. Such arrangements must be considered by the public hospital on a case by case basis. That is, public hospitals will assess any proposal against the Medicare principles requiring access to public health services as stated in the NHRA or any future National Health Agreements agreed to by the Victorian Government.

Public hospitals must consider whether it is beneficial to offer private health services to eligible patients. When establishing a new specialist clinic to treat private patients or reviewing an existing one, public hospitals must consider the likely benefits and costs of this service delivery and funding arrangement, ensure that services required to meet demand are available, and the cost of operating these clinics is revenue neutral. Specialist clinics must not be established or provided by public hospitals to provide preferential treatment and access to services for private patients.

## Patient consent

Eligible persons attending public hospitals are entitled to be treated as public patients. Eligible persons may elect to be treated as private patients with informed financial consent (written or electronic). Public hospitals must not direct patients or their legally authorised representatives towards making a choice to be treated as a private patient.

Eligible persons who have private health insurance may elect to be treated as a private patient and have their hospital accounts lodged with their private health insurer and Medicare. These patients are responsible for paying any accommodation, medical, prosthesis, diagnostic imaging and pathology costs, not covered by their private health insurer and Medicare, unless the hospital has provided written confirmation that the patient's charges will not exceed the insured and Medicare rebates and the patient has signed this statement.

Eligible persons who do not have private health insurance may also elect to be treated as a private patient. These patients are responsible for paying any accommodation, medical, prosthesis, diagnostic imaging and pathology costs, unless the hospital has provided written confirmation that the patient's charges will not exceed the Medicare rebates and the patient has signed this statement.

Eligible persons who have elected to be treated as private patients in an outpatient clinic must be bulk-billed under the MBS for the outpatient services and diagnostic imaging and pathology services requested during the outpatient service. Non-admitted patients may only incur out-of-pocket fees for those services permitted under the NHRA.

Ineligible persons attending public hospitals are private patients. As such, these patients are responsible for paying all accommodation, medical, prosthesis, diagnostic imaging and pathology costs and must provide informed financial consent (written or electronic). Public hospital services for these patients cannot be billed to the MBS.

# Legislation

* *Health Insurance Act 1973*
* *Health Insurance Regulations 2018*
* *Health Services Act 1988*

# Supporting documents

* MBS billing in Victorian public hospitals: Best practice guidelines.
* Medical Indemnity Master Insurance Policy
* Medicare Benefits Schedule
* National Health Reform Agreement
* Non-admitted specialist services in Victorian public hospitals: Access policy
* Patient fees and charges for public health services
* Planned surgery and other procedures in Victorian public hospitals: Access Policy
* Policy and funding guidelines
* Private patients: Principles for public health services

# Review

This policy framework will be reviewed as required to ensure relevance and recency. At a minimum, this policy framework will be reviewed at least every three years.

# Revision History

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| Version | Date | Comments |
| 1 | June 2008 | Original Policy |
| 2 | February 2011 | This version has been updated in the context of the National Healthcare Agreement and the Victorian Auditor-General’s 2008 report, *Private Practice Arrangements in Health Services*. This document intended to assist public hospitals in developing business cases for MBS services. |
| 3 | January 2019 | Errata issued, while reviewing the 2011 version of the policy. |
| 4 | July 2020 | This version has been updated in the context of the National Health Reform Agreement and the Victorian Auditor-General’s 2019 report, *Managing Private Medical Practice in Public Hospitals*. This document establishes and separates the policy framework from guidance provided in earlier versions. |
| 5 | March 2023 | The contact details have been updated in this version. |

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