Northern Territory Primary Health Network

Report on MBS Billing for Shared Medical Appointments

14 April 2025

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Disclaimer

This report does not constitute legal advice. This report has been prepared in response to your request for our professional opinion regarding your medical billing practices and procedures in the context of the Shared Medical Appointments that you conduct. While we have drawn on our deep knowledge and experience of Australian medical billing law and practice in preparing this report, we have not been provided full and complete information and records beyond the limited materials you provided to us.

Before you act or rely on this report you need to seek your own legal or other advice.

While we make reasonable efforts to ensure the contents of this report are accurate, current and complete, we don't represent, warrant or guarantee its accuracy, currency or completeness (to the maximum extent permitted by law).

Executive Summary

Shared Medical Appointments (**SMA**) are a type of group medical appointment that typically lasts 90 minutes during which 8-12 patients have individual and consecutive consultations with a GP, while other participants listen and can participate.

Medicare Benefits Schedule (**MBS**) billing has been used for SMAs, however, we understand that some healthcare workers who would otherwise be interested in being involved in SMAs have expressed a degree of uncertainty around whether this is compliant with Medicare billing requirements. Advice has been sought from the Commonwealth Government's AskMBS service, but AskMBS advice is not legal advice and its own disclaimers state that it may be inaccurate.

The Northern Territory Primary Health Network engaged Synapse to provide this report on MBS billing for SMAs. Specifically, Synapse was asked to advise on the legality of existing MBS billing arrangements for SMAs and, if necessary, consider whether alternative MBS billing arrangements or other funding sources may be more suitable.

Through our analysis it became apparent that there are low levels of legal literacy regarding correct Medicare billing among those who have taken responsibility for the current MBS billing arrangements. This is not uncommon, given empirical evidence makes clear that neither GPs nor anyone receives formal education on correct MBS billing at any point in their careers and there is no place to go for reliable advice and support. We are strongly of the view that the project team, including all the GPs, would benefit from education on this important topic and we offer recommendations about this in the conclusion section of this report. It should be noted that irrespective of who administers the billing, GPs remain personally responsible for their MBS itemisation and can never delegate or abrogate this responsibility.

Even though we found a number of concerning billing behaviours, we are of the view that SMAs can be billed through the MBS, provided that all requirements of the correct MBS items are met.

Introduction and Background

SMAs are a type of group medical appointment that is well reported in academic literature. Over 9000 academic articles have reported successful outcomes using this model of service delivery, particularly in the context of managing the health of marginalised groups such as Aboriginal and Torres Strait Islander people, and people with chronic illnesses.

SMAs typically last for 90 minutes with 8-12 patients in attendance in a location that they have chosen. In the context of indigenous Australians, this is not usually a traditional medical consulting room, it may be an outdoor space such as a verandah or an indoor space such as a gym. SMAs can also take place via video, using platforms such as Zoom. Patient selection is managed carefully, ensuring all patients have similar health concerns and will benefit by listening and learning from others with the same health concerns. SMAs are not group education, they are individual and consecutive medical appointments, usually with a GP. There is also a trained facilitator present to manage the overall flow of each session.

Associate Professor John Stevens has been involved in the development of SMAs in Australia for approximately 10 years and was engaged by the Northern Territory and others to conduct a 2-phase proof of concept project, with the objective of engaging Aboriginal communities. This has been very successful. It was Associate Professor Stevens who first reached out to Synapse seeking our assistance around the issue of Medicare billing compliance, which led to this report.

Associate Professor Stevens and SMA project teams have been unable to gain certainty around the legalities of using Medicare, via MBS billing, as an ongoing funding source for SMAs. While MBS billing has been used to date, there remains a degree of uncertainty. Advice has been sought from the Commonwealth Government's AskMBS service, but AskMBS advice is not legal advice and is known to be frequently confusing and sometimes wrong. Further, every AskMBS advice includes disclaimers stating that the advice is not legal advice, cannot be relied upon, and may be inaccurate.

In 2014-2015 an attempt was made to obtain a new MBS item for SMAs through the Commonwealth Government's Medical Services Advisory Committee process. This was unsuccessful.

Associate Professor Stevens and the Northern Territory Primary Health Network subsequently engaged Synapse to provide this report on MBS billing for SMAs. Specifically, Synapse was asked to advise on the legality of existing MBS billing arrangements for SMAs and, if necessary, consider whether alternative MBS billing arrangements or other funding sources may be more suitable.

This report represents the expert opinion of the author, Dr Margaret Faux. A brief bio of Dr Faux is included at the end of the report.

The report is loosely divided into three parts as follows:

1. The regulatory framework
2. The current approach to funding SMAs through MBS billing
3. The proposed future approach to funding SMAs through MBS billing

Resources and materials

We have read and referred to the following briefing materials that Associate Professor Stevens provided to us.

1. Briefing document titled "SMA & MBS Stevens 4th Feb 2025".
2. "Shared Medical Appointments Toolkit for General Practice," Version 1: January 2024. Published by the Brisbane South PHN (**the Toolkit**).
3. "ASLM Report on SMA Proof of Concept Project for NTPHN Agreement (C1306) – July 2024".
4. "A Brief Review of the Evidence for Shared Medical Appointments/Medical Yarn Ups" (V3 171023).
5. This link to a short video about SMAs - https://www.youtube.com/watch?v=Q7tiCU0t5zc

During communications between Dr Faux and Associate Professor Stevens, additional materials were reviewed such as PowerPoint presentations and the following further questions and answers were conveyed (emphasis added).

1. SMAs are also being undertaken via telehealth. Since covid, and the sustained and broadening of telehealth coverage, online SMAs have been very popular. The same principles apply E.g. A facilitator manages the group, the GP consults with each patient individually, with other listening on. The technology provides the capacity to pause sound and video on the audience if private conversation and or examination is required. The equivalent (equivalent to face-to-face consults) telehealth item numbers have been known to have been claimed by some practices.
2. The most commonly used item number for telehealth is 91891 - for complex care beyond 6 minutes but less than 20
3. **Where do SMAs take place?** SMAs, in normal context, are delivered in the medical practice/clinic where clinician is registered. However, when we are working in the ACCHO sector the location of the SMA can be negotiated with the participants and can be held outside the ACCHO clinic in the community such as a gym, recreation hall, a town camp, someone's private verandah etc. where the participants and the clinicians feel comfortable and safe. In these cases, the clinician has contacted MBS to notify them of their change location if that is a requirement. In most cases the clinic is normally quite close to the locations, but the participants generally do not want to have their SMA consultations in the clinic.
4. **In circumstances where an AHW reviews a GP plan, where is the AHW?** The Aboriginal Health workers (AHW) and practitioners (AHP) and other clinical staff will undertake the reviews, care plans and case conferences one to one with patients as per usual practice. Most commonly these are undertaken some time before SMAs are held. In some cases, the SMA has provided an incentive to have care plans, reviews and case conferences undertaken and/or updated.
5. The documentation refers to compliance with the *"Health Insurance Regulations (2021)"* however, in subsequent correspondence Associate Professor Stevens clarified that this was in fact the *"Health Insurance (General Medical Services Table) Regulations 2021"*

Medicare Overview

Medicare's enabling legislation is the *Health Insurance Act 1973 (Cwth)* (**HIA**). The HIA is accompanied by a vast array of associated regulations, the most relevant of which for present purposes are the *Health Insurance (General Medical Services Table) Regulations 2021* (**Regs**).

It has been almost 50 years since the Medicare scheme was first introduced in 1975 as Medibank (reintroduced as Medicare in 1984), and while successive governments have continually modified the scheme, the following core elements remain unchanged.

1. Medicare reimburses each ***professional service.*** A professional service is defined as: *"a service (other than a diagnostic imaging service) to which an item relates, being a clinically relevant service that is rendered by or on behalf of a medical practitioner;"*

2. A ***clinically relevant service*** is defined as: *"a service rendered by a medical or dental practitioner or an optometrist that is generally accepted in the medical, dental or optometrical profession (as the case may be) as being necessary for the appropriate treatment of the patient to whom it is rendered."*

In 1994, the Professional Services Review Agency (PSR) was established to police the Medicare scheme. The PSR is known as the "Medicare Watchdog." It is an independent government agency that investigates and prosecutes non-compliant Medicare billing referred to as "inappropriate practice". In the thirty years since it was established, a substantial body of case law has developed concerning the interpretation of Medicare item numbers. This has evolved on the back of numerous legal challenges defended by the PSR in the Federal Court. As a result of these PSR cases, the legally correct approach to Medicare item number interpretation is settled. This approach is purposive and contextual, taking into account the whole of the MBS, not just individual items, in order to achieve the best possible practical result. In the context of this report, the MBS items that are currently being billed for SMAs will be interpreted and contextualised by us, using this approach.

Since 2019, the PSR has published monthly case reports on its website, which are accessible at this URL https://www.psr.gov.au/case-outcomes These reports illuminate the types of billing behaviour that causes medical practitioners and others to fall foul of legal obligations.

Flowing from the above and other provisions in the Regs are the following overarching compliance concepts.

Overarching Compliance Concepts

1. The MBS is not an instrument of parliament. It is a book. The inside cover of the MBS book states: *"This book is not a legal document, and, in cases of discrepancy, the legislation will be the source document for payment of Medicare benefits."* There are often discrepancies between the law and the book, including one which will be presented and analysed in this report.

2. Medicare is a fee-for-service system. Every MBS item is a separate and distinct service. Therefore, no global consent to bulk bill is permitted. Detailed consent must be obtained from the patient for every bulk billed service.

3. Medicare dispenses public money, so the scheme necessarily includes criminal fraud offences.

4. Every service rendered must be clinically relevant, meaning *necessary* to treat the patient. This is often the difference between something the patient needs (treatment for high blood pressure), as opposed to something the patient wants (cosmetic botox). It also often requires practitioners to discern MBS items that could be provided but that the patient does not need. Put another way, the fact that a Medicare item *could* be billed does not mean it *should* be billed.

5. *All* requirements of *every* Medicare item billed must be satisfied *every* time it is billed. No exceptions. For example, if an item specifies the place where a service must be provided (E.g. consulting rooms, a hospital or an aged care facility), it cannot be billed unless the service was provided in that place.

6. Medicare is driven by date-of-service (DOS). The correct DOS is an essential data element from a compliance perspective. Intentionally billing with an incorrect DOS is fraud.

7. The practitioner who provides the service bills the service. No sharing of provider numbers.

8. Provider numbers are linked to physical street addresses. It is not possible to have provider numbers linked to patients' homes or random spaces.

9. If an item describes a minimum time requirement, it is generally time *with the patient*, not time writing up notes or talking on the phone with relatives or colleagues.

10. Adequate and contemporaneous records are required for every MBS item billed. The legal definition of adequate and contemporaneous records, which reinforces the requirement to correctly record the DOS, is contained in the *Health Insurance (Professional Services Review Scheme) Regulations 2019,*[1] copied below.

6 Standards for adequate and contemporaneous records

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

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

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

(c) each separate entry for a service must:

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

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

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

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

[1] https://www.legislation.gov.au/Details/F2022C01039

The Workflow of an SMA

Based on the materials provided to us, we understand the typical SMA workflow is as follows:

a) Patients arrive at the nominated time and are greeted by a trained facilitator.
b) For the first 20-30 minutes the facilitator conducts welcome formalities. There is no GP present during this period.
c) A GP joins the SMA after welcome formalities have been completed.
d) The GP commences the first consultation with the first patient, with other patients being present who are listening and able to participate.
e) A timekeeper rings a bell (or similar) at 5 minutes and 6 minutes to notify the GP that it is time to complete the first patient consultation and move on to the second.
f) This continues for approximately 1 hour during which all patients have had their one-on-one consultation with the GP.

Do SMA services meet the threshold clinical relevance standard?

The Toolkit provided to us describes a lengthy planning process for SMAs which commences eight weeks in advance. The process includes promoting the event and actively recruiting patients to attend and participate.

The concept of recruiting patients is somewhat inconsistent with Medicare's threshold clinical relevance standard because it implies that patients are being asked to visit the GP rather than making their own decision to see the GP about a medical concern. However, we do not view this as insurmountable providing the clinical relevance standard is satisfied.

Medicare's clinical relevance standard is cited by the PSR as a contributing factor to findings of inappropriate practice in one hundred percent of cases. It is therefore to be taken very seriously.

In the context of SMAs for indigenous Australians in remote locations, relevant considerations in meeting this standard would include the frequency of the SMAs. If, for example, the same group of patients participated in the same SMA every week, this would likely be found to be non-compliant because it would not be clinically relevant (necessary) to have consultations at such frequent intervals.

However, it is our understanding that SMAs occur at less frequent intervals than weekly. We note one example provided to us where there were 6 SMAs provided over a 12-24 week period. On the basis that this type of frequency is the norm, and patients do not attend when they do not have a genuine clinical need, we are of the view that the clinical relevance standard is able to be satisfied. Moreover, we are advised that these patients are indigenous Australians who are known to have specific vulnerabilities in regards unmet healthcare needs. This fact provides further support for our view that a body of clinical peers (who would decide whether the threshold had been met) would find favourably that this important threshold standard had been met.

It should be noted that the clinical relevance standard applies to each individual patient not the SMA group, meaning that each patient must individually have a clinical need for the consultation service that the GP provides, every time it is provided.

We suggest that this is an area to keep a close eye on. The standard would not be met if patients began attending SMAs at very frequent intervals and it becomes more a social outing than a genuine medical appointment.

Do SMA services meet Medicare's attendance requirements?

It is apparent from the materials provided to us that a great deal of attention has been paid to ensuring compliance with Medicare requirements for GP attendances. Specifically, we understand that between 8-12 patients will attend each SMA, and a GP will spend approximately 1 hour conducting consultations with each of them, in turn. All patients in the group will have a similar health concern and while one patient is having their consultation, others observe and sometimes participate.

The Regs provide that GP consultations require a personal attendance by a single GP with a single patient on a single occasion of service. The SMA materials show that this has been very clearly communicated to the GPs who provide the services. For example, information in the Toolkit includes the following guide.

"Do not bill Medicare twice for the same service. The patients' consults should not overlap temporally and the advice you give to one patient during a billed consult should not also form part of another patient's billed consultation. By extension, seeing two patients for 20 minutes in total would not constitute a long consult, rather it would be billed as two shorter consults. Inala Primary Care feel comfortable billing a level B as per MBS guidelines, if they have taken a history, made a plan, and/or delivered preventive health care to a patient regarding a non-obvious issue, with examination and investigations where clinically indicated, and taken good notes. If those criteria are not met, you might bill a level A (item 3) if it meets that descriptor, or not bill at all. Adequate documentation – ideally with the use of a template for consistency – will make it much easier for you to decide what MBS items may be appropriate to bill for during an SMA."

While the SMA model is certainly unconventional and not well aligned with Medicare's fee-for-service delivery model that was designed in the 1970s, the fact remains that there is no regulated barrier to other people being present during a patients' consultation. Indeed, it is not uncommon for family members to be present during a medical consultation with a loved one.

On the basis that all consultations are strictly separated temporally, in the same way that a doctor doing a ward round in say, a 4-bed hospital bay, where all patients can hear each consultation, our view is that there is no legal barrier to this model of service delivery. This is of course predicated on patient consent and record keeping requirements clearly demonstrating that each individual consultation took place sequentially, with no overlap.

Provider number issues

The legal definition of a provider number is as follows:

> *"**provider number** means a number that:*
>
> *(a) is allocated by the Chief Executive Medicare to a medical practitioner, dental practitioner, approved pathology practitioner, optometrist, participating midwife or participating nurse practitioner; and*
>
> *(b) identifies the person and a place where the person practises the person's profession."*[2]

As can be seen from the legal definition, and contrary to popular belief, Medicare provider numbers identify the person and a place where the person practices, not the place where the service was provided.

That said, the Department advises all health practitioners to use the provider number linked to the location where a service was provided where possible, and when conducting telehealth services, they should use the provider number linked to their usual place of practice.

Medicare provider numbers are linked to physical street addresses and the department currently only allows one provider number per street address.

In our communications with you we were advised that the GPs notify Medicare of their change in location if required. However, we suggest that this may be a misunderstanding as there is nowhere to call and no formal pathway to notify medicare 'on the fly' when a service is provided from a place that is not the GPs usual place of practice. In addition, Medicare does not issue provider numbers for outdoor/random spaces. For example, a medical practitioner may provide ad-hoc services to students at a school, but the practitioner will not usually be issued a provider number at the school.

[2] https://www.legislation.gov.au/F2018L01365/latest/text

For present purposes, we assume that the GPs each have a provider number linked to the street address of the clinic where they usually practice. When they consult patients during SMAs, which usually happen away from the clinic (see below), they should continue to use that same provider number. However, they must not represent to Medicare that SMA services were provided from their clinic location if that was not true. They are legally required to select MBS items that accurately describe the place where the service was provided.

MBS place requirements

Being a taxpayer funded scheme, it is important and appropriate that the department has as much visibility as possible over Medicare service provision. Visibility supports payment integrity, health service planning and policy initiatives. This legitimate requirement has underpinned the introduction of many new or revised MBS items that specify the place where the service was provided. For example, many services now specify that the service must take place at consulting rooms, an aged care facility or a hospital. Further, in March 2025 sweeping changes were made to over 800 items for which the 85% (outpatient) rebate was removed, and the letter H was inserted at the end of their descriptions, meaning that from now on, these services can only ever be billed to patients who are admitted to a hospital.

A basic principle of MBS itemisation is that all requirements of every item description must be complied with every time it is billed, no exceptions.

The briefing materials suggested to us that SMAs typically do not take place in a 'consulting room'. Instead, the patients nominate their preferred place, which may be a gym, a verandah or other available setting, but usually not a consulting room.

In terms of the definition of a 'consulting room', to the best of our knowledge this has never been formally interpreted by our courts. However, applying the settled approach to MBS item interpretation mentioned earlier, the term 'consulting room' is a term of art which is well known to medical practitioners. Put another way, a medical practitioner knows what a 'consulting room' is. It is typically a modest-sized, quiet room, with an examination bed, a curtain around the bed, medical devices and equipment that provide a safe place for a private

consultation between a doctor and patient to take place. Further, a typical consulting room would not cater for an SMA group of up to 14 people (12 patients, 1 GP and 1 facilitator).

On this basis, we are strongly of the view that items 3 and 23, which are currently the main items being used for SMAs (and mostly the higher paying item 23), are often being billed incorrectly. Both items expressly refer to the service taking place at 'consulting rooms', and our information suggests this is not where SMAs take place. We therefore recommend this billing practice be reviewed immediately. Items 3 and 23 can only be billed if the SMA takes place in a genuine consulting room. In circumstances when SMAs take place away from consulting rooms, different MBS items, which we will come to, should be used.

MBS time requirements

GP attendances are mostly time-based, and it is necessary to ensure the time requirements are met. Non-compliance with time requirements is another very common finding in the PSR case reports.

On the basis that SMAs have an average of 10 patients and the item currently being billed (item 23) has a minimum 6-minute time requirement, compliance with this requirement is tight. Twelve patients in 1 hour would not meet the requirement noting that time while the patient is physically present with the GP is the only time that should be counted.

We do not propose saying more on this topic other than suggesting that bells or alarms are set to six-minute intervals not five.

We note the sample medical record provided in the Toolkit appears to us to be sufficient to meet relevant requirements, however we are concerned about MBS item number selection.

Bulk billing compliance requirements

Before moving on to MBS itemisation, it will be helpful to briefly explain correct bulk billing, which we understand to be the main billing type used for SMAs.

Consent

Section 20A of the HIA[3] describes the bulk billing process and confirms that the patient holds the legal right to the Medicare benefit, not the practitioner. A simple two-step process follows, whereby the patient assigns their right to a Medicare benefit to the practitioner, and the practitioner accepts it in full payment for the service provided.

Implicit in this arrangement is the concept of consent and the HIA expressly states that the patient has to sign the assignment of benefit form to evidence their consent to being bulk billed. Further, asking patients to sign blank or part-filled assignment of benefit forms is illegal. This is a sound policy because patients obviously cannot consent to something they cannot see.

We note that SMA patients are asked to sign that they agree to be bulk billed, however, the legal requirement is that they agree to specific MBS items. We do not have enough detail to comment further on this point other than to state that patients must be shown the details (meaning MBS items) of what they agree to before they agree to it.

Charging gaps is strictly prohibited when bulk billing

We are compelled to raise this important issue because of a sentence in the Toolkit, suggesting a $15 gap may be charged when bulk billing. This is a crime.

The bulk billing law requires that practitioners must accept the patient's Medicare rebate *'in full payment'* for their service. This means the doctor cannot charge any extra amount for anything and our courts have confirmed it in two criminal cases involving GPs.

[3] https://www.legislation.gov.au/C2004A00101/latest/text

In the first such case,[4] the additional fee was called a 'facility fee' and it was charged by a separate legal entity not the individual bulk billing GPs, but it still constituted fraud.

In the second case,[5] another GP was found guilty of 96 counts of criminal fraud by a jury for bulk billing and charging a gap that she called a 'counselling and theatre fee'.

What we know from these cases is that it makes no difference what you call the fee or whether a different legal entity charges it, if in truth, the fee is for the MBS service being bulk billed, it cannot be charged. The offence is necessarily a crime because it relates to public money.

Here is the content from the Toolkit, with the concerning sentence underlined.

> *"Here is how the arithmetic might work out for different billing approaches with 10 patients (as of January 2024)*
>
> *10 x level B consults ($41.40) = $414.00*
> *10 x level B consults with 10990 bulk billing incentives (MMM1 area $6.90) = $483.00*
> *<u>10 x level B consults with $15 private gap = $564.00</u>*
> *10 x level B consults and 10 x 10997 nursing items ($13.20) = $546.00*
> *10 x level B consults and 10 x 10997 nursing items, with 10990 bulk billing incentives = $615.00.*
> *Triple bulk billing incentives can also apply here – for metropolitan areas $62 and $81 for very remote areas per eligible person."*

For the avoidance of doubt, charging SMA participants, or anyone, a "$15 private gap", or any amount, when bulk billing for the same service is a criminal offence. The law provides two billing options which operate basically on an all or nothing basis. They work like this:

1. Bulk bill and charge nothing, or
2. Charge the patient a full private fee, and the patient then claims back their available rebate. For example: Patient pays the full $55 up front and claims back $40.

[4] Dalima Pty Ltd v Commonwealth of Australia (New South Wales Supreme Court, Unreported, 22 October 1987
[5] Suman SOOD v Regina 2006 NSWCCA 114

It should be noted that the department's compliance priorities for 2025, which you can access at this URL Health Provider Compliance Priorities 2025 | Australian Government Department of Health and Aged Care suggest it is cracking down on these illegal gaps and intends to take action against perpetrators.

The main MBS items currently being billed for SMAs

Item 23

We understand that item 23 is the main MBS item being claimed for SMAs. It is copied below.

> *"Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant:*
> *(a) taking a patient history;*
> *(b) performing a clinical examination;*
> *(c) arranging any necessary investigation;*
> *(d) implementing a management plan;*
> *(e) providing appropriate preventive health care;*
> *for one or more health-related issues, with appropriate documentation"*

Irrespective of whether the time and other requirements for item 23 are met, as already explained, this item cannot be claimed for services that do not take place inside a physical consulting room. We understand that SMAs do not usually take place inside consulting rooms and therefore advise that item 23 is not billable. The shorter item 3 is also not billable for the same reason.

Item 10997

The issue of whether item 10997 can be billed invokes the threshold standard of clinical relevance. Item 10997 is copied below:

> *"Service provided to a person with a chronic disease by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner if:*
> *(a) the service is provided on behalf of and under the supervision of a medical practitioner; and*
> *(b) the person is not an admitted patient of a hospital; and*
> *(c) the person has a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan in place; and*
> *(d) the service is consistent with the GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan*
> *to a maximum of 5 services per patient in a calendar year"*

In the context of SMAs, if, during the patient's consultation with the GP, the GP discusses matters associated with the patient's existing care plan, it would be difficult to mount an argument that it was clinically necessary for a practice nurse to see the patient straight after that consultation and basically discuss the same things. In an audit, the department would want to know what the nurse did that the GP had not already done.

Practically, we cannot see how the separate nurse consult would work in the flow of an SMA. For example, if the GP has completed their consult with patient 1 and is now consulting patient 2, does the nurse follow behind and have a separate consult with patient 1? This would mean that four people were talking at once, which would disturb the flow of the SMA. If, on the other hand, patient 1 and the nurse leave the room for the separate nurse consult, then patient 1 would be unable to listen, learn and participate in the SMA. These are the sorts of questions that would be raised in an audit.

Our view is that it would be unwise to adopt a mode of billing whereby item 10997 is always billed with every GP appointment. Not only is it statistically unlikely that every patient would have a clinical need for a separate practice nurse consultation on the same day as a GP consultation, but it may bring you to the attention of the PSR.

We stress the importance of maintaining adequate and contemporaneous records here. If there is a genuine clinical need for the practice nurse consultation, your records would need to very clearly distinguish between the two separate, clinically necessary services, one provided by the GP and the other provided by the practice nurse. They will be your first line of defence in an audit.

One additional point to make about records is to caution on the use of templates. Over the past few years, criticism of unparticularised templates has been frequently reported in the PSR Case Reports. Copying and pasting templates is not prohibited but you must sufficiently particularise the contents for each patient. For example, if the PSR reviewed the records of 10 patients who attended an SMA and they were all identical, or nearly identical, that would almost certainly constitute inappropriate practice, invoking substantial repayments and potential disqualification from MBS billing for a period.

Item 91891

We are advised that the main telehealth item being billed for virtual SMA's is 91891, which is copied below (emphasis added).

> *"Phone attendance by a general practitioner lasting at least 6 minutes if the attendance includes any of the following that are clinically relevant:*
> *(a) taking a short patient history;*
> *(b) arranging any necessary investigation;*
> *(c) implementing a management plan;*
> *(d) providing appropriate preventative health care"*

We also note the information below is included in the Toolkit.

> "Do I need to be an existing patient to attend an SMA?
>
> Yes. If you would like to participate in our SMAs but haven't attended the practice before, please book a new patient appointment before your first SMA session."

It is a legal requirement that, unless an exemption applies, telehealth services can only be provided by the patient's usual GP. This is defined as meaning the patient has had a face-to-face appointment with the GP, or another practitioner who works in the same practice, in the last 12 months. We assume that the reason for the Toolkit content (copied above) is to meet the face-to-face requirement, which is the correct approach.

However, a patient who receives a telehealth service from a GP who is located at an Aboriginal Medical Service, or an Aboriginal Community Controlled Health Service is exempt from the 12-month face-to-face rule. We are bringing this to your attention only for information purposes because it may be relevant in the context of your SMAs. This exemption means that patients do not need to have had a face-to-face consultation in the last 12 months if the service is provided by a GP "who is located at an Aboriginal Medical Service, or an Aboriginal Community Controlled Health Service."

For the same reasons that the place where a service is provided is important for national data collection, the mode of service delivery is equally important. Further, deliberately billing an incorrect mode such as by choosing phone when the service was provided by video, is fraud.

It is our understanding that SMAs are usually being conducted by video rather than phone, but that the phone item 91891 is commonly being billed. If we are correct in this assumption, we advise that this is non-compliant. The correct item is 91800, which is the video consultation equivalent of item 23. It is copied here for your convenience (emphasis added).

> *"Video attendance by a general practitioner lasting at least 6 minutes but less than 20 minutes if the attendance includes any of the following that are clinically relevant:*
> *(a) taking a detailed patient history;*
> *(b) arranging any necessary investigation;*
> *(c) implementing a management plan;*
> *(d) providing appropriate preventative health care"*

One final point regarding modality is that it applies to each patient not the group. For example, if some patients are connected by phone and others by video, the correct modality must be selected for each patient.

Bulk Bill Incentives and additional items

Bulk bill incentive items can be used, in accordance with the Regs, however, they must be co-claimed with the correct MBS item.

We understand that numerous additional MBS services have been billed in the context of SMAs. They include, but are not limited to 732, 705+, 723, 701-7, 900, 10987 and various case conferences.

On the basis that all MBS item requirements are met for each item, there is no barrier to billing these services before or after the SMA or on a different day. The information we have been provided suggests that this is happening correctly.

However, for the sake of completeness it is appropriate to mention briefly that it would be concerning if these additional services were being billed during the SMA, because the numbers just would not add up. Specifically, based on the 90-minute SMA timeframe and the fact that the GP is only in attendance for 60 of those minutes and has 8-12 patients to see, it would not be possible for any of the above services to be billed correctly, contemporaneous with an SMA.

Alternative MBS billing items that are suitable for SMAs

When GPs provide medical services to patients at home or admitted to private hospitals, they typically bill using items 4, 24, 37 and 47, which are the non-consulting room equivalents of 3, 23, 36 and 44.

Below are items 4 and 24, copied directly from the Regs.

Division 2.2—Group A1: General practitioner attendances to which no other item applies

2.2.1 Items in Group A1

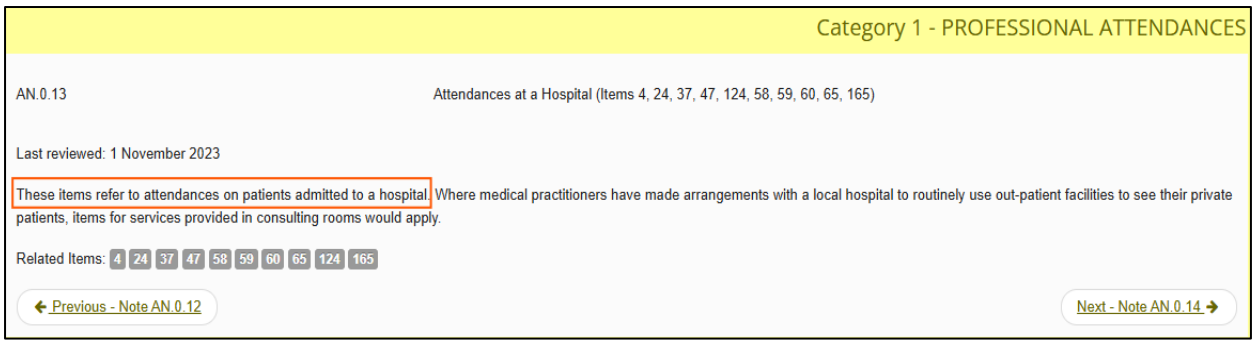
This clause sets out items in Group A1.

Note: The fees in Group A1 are indexed in accordance with clause 1.3.1.

Group A1—General practitioner attendances to which no other item applies

Column 1 Item	Column 2 Description	Column 3 Fee ($)
3	Professional attendance at consulting rooms (other than a service to which another item applies) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management	17.90
4	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in this Schedule applies) that requires a short patient history and, if necessary, limited examination and management—an attendance on one or more patients at one place on one occasion—each patient	Amount under clause 2.1.1
23	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	39.10
24	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in this Schedule applies), lasting at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one place on one occasion—each patient	Amount under clause 2.1.1

Below is an explanatory note in the MBS book stating that these items refer to attendances on patients admitted to a hospital. However, this statement is not in the Regs. Further, the below statement does not mention common services provided in other places that are outside of consulting rooms such as in a patient's home. We know that items 4 and 24 are used by GPs who do home visits, and we suggest that this omission suggests the explanatory note is intended only as a guide, to show one example of a setting that is outside of consulting rooms.



Category 1 - PROFESSIONAL ATTENDANCES

AN.0.13 Attendances at a Hospital (Items 4, 24, 37, 47, 124, 58, 59, 60, 65, 165)

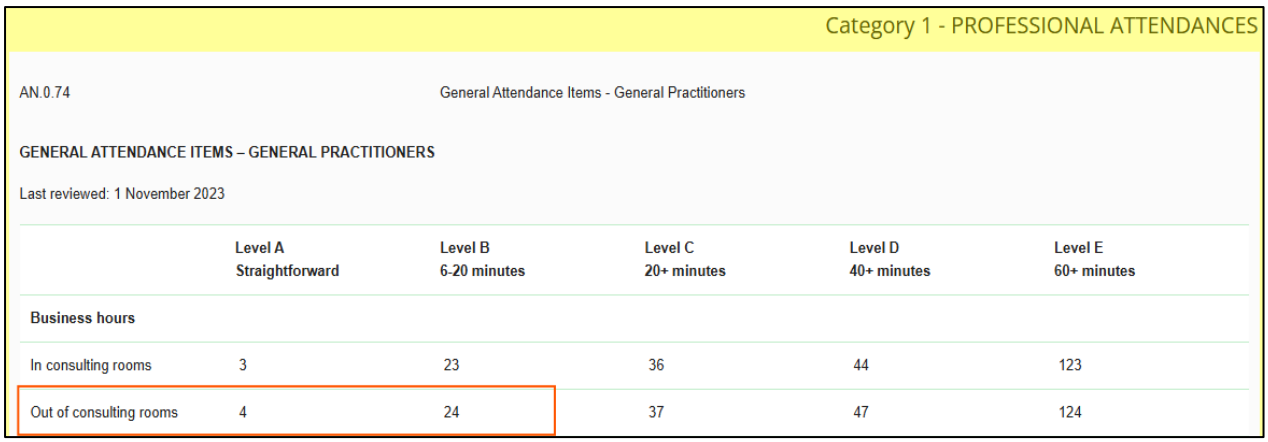
Last reviewed: 1 November 2023

These items refer to attendances on patients admitted to a hospital. Where medical practitioners have made arrangements with a local hospital to routinely use out-patient facilities to see their private patients, items for services provided in consulting rooms would apply.

Related Items: 4 24 37 47 58 59 60 65 124 165

← Previous - Note AN.0.12 Next - Note AN.0.14 →

The MBS book also includes the below, somewhat contradictory content, where there is no reference to a hospital. It specifies only that the services (4 and 24) must being provided 'Out of consulting rooms', which is consistent with the Regs.



Category 1 - PROFESSIONAL ATTENDANCES

AN.0.74 General Attendance Items - General Practitioners

GENERAL ATTENDANCE ITEMS – GENERAL PRACTITIONERS

Last reviewed: 1 November 2023

	Level A Straightforward	Level B 6-20 minutes	Level C 20+ minutes	Level D 40+ minutes	Level E 60+ minutes
Business hours					
In consulting rooms	3	23	36	44	123
Out of consulting rooms	4	24	37	47	124

As mentioned at the beginning of this report, it is not uncommon for the MBS book and the Regs to differ and to the extent of any inconsistency, the Regs prevail over the book. The only differences between items 3 and 23, and items 4 and 24, are the place and the fees. Based on our understanding that your SMAs are usually taking place 'other than at consulting rooms or a residential aged care facility' as the Regs require, we are of the view that these items can be billed for SMAs, provided all other requirements detailed in this report are also satisfied.

The services attract derived fees involving the application of a step-down formula. This is shown in the following image copied from the Ready Reckoner available at this URL https://www9.health.gov.au/mbs/ready_reckoner.cfm?item_num=24

Level A (Item 4)

Patients	Schedule Fee	Benefit 100%
One	$49.60	$49.60
Two	$34.60	$34.60
Three	$29.60	$29.60
Four	$27.10	$27.10
Five	$25.60	$25.60
Six	$24.60	$24.60
Seven+	$22.00	$22.00

Level B (Item 24)

Patients	Schedule Fee	Benefit 100%
One	$72.85	$72.85
Two	$57.85	$57.85
Three	$52.85	$52.85
Four	$50.35	$50.35
Five	$48.85	$48.85
Six	$47.85	$47.85
Seven+	$45.25	$45.25

Conclusion and Recommendations

In conclusion, while current MBS billing practices are largely non-compliant, there is a clear path forward for achieving compliance.

In our view, the correct MBS items able to be billed for most SMAs (that take place outside of consulting rooms) are items 4 and 24, together with any applicable bulk bill incentives. Items 3 and 23 should only be billed when an SMA takes place in a genuine consulting room at the street address where the GP's provider number is linked. Bulk bill incentives also apply to these items. All other MBS items should be carefully reviewed. We are particularly concerned about correct telehealth modality selection and the frequent co-claiming of item 10997.

With the right education and guidance, SMA project teams can easily meet necessary standards. We recommend this online course https://store.leocussen.edu.au/medicare-billing-course that was developed in consultation with the author of this report and the Leo Cussen Centre for Law. It is the only legally correct course on MBS billing in Australia currently.

In the interests of full transparency, we advise that neither Dr Faux nor any of her companies have any financial interest whatsoever in this course.

An additional service, that is owned and operated by Dr Faux and may benefit the SMA teams, is "MBS Answers" which you can access here https://aimactraining.com/welcome-to-mbs-answer/ Through this service I provide detailed answers to questions submitted by health professionals on a weekly basis, and a payment integrity newsletter monthly.

We are confident that the teams involved in the impressive SMA model of service delivery can adjust their approach and ensure adherence to regulations. Specifically, we believe they can successfully bill SMAs to Medicare through MBS billing provided that they revise the items they are currently billing. We also cannot stress enough the importance of record keeping and the need to avoid copying and pasting from templates without particularising the template for each patient.

Through focused training and support, we anticipate that compliance can be fully achieved, enabling both operational and financial success.

Dated 14 April 2025

Dr Margaret Faux (PhD)

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Dr Margaret Faux – short bio

1. I am currently employed as the Chief Executive Officer of a company that runs one of the largest medical billing services in Australia, Synapse Medical Services (Synapse). Synapse administers all types of medical bills for health practitioners across every medical and many allied health specialties, as well as providing medical billing solutions and services to public and private hospitals, large corporate organisations and government agencies. Synapse also provides clinical coding, transcription, and consulting services, which includes a range of health financing and payment integrity projects such as medical billing compliance audits.

2. A related legal entity, The Australian Institute of Medical Administration and Compliance, publishes weekly answers to complex questions submitted by health sector professionals on Medicare and medical billing interpretation.[6] The answers are written exclusively by me.

3. I am a practicing solicitor specialised in Medicare and medical billing law and practice.

4. I have a PhD on Medicare claiming and compliance. My research examined the Medicare billing system through a legal, administrative and system lens using a mixed methods design. The thesis is publicly available in the UTS online thesis collection.[7]

5. Prior to studying law, I qualified and practised as a registered nurse for over a decade and still maintain my non-practising registered nurse status with the Australian Health Practitioner Regulation Agency.

6. In my capacity as a solicitor, former clinician, and Medicare expert, I regularly receive instructions from law firms to act as an expert in legal proceedings, both civil and criminal, concerning the operation of Medicare and Australia's broader health financing arrangements. I also provide consulting services in various contexts for organisations seeking advice on correct Medicare billing practices. Examples of my current consulting projects are as follows:

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[6] https://aimactraining.com/welcome-to-mbs-answer/
[7] Medicare claiming and compliance, UTS thesis collection: https://opus.lib.uts.edu.au/handle/10453/155387

a. I am the expert in criminal proceedings before the District Court QLD which were initiated by the Commonwealth Department of Public Prosecutions against a General Practitioner. The matter is a retrial of alleged fraudulent Medicare billing involving profoundly complex aspects of legal interpretation of General Practitioner Medicare Benefits Schedule (MBS) items and medical billing practices.

b. I am assisting a legal team who have appealed a Professional Services Review (PSR) decision against a medical practitioner, in the Federal Court.

7. Synapse operates in international markets doing the same work (medical billing, clinical coding, and health financing consulting) and has various projects in the Middle East and an office in Dubai. I recently led a team who developed the non-admitted casemix classification for the Kingdom of Saudi Arabia.

8. I am regularly asked to comment in the media on the topic of Medicare law and interpretation. This has included featuring in the Sydney Morning Herald, The Age, The Guardian, The ABC, Channel 9, 60 Minutes, and the ABC's 7.30 and 4 Corners.

9. I have published over 200 articles, both peer reviewed and popular media, on the topic of Medicare and private health insurance law and billing and contribute widely to Australia's health reform debate.[8]

10. I have an adjunct research appointment at Southern Cross University, New South Wales. My research interests are focused on enabling equitable access to well-functioning Universal Health Coverage systems. My specific areas of interest are directly connected to my four decades of industry experience which has spanned health system financing, payment integrity, codes and classifications, regulation, and digital enablement.

11. I have deep knowledge of the realities of the street in terms of how Medicare is used in the real world having personally administered hundreds of thousands of medical bills over the course of my four-decade career.

[8] My consolidated articles and media appearances are available at this link: https://synapsemedical.com.au/news/category/publications/