Australian Government
Department of Health

Guidance on when to claim 75 / 85 / 100% benefits under Medicare for health professionals – December 2021

Guidance on when to claim hospital treatment benefits (75%)

The following guidance is aimed at helping practitioners, billing agents and other parties involved in Medicare billing to understand when hospital treatment (75%) benefits apply to services claimed under the Medicare Benefits Schedule (MBS), and by extension, when 85% and 100% benefits apply. These benefits are all paid as proportions of the Medicare Schedule Fee for the relevant item set out in the MBS. Guidance has also been included for consumers.

For privately funded services, the intent of the legislative framework as set out in the *Health Insurance Act 1973* (HIA) and the *Private Health Insurance Act 2007* (PHI Act) is for the Government to pay 75% of the MBS fee for any 'hospital treatment' (as defined in the PHI Act)) and for the patient's private health insurance, if the patient has insurance and the insurance covers the medical service, to pay at least the remaining 25% of the MBS fee. If the patient does not have private health insurance, or the patient's private health insurance does not cover that service, then the patient themselves can be expected to cover the gap, if the provider chooses to charge more than the 75%.

'Hospital treatment' is defined in Section 121-5 of the Act 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).

Some MBS items are specifically excluded from the definition of hospital treatment unless a certification under section 7(2) of the *Private Health Insurance (Benefit Requirements) Rules 2011* (Benefit Rules) is provided (a Type C certificate). Part 3, Schedule 3 of the Benefit Rules provides a list of these excluded MBS numbers.

Guidance for practitioners and billing agents

The following can be used to determine when to bill Medicare for an item as 'hospital treatment'*:

- Interventional services** (e.g. surgeries, interventional diagnostic services such as colonoscopies) done at hospitals are generally hospital treatment so attract 75% benefits. This includes services provided to admitted patients, or patients in the outpatient (or in a 'day-hospital') setting.
    - Interventional services, or other services provided to private patients in emergency departments *do not*, under legislation, attract 75% benefits

  - The decision when to provide a service at, or outside of, a hospital and whether it requires direct involvement of a hospital is a matter for the clinical judgement of the practitioner. Some services may be clinically appropriate to provide outside of a hospital (for example, cryotherapy or minor skin surgeries) with no involvement of a hospital and can attract an 85%[1] or 100% benefit. If a service attracts an 85%[2] or 100% MBS benefit, there will be no requirement for a private health insurance contribution of at least 25% of the Schedule fee to be paid toward the cost of the service.
- Most consultations, pathology** and diagnostic imaging** services are listed Type C procedures*** and therefore default to 85% or 100% benefits. These services can attract 75% benefit if they are certified, for example:
  - the hospital facilities were required for the service; or
  - the imaging or testing was done in relation to a hospital-in-the-home service; and
  - This will also mean the patient's private health insurance must contribute at least 25% of the Schedule fee toward the cost of the service.
- Other services attract an 85% or 100% benefit (the latter being for general practitioner services) as appropriate. Temporary specialist in-patient telehealth items, introduced on a time-limited basis on 15 September 2021, attract an 85% rebate only.[3]

* Services can be noted as hospital treatments when billing by placing an asterisk '*' or the letter 'H' directly after an item number where used; or a description of the professional service and an indication the service was rendered as an episode of hospital treatment (for example, 'in hospital', 'hospital outpatient service', 'admitted' or 'in patient').

** Hospital-substitute treatment also covers a limited range of interventional services and the associated pathology and diagnostic imaging services. This guidance does not cover the claiming of hospital-substitute treatment as it does not include the involvement of hospitals.

*** For a list of MBS items that are Type C procedures that can be certified, visit: https://www.health.gov.au/resources/publications/mbs-items-assigned-to-a-private-health-insurance-clinical-category-or-procedure-type

[1] In certain circumstances an 85% benefit may be higher than 85% of the schedule fee. See https://www1.health.gov.au/internet/main/publishing.nsf/Content/EMSN_Landing_Page for more information.
[2] In certain circumstances an 85% benefit may be higher than 85% of the schedule fee. See https://www1.health.gov.au/internet/main/publishing.nsf/Content/EMSN_Landing_Page for more information.
[3] More information on temporary COVID-19 MBS Telehealth Services – specialist inpatient services is available at http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-Specialist-Tele

Australian Government
Department of Health

Hospital treatment and benefits– further information and exceptions[4]

Hospital treatment is treatment intended to manage a disease injury or condition, that is provided by a person authorised by a hospital to do so or by a person under the management or control of a hospital/hospital administrator. It is treatment that is being provided to a person at a hospital or is being provided or arranged with the direct involvement of a hospital. This includes treatment provided to day-hospital patients and outpatients (excluding Type C procedures, where not certified). It does not include treatment done in private rooms that are co-located, but unaffiliated with a hospital.

Hospital treatment does not include treatment of a private patient in a hospital emergency department, type C procedures that have *not* been certified, ongoing chronic disease management or treatment for people who are not 'patients' under legislation - as these patients are not eligible for Medicare benefits.

Guidance for consumers

The Government sets a Medicare Schedule Fee to determine the amount of the benefit that patients receive from the Government.

Medicare benefits are paid as a percentage of the Medicare Schedule Fee as follows:

- For services provided by general practitioners to patients in the community, the benefit is 100% of the Schedule Fee.
- For most professional services rendered to a patient as part of an episode of hospital treatment (or part of an episode of hospital-substitute treatment), the benefit is 75% of the Schedule Fee. This includes 'hospital-in-the-home' services where a patient's private health insurance is used, and services in hospital outpatient clinics, but does not include services provided to patients in emergency departments.
- For other professional services, the rebate payable is 85%[5].

You can ask your treating health professional, or their staff, about the level of Medicare benefit payable for any services you receive and your likely out of pocket costs. You should do this prior to receiving the service.

[4] For inclusion in information provided to practitioners if needed.
[5] In certain circumstances 85% benefit may be higher than 85% of the schedule fee. See https://www1.health.gov.au/internet/main/publishing.nsf/Content/EMSN_Landing_Page for more information.