Australian Government
Department of Health

Jurisdictional guidance on when to claim 75 / 85 / 100% benefits under Medicare – 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% MBS 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 PHI 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 guidance can be used to determine when to bill Medicare for an item as a 'hospital treatment'*:

- With the exclusion of an emergency department, most procedures undertaken at a hospital are hospital treatment and therefore attract 75% benefit.
- Some procedures are only hospital treatment if a Type C certification is provided. For Type C certification the medical practitioner providing the Type C procedure must certify, in writing, a number of things outlined in subsection 7(2) of Schedule 3 to the Benefit Rules.

- Subsection 7(2) of the Benefit Rules states that:

  > Certification must be provided as follows, the medical practitioner providing the professional service must certify in writing that:
  >
  > (a) because of the medical condition of the patient specified in the certificate; or
  > (b) because of the special circumstances specified in the certificate,
  >
  > it would be contrary to accepted medical practice to provide the procedure to the patient unless the patient is given hospital treatment at the hospital for a period that does not include part of an overnight stay.

- If a Type C certificate is not provided to the patient's private health insurer, the procedure should be claimed at the 85%, not 75%, benefit.
- 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.
    - 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% 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 an 85% or 100% benefit. These services can attract a 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.

  This will also mean the patient's private health insurance must contribute 25% of the Schedule fee toward the cost of the service.
- Other services attract an 85% or 100% MBS 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% benefit only.[2]

[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] 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

* 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 can be certified as Type C hospital treatments, visit: https://www.health.gov.au/resources/publications/mbs-items-assigned-to-a-private-health-insurance-clinical-category-or-procedure-type

Hospital treatments and benefits – further information and exceptions

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 treatments provided to day-hospital patients and outpatients (excluding Type C procedures, where not certified). Importantly, the phrase 'outpatient' is not defined in the Act. Therefore, treatment provided to a person as an outpatient at a hospital, unlike 'treatment provided to a person at an emergency department of a hospital', is not excluded from the definition of 'hospital treatment'

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 majority of the 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%[3].

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

[3] 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.

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Legislation on hospital treatment (75% benefits)

The following part provides the relevant legislation on when a service is a hospital treatment and attracts a 75% benefit, with comments on the effect of the legislation and where linkages appear between legislation and regulations.

Legislation – *Health Insurance Act 1973* (HIA)

10 Entitlement to Medicare benefit

(1) Where, on or after 1 February 1984, medical expenses are incurred in respect of a professional service rendered in Australia to an eligible person, medicare benefit calculated in accordance with subsection (2) is payable, subject to and in accordance with this Act, in respect of that professional service.

…

(2) A benefit in respect of a service is:

(a) in the case of a service provided:

(i) as part of an episode of hospital treatment; or

(ii) as part of an episode of hospital substitute treatment in respect of which the person to whom the treatment is provided chooses to receive a benefit from a private health insurer;

an amount equal to 75% of the Schedule fee; or

(aa) in the case of a service to which paragraph (a) does not apply and that is prescribed by the regulations for the purposes of this paragraph—an amount equal to 100% of the Schedule fee; or

(b) in any other case—an amount equal to 85% of the Schedule fee

(2A) Without limiting the generality of regulations for the purposes of paragraph (2)(aa), the regulations may prescribe services for the purposes of that paragraph by identifying, in the table, the services concerned.

Department comment

The terms 'hospital', 'hospital treatment' and 'hospital-substitute treatment' are defined in section 3 of the HI Act, as follows:

> ***hospital*** has the meaning given by subsection 121-5(5) of the *Private Health Insurance Act 2007*.
> ***hospital substitute treatment*** has the same meaning as in the *Private Health Insurance Act 2007*.
> ***hospital treatment*** has the meaning given by section 121-5 of the *Private Health Insurance Act 2007*.

Both 'hospital' and 'hospital treatment' are therefore defined by reference from the HI Act to section 121-5 of the *Private Health Insurance Act 2007* (PHI Act).

Legislation - *Private Health Insurance Act 2007* (PHI Act)

121-5 Meaning of hospital treatment

(1) Hospital treatment is treatment (including the provision of goods and services) that:
  (a) is intended to manage, a disease, injury or condition; and
  (b) is provided to a person:
    i. by a person who is authorised by a *hospital to provide the treatment; or
    ii. under the management or control of such a person; and
  (c) either:
    i. is provided at a hospital; or
    ii. is provided, or arranged, with the direct involvement of a hospital.

(2) Without limiting subsection (1), ***hospital treatment*** includes any other treatment, or treatment included in a class of treatments, specified in the Private Health Insurance (Health Insurance Business) Rules for the purposes of this subsection.

(2A) Without limiting subsection (1) or (2), hospital treatment also includes benefits for travel or accommodation relating to treatment covered by subsection (1) or (2).

(3) Without limiting subsection (1) or (2), the reference to treatment in those subsections includes a reference to any of, or any combination of, accommodation, nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition.

(4) Despite subsections (1) and (2) and (2A), treatment is not *hospital treatment if it is specified in, or is included in a class of treatments specified in, the Private Health Insurance (Health Insurance Business) Rules for the purposes of this subsection.

(5) A ***hospital*** is a facility for which a declaration under subsection (6) is in force.

(6) The Minister may, in writing:
  (a) declare that a facility is a *hospital; or
  (b) revoke such a declaration

(7) In deciding whether to declare that a facility is a *hospital, or to revoke such a declaration, the Minister must have regard to:
  (a) the nature of the facility; and
  (b) the range and scope of the services provided, or proposed to be provided, under the management or control of the facility and at or on behalf of the facility; and
  (c) whether the necessary approvals by a State or Territory, or by an authority of a State or Territory, have been obtained in relation to the facility; and
  (d) whether the accreditation requirements of an appropriate accrediting body have been met; and
  (e) whether undertakings have been made, or have been complied with, relating to providing to private health insurers information, of the kind specified in the Private Health Insurance (Health Insurance Business) Rules, relating to treatment of persons insured under *complying health insurance products that are *referable to *health benefits funds; and
  (ea) if the Minister is deciding whether to revoke such a declaration—any contravention of conditions to which the declaration is subject; and
  (fa) any other matters specified in the Private Health Insurance (Health Insurance Business) Rules.

(8) A declaration under subsection (6) that a facility is a *hospital must include either a statement that the hospital is a public hospital or a statement that the hospital is a private hospital.

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Department comment

Subsection 121-5(1) sets out that hospital treatment may be provided at a hospital or provided or arranged with the direct involvement of a hospital. There is no requirement that the patient must be 'admitted', nor for a patient to have an overnight (or day) stay at the hospital for this subsection to apply.

Subsections 121-5(2), (3) and (4) set out that hospital treatment includes or excludes any class of treatment specified in the Private Health Insurance (Health Insurance Business) Rules.

No other treatment is included. However, there is excluded treatment, which is set out in Rule 8 of the Private Health Insurance (Health Insurance Business) Rules 2018, set out below.

Subsections 121-5(5) and (6) set out that a hospital is a facility declared by the Minister to be a hospital. Almost every hospital in Australia, whether public, private or a 'day-hospital' facility, is a declared hospital for the purpose of these subsections.

In summary, if a facility is declared as a hospital, any treatment provided/managed by and either at that facility or directly involving the facility is hospital treatment, unless an exception applies

Legislation – *Private Health Insurance (Health Insurance Business) Rules 2018*

8 Hospital treatment – excluded treatment

The following classes of treatment are specified for the purposes of subsection 121-5 (4) of the Act:

(a) Treatment which involves a procedure that has an item number that is specified in clause 8 of Schedule 3 of the Private Health Insurance (Benefit Requirements) Rules if no certificate for that procedure has been provided under clause 7 of that Schedule; and

(b) treatment provided to a person at an emergency department of a hospital; and

(c) treatment provided to a person who is not a patient within the meaning of that word in paragraph (b) of the definition of 'patient' in subsection 3 (1) of the *Health Insurance Act 1973*; and

Note: 'Patient' as used in paragraph (b) of the definition of 'patient' in subsection 3 (1) of the Health Insurance Act 1973 does not include a newly-born child whose mother also occupies a bed in the hospital except in certain specified circumstances

(d) treatment which is part of a chronic disease management program that is intended to delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease.

Note: Paragraph (d) does not refer to a chronic disease management program that is intended to prevent the onset of chronic disease for a person with identified multiple risk factors for chronic disease as hospital treatment is treatment intended to manage a disease, injury or condition and does not cover prevention—see the meaning of hospital treatment in subsection 121-5 (1) of the Act. Treatment intended to prevent a disease may be general treatment—see subsection 121-10 (1) of the Act.

(e) excluded natural therapy treatment;

(f) any treatment which is a service to which an item in the tables of Schedule 5 of the *Health Insurance (Section 3C General Medical Services – COVID-19 Telehealth and Telehealth Attendances) Determination 2020* applies".

Definition of patient (HI Act):

(1) …

patient, in relation to a hospital, does not include:

(a) a member of the staff of the hospital who is receiving treatment in his or her own quarters; or

(b) except as provided by subsection (2), a newly-born child whose mother also occupies a bed in the hospital.

(2) For the purposes of this Act:

(a) a newly born child who occupies an approved bed in an intensive care facility in a hospital, being a facility approved by the Minister for the purposes of this subsection, for the purpose of the provision of special care shall be deemed to be a patient of the hospital; and

(b) where there are two or more newly born children of the same mother in a hospital and those children are not in patients of the hospital by virtue of paragraph (a)—each such child in excess of 1 shall be deemed to be a patient of the hospital.

Department comment

Five types of treatment are excluded from the definition. These are:

- certifiable Type C procedures as per the Private Health Insurance (Benefit Requirements) Rules (Benefits Rules);
- treatment provided at an emergency department;
- treatment provided to someone who is not a patient and therefore not eligible for Medicare benefits;
- treatment that is part of a chronic disease management program in the circumstances specified in the rule; and
- excluded natural therapy treatment.

Only Type C procedures can attract either 75% or 85/100% benefits – there are no exceptions allowed for the other services in the list above, which must always attract 85%, 100% or no benefits (for ineligible patients or services where this is no relevant MBS item). A Type C procedure may be certified by the treating practitioner as a Certified Overnight Type C procedure or a Certified Type C procedure.

In those circumstances, the practitioner must certify that overnight hospital treatment or same day hospital treatment for the patient is required because of the medical condition of the patient specified in the certificate or because of the special circumstances set out in the certificate such that it would be contrary to accepted medical practice to provide the procedure to the patient unless the patient is given hospital treatment at the hospital for a period that includes or does not include (whichever is applicable) part of an overnight stay (Certified Overnight Type C procedure and Certified Type C procedure respectively).

See:
Schedule 1, Part 3, Rule 11 of the Benefits Rules (overnight); and
Schedule 3, Part 2, Rule 7 of the Benefits Rules (same day).

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Legislation – PHI Act: hospital substitute treatment

Hospital-substitute treatment is defined in section 69-10 of the PHI Act as:

69-10 Meaning of hospital-substitute treatment

Hospital-substitute treatment means *general treatment that:

(a) substitutes for an episode of *hospital treatment; and

(b) is any of, or any combination of, nursing, medical , medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition; and

(c) is not specified in the Private Health Insurance (Complying Product) Rules as a treatment that is excluded from this definition.

Department comment

There are no exceptions set out in the Private Health Insurance (Complying Product) Rules. However, because hospital-substitute treatment is general treatment, it is affected by the definition of general treatment, set out in section 121-10 of the PHI Act.

Legislation – PHI Act: general treatment

121-10 Meaning of *general treatment*

(1) ***General treatment*** is treatment (including the provision of goods and services) that:

(a) Is intended to manage or prevent a disease, injury or condition; and

(b) Is not *hospital treatment.

(2) Without limiting subsection (1), ***general treatment*** includes any other treatment, or treatment included in a class of treatments, specified in the Private Health Insurance (Health Insurance Business) Rules for the purposes of this subsection.

(2A) Despite paragraph (1)(b), ***general treatment*** also includes benefits for travel or accommodation relating to hospital treatment.

(3) Despite subsections (1), (2) and (2A), neither of the following is *general treatment:

(a) the rendering in Australia of a service for which *medicare benefit is payable, unless the Private Health Insurance (Health Insurance Business) Rules provide otherwise;

(b) any other treatment, or treatment included in a class of treatments specified in the Private Health Insurance (Health Insurance Business) Rules for the purpose of this paragraph.

Department comment

Subsection 121-10(3) excludes certain treatment set out in the Private Health Insurance (Health Insurance Business) Rules from the definition of general treatment. In respect of Medicare, this means a 75% benefit is payable for this treatment. In respect of private health insurance, it means private health insurers may (it is optional) cover this treatment under a private health insurance policy. In plain English, these exceptions are hospital-substitute treatment.

The exceptions are set out in Rules 10/11 of the Private Health Insurance (Health Insurance Business) Rules.

Legislation: *Private Health Insurance (Health Insurance Business) Rules*

10. General treatment – services for which medicare benefit is payable

For paragraph 121-10(3) of the Act, the following classes of services for which medicare benefit is payable are general treatment:

(a) the professional medical therapeutic services identified in Groups T1 to T11 of the general medical services that are:
   i. items in the table without the symbol (H) or
   ii. not stated in the item to be services that are to be performed in a hospital for the medicare benefit to be payable; and

(b) oral and maxillofacial services set out in Groups 01 to O11 of the general medical services table that are:
   i. items in the table without the symbol (H); or
   ii. not stated in the item to be services that are to be performed in a hospital for the medicare benefit to be payable; and

(c) the associated services in the:
   i. pathology services table; and
   ii. diagnostic imaging services table,

that are integral to the provision of the services specified in the paragraphs (a) and (b), but only when any of the services in the above classes are provided as part of hospital-substitute treatment.

Note 1: The effect of this rule is to provide for the above treatments or services that are eligible for a medicare benefit to come within the definition of hospital-substitute treatment.

Note 2: Private health insurers cannot cover, as part of general treatment (including hospital-substitute treatment) professional services for which medicare benefit is payable, except as provided for in this rule.

Note 3: Section 126 of the *Health Insurance Act 1973* prohibits insurance regarding professional services for which medicare benefit is payable, other than a complying health insurance policy entered into by a private health insurer that covers hospital treatment or hospital-substitute treatment, or insurance regarding a person who is an eligible person by reason only of being treated as an eligible person under subsection 7(2) of the *Health Insurance Act 1973*.

11. General treatment – excluded treatment

(1) For paragraph 121-10(3)(b) of the Act, the following treatments or classes of treatment are specified:
   (a) treatment which primarily takes the form of sport, recreation or entertainment, other than treatment that is part of a chronic disease management or a health management program if the programs have been approved by the private health insurer;
   (b) excluded natural therapy treatment

(2) In this rule:

health management program means a program that is meant to ameliorate a person's specific health condition or conditions, but does not include treatment that is excluded natural therapy treatment.

Part 3 – reference material

For a list of Medicare items specified as Type C Procedures see - https://www.health.gov.au/resources/publications/mbs-items-assigned-to-a-private-health-insurance-clinical-category-or-procedure-type

A list of declared hospitals, for the purpose of PHI Act and determining whether a facility is in scope, can be found at: https://www1.health.gov.au/internet/main/publishing.nsf/Content/hospitals2.htm