Section 19(2) Exemption – Patient Assignment of Medicare Benefit Guideline

1. Guiding Principles

The 'Improving Access to Primary Care in Rural and Remote Areas - Section 19(2) Exemptions Initiative' was implemented in 2006 by the Council of Australian Governments (COAG) and allows exempted eligible sites to claim against the Medicare Benefits Schedule (MBS) i.e. bulk bill for non-admitted, non-referred professional services (including nursing, midwifery, allied health and dental services) provided in emergency departments, hospital clinics and community settings at both Activity Based Funding (ABF) and non ABF sites.

The Initiative is governed by a Memorandum of Understanding with the Commonwealth and recognises that people living in rural and remote communities have limited access to primary health care services and many rural and remote public hospitals provide primary care services that would otherwise be available through alternate private providers in the community.

The aim of the exemption is to increase and improve primary health care services within these communities, which is achieved by optimising WA Country Health's (WACHS) capacity to access Medicare funds and the requirement that all funds derived from the Initiative are to be used to fund new or enhanced primary care services at the site. This may include funding of new/additional primary care services, purchase of equipment, capital improvements and staff training/supports.

Eligible services at Section 19(2) exempt sites are able to be bulk-billed to Medicare providing that all legislative requirements are met, including the assignment of benefits requirements. This requires that the recipient of the services (the patient) assigns their rights to the Medicare rebate to the servicing provider (the health practitioner providing the service) via the signing of a Medicare approved form.

Note: This requirement is not unique to this initiative and also applies to services bulk-billed Australia-wide under ordinary arrangements with Medicare.

2. Guideline

The guideline provides instructions, processes and recommendations for the completion of billing documentation, including the assignment of benefits form at Section 19(2) exempt sites.

2.1 Scope

This guideline applies to all sites bulk-billing Medicare for non-admitted, non-referred services under a Section 19(2) exemption. Sites with current exemptions are listed on the Intranet.

Services provided using the Community Health Information System (CHIS) or Best Practice software, which are billed to Medicare, must also comply with the assignment of benefit requirements. Instructions relating to CHIS and Best Practice are included in this guideline.

Radiology bulk-billing under a Section 19(2) exemption, or for privately referred services, should still comply with assignment of benefit requirements. Instruction on the process for radiology billing is not covered under this guideline as the process is dependent on the radiology service model and radiology information system installed at the site.

This guideline **does not** apply to private, compensable or ineligible patients whose services are not bulk billed to Medicare. Sites may use a common billing sheet to record these services but the patient is not required to assign benefits for any services that are not being bulk-billed to Medicare.

2.2 Medicare Requirements

Sites are responsible for ensuring that patients who receive eligible services assign their Medicare benefits in accordance with Medicare Australia requirements. It is important to note that the requirements for the assignment of Medicare benefits remain unchanged under the Section 19(2) exemptions initiative.

The legislative requirements for the assignment of benefit are:

- an agreement must be made between the patient (assignor) and the provider for the assignment of benefit
- the agreement is 'evidenced' through the use of the assignment of benefit form
- the patient is required to sign the form
- a copy of the agreement must be provided to the patient.

Patients must not be charged a co-payment (also known as a ‘gap’ or ‘out of pocket’) for services billed under this initiative.

2.3 Documentation Requirements

2.3.1 Services in a Paper-Based Environment

Services provided in Emergency Departments and at some sites will not use CHIS or Best Practice and will complete paper-based billing forms. Sites will need to develop patient and form flows depending on staffing, existing practices and physical layout of the service setting.

The following pieces of information are required:

a) WACHS Billing Sheet
b) The Medicare DB4 Assignment of Benefits Form (printable 2 to a page).

It is recommended that these are printed separately so there is no need to photocopy the billing sheet in order to meet the legislative requirement; "a copy of the agreement must be provided to the patient" [1].

It is acknowledged that there is some level of duplication required in the completion of the two forms. If there is a limited number of regular service providers, forms could be preprinted with the provider's name and provider number.

A local approach is required to ensure all billable services are identified and recovered from Medicare Australia. The administration staff, health worker, nurse, doctor and patient all play a role in ensuring that the required paperwork is completed to meet the legislative requirements.

a) Completion of the WACHS Billing Sheet

The billing sheet is for internal use and is used to provide billing information for data entry into Patient Billing & Revenue Collection (PBRC) for billing to Medicare. The billing sheet is a form which can be customised at each site based on the services typically presenting to that site. An example can be found on the Section 19(2) Exemption Resources Intranet page. The form must include the following:

1. Patient details/sticker
2. Date, start time, and end time of the consultation
3. Name and signature of the service provider (the signature verifies that the provider has assigned the item numbers and performed the consultation)
4. Item numbers of all services provided to the patient; these must only be entered by the practitioner whose provider number is being used to bill the services

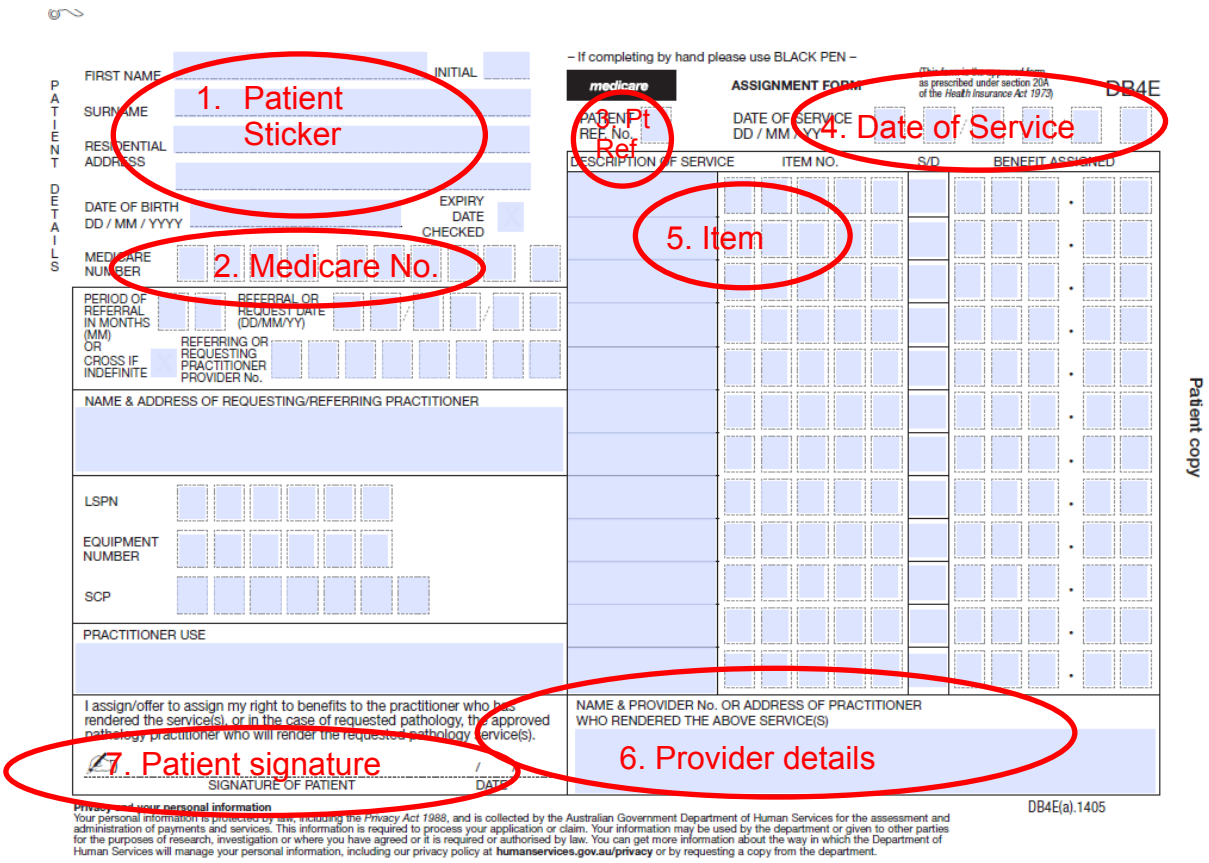
b) Completion of the Medicare DB4 Assignment of Benefits Form

The patient assigns their benefit using the DB4 form which can be printed from here. Note: the DB4 does not replace the billing sheet and is given to the patient to satisfy the assignment of benefit requirement "a copy of the agreement must be provided to the patient"[1].

The form requires the following (as shown below):

1. Patient details/sticker
2. Medicare number
3. Patient Reference number (the number next to the person's name on their Medicare card which is also the last digit recorded of their Medicare number on WebPAS/CHIS)
4. Date of service
5. Service items (these would be the same as those ticked on the billing sheet), item numbers only required
6. Provider Name and s19(2) linked Provider Number OR address e.g. Dr James 12345GK OR Dr James Anytown Hospital. Sites may choose to pre fill this information for each participating doctor and then copy the forms
7. Patient signs the form after the service has been provided. The patient must not sign a blank or incomplete assignment of benefit form
8. Patient is given the form to take

Note: other fields not listed above do not need to be completed



2.3.2 Services Using CHIS or Best Practice

Both the Community Health Information System (CHIS) and Best Practice software include the Medicare service item billing details which are entered directly by the provider at the time the services are provided. Both systems also generate an approved assignment of benefits form.

The service provider enters the relevant Medicare numbers into the system and then selects the option to print claim form. The patient is then given the form to take.

Depending on the site patient flow, the form may be printed by either the service provider or administration staff who will ask the patient to sign the form and provide it to them.

Note: On the CHIS generated form the provider will need to stamp the form or handwrite their name and provider number on the form as this is not currently pre-populated. For CHIS screenshots and further details refer to the Medical Officer Guide to CHIS.

2.3.3 Services Provided via Telehealth

Where services are provided via Telehealth this adds some complexity to the requirement to obtain the patient's signature. Medicare recommends three options to obtain the patient's signature[3]:

1. You can send the completed assignment of benefit form (DB4) to the patient to sign and return to you.

2. You can get an email agreement from the patient. Refer to additional information on this process here.
3. If present, the health professional supporting the patient during the telehealth consultation (receiving end) can ask the patient to sign the form (DB4) and return it to you.

2.3.4 Patient Unable to Sign[2]

Where a patient is unable to sign the assignment of benefit form:

- the signature of the patient's parent, guardian or other responsible person (other than WACHS staff) is acceptable; or
- In the absence of a "responsible person" the patient signature section should be left blank.

Where the signature space is either left blank or another person signs on the patient's behalf, the form **must** include:

- the notation "Patient unable to sign" and
- in the section headed 'Practitioner's Use', an explanation should be given as to why the patient was unable to sign (e.g. unconscious, injured hand, infectious etc.) This note should be signed or initialled by the doctor. If in the opinion of the practitioner the reason is of such a "sensitive" nature that revealing it would constitute an unacceptable breach of patient confidentiality, or unduly embarrass or distress the patient, a concessional reason "due to medical condition" to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases it is expected that the reason given will be more specific.

2.4 Audit

The patient will never be asked for a copy of the assignment of benefits form by Medicare. From Medicare Australia, “If we need to confirm that the service was provided to a patient, we will seek alternative evidence from you that the service was provided. Evidence may include electronic billing information, notes in practice software appointment records, and, if the practice chooses to retain them, the copy of the assignment of benefit form.”[1]

As WACHS uses Medicare Online (via PBRC) there is no legal requirement for WACHS to store the assignment of benefit forms or copies of the form[1].
WACHS has sought advice from Medicare regarding the assignment of benefits process given the lack of audit on the completed forms that are given to the patient and have been advised that this process is a legislative requirement and no exemption from this process is available.

3. Definitions

Eligible Services	Professional non-admitted, non-referred services (including eligible nursing and midwifery services) and eligible allied health and dental services. For diagnostic imaging services, the same provisions that currently apply to GPs would also apply under the Initiative.
Eligible Site	An eligible site is a health facility from which services are traditionally provided by the state health authority - including hospitals and their outreach services, Multipurpose Services (MPS), and community clinics - and that is situated in a locality that is subject to a s19(2) exemption.
Non-Admitted Patients	A non-admitted patient is a patient who does not undergo a hospital's formal admission process. There are three categories of non-admitted patient: - emergency department patient - outpatient - a patient treated by hospital employees off the hospital site – includes community/outreach services.
Non-Referred	Medical services for which Medicare does not require a referral in order to pay a benefit i.e. non-specialist services.

4. Roles and Responsibilities

WACHS Finance is responsible for:

- Ensuring this information remains up to date with current legislative requirements and aligns with the Section 19(2) exemption Memorandum of Understanding.

Sites are responsible for:

- Implementing local processes which fulfill the requirements outlined in this guideline.
- Ensuring relevant staff are aware of the legislative requirements in respect to these processes.
- Monitoring and evaluating these processes to ensure continued compliance with the requirements set out in this guideline.

Participating Medical Officers and eligible health professionals are responsible for:

- Compliance with Medicare Australia rules in respect to the assignment of Medicare benefits from the patient.
- Allocation of appropriate MBS item numbers including the rural practice bulk bill incentive item where it applies.

5. Compliance

The assignment of benefit requirements summarized in this guideline are mandatory under the *Health Insurance Act 1973*.

Failure to comply with this policy document may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

6. Records Management

All WACHS corporate records must be stored in the approved Electronic Documents and Records Management System.

Records Management Policy
Health Record Management Policy

7. Evaluation

This guideline will be reviewed by WACHS Finance every two years.
Sites may be audited by Medicare Australia to ensure compliance with legislative requirements.

8. Standards

National Safety and Quality Health Service Standards: 1.7

9. Legislation

Health Insurance Act 1973

10. References

1. Medicare Online for Health Professionals
2. Medicare Benefits Schedule
3. Medicare Bulk Billing Telehealth
4. WA Health MBS Billed Non-Admitted Services Manual

11. Related Forms

Nil

12. Related Policy Documents

Nil

13. Related WA Health System Policies

WA Health MBS Billed Non-Admitted Services Manual

14. Policy Framework

Financial Management Framework

This document can be made available in alternative formats on request for a person with a disability

Contact:	Manager Revenue Enhancement (K. Burton)		
Directorate:	WACHS Finance	**EDRMS Record #**	ED-CO-20-58826
Version:	1.00	**Date Published:**	17 August 2020