Access All Areas

While Telehealth is a rational approach to addressing specialist shortages in rural and remote parts of the country, **Margaret Faux** says there are complex issues for all practitioners to get to grips with.

Telehealth – the delivery of a specialist video consultation through the Internet – is recognised as being an ideal medium to improve accessibility to specialist medical services in rural and remote Australia. Numerous telehealth success stories were trumpeted at the recent Health Informatics Society of Australia (HISA) conference in Adelaide, together with real concern over recognised barriers to using the new technological system. Among the barriers was the dearth of knowledge about the Medical Benefits Scheme (MBS) and how to correctly bill for these services.

The new MBS telehealth items were first introduced on 1 July 2011 and include both specialist and patient-end rebates, which are claimable for outpatient services in 'telehealth eligible' areas. An eligible-area exemption applies to all residential aged-care facilities and aboriginal medical services, so indigenous people and residents in nursing homes have access to telehealth at all times.

There are two ends of the service to consider – the (usually rural) patient end and the (usually metropolitan) specialist end. From 1 November 2012, these two ends must be at least 15 kilometres apart. The specialist-end service must be an eligible service (meaning a rebate is available).

Questions relating to telehealth claiming arise in a variety of contexts, some of which are quite straightforward – such as questions concerning referrals and aftercare. All requirements for valid referrals (which you can read about in the Winter 2013 edition of *The Private Practice eZine*) apply to telehealth, as do the aftercare rules – so, no rebate for aftercare, real or virtual.

Margaret Faux is Managing Director of Synapse Medical Services.

TELEHEALTH CLAIMING ESSENTIALS

- The threshold question is always related to the patient, not the provider.
- All usual Medicare requirements, such as referrals and aftercare, apply.
- The specialist service must be claimable before the patient-end service becomes claimable.
- Both services do not have to be claimed but must be claimable.

But, as is always the case, there is nothing to prevent any patient-end service being charged to the patient outside of the Medicare scheme. If the specialist service is not claimable then neither is the patient-end service, and an MBS item number should not be claimed, but more about that shortly.

At the other end of the spectrum are more complex questions, with the answer lying buried deep in the health-law labyrinth of acts and agreements. Consider the following examples.

CASE STUDY 1

A patient from a residential aged care facility attends an outpatient appointment at a public hospital by video consultation from their local general practice. The specialist they see does not bill the patient because they choose not to exercise their right of private practice in this particular situation. Can the GP or other eligible healthcare provider bill a telehealth item number for assisting with the consultation?

This scenario raises two issues:

- Can the patient-end service be claimed if the specialist-end service is not claimed, or visa versa?
- If the patient lives in a residential aged-care facility but is transported to the GP for an arranged public hospital outpatient appointment, does the residential aged-care facility exemption still apply?

As with all Medicare claiming, the threshold question always relates to the patient, not the provider. The legal validity of our national health scheme rests on the constitutional guarantee provided in s51(xxiiiA), ensuring Medicare rebates are always payable to patients not providers. Once a service has been provided, a patient can choose to assign their right to the Medicare rebate to the provider, which we all know as bulk billing.

Therefore the initial question does not relate to whether the specialist is exercising a right of private practice but whether a claim can lawfully be raised against the patient. In general terms, if the patient is a public patient in a public hospital, Medicare benefits cannot be claimed. If the patient is private, Medicare benefits can be claimed, and telehealth services can only be claimed when the patient is located in an eligible telehealth area and the two providers are at least 15 kilometres apart. Easy!

A preliminary point concerns the difference between an item being claimed and an item being claimable. The key machinery provisions of the *Health Insurance Act 1973* are sections 10, 20 and 20A. Section 10 creates an entitlement to a Medicare benefit, section 20 sets out who obtains that entitlement and section 20A provides for the assignment of the entitlement. Nowhere in the Act is there a further provision giving rise to a legal compulsion to claim or collect the entitlement. In fact, it's quite the opposite. Providers have two years in which to submit claims, after which a late lodgement application is required to show cause as to why benefits should be paid after so long. Sound policy when you consider that the current cost of Medicare claims (not including PBS claims and the grants to the states to fund public hospitals) is in the vicinity of $22 billion per annum.

In the telehealth context, the threshold issue of whether a private claim can lawfully be raised against the patient is therefore not dependant on whether the specialist chooses to claim, but whether the patient is physically in an approved telehealth location where a Medicare service can be claimed.

Given the intention of telehealth is to increase accessibility to specialist services, the specialist service takes precedence over the patient-end service and must be claimable before the patient-end service will be claimable. But the two are not interdependent, in that there is no necessity for both services to be claimed.

So, the answer to the first issue raised in the case study is 'Yes' – if the patient is in a telehealth eligible area.

The second issue raised by the case study relates to the patient's location at the time the consultation takes place. This is pretty simple if the patient had stayed in the residential aged-care facility. Under the exemption the service would have met the telehealth requirements, and the patient-end service would have been claimable even if the specialist had chosen not to lodge a claim.

But by moving the patient to the GP's surgery, the service would only remain a telehealth-eligible service if the GP's surgery was located in an eligible telehealth area. If not, this service would no longer meet the telehealth criteria.

So, if the GP's practice is in a telehealth-eligible area, it is a telehealth-eligible service. But if the GP's surgery is not in a telehealth-eligible area (such as metropolitan Melbourne), it is not claimable as a telehealth service.

The GP could perhaps claim a usual attendance item for the surgery attendance if all other requirements

of the MBS item descriptor were met, but the specialist would be excluded from claiming at all.

But an aged-care facility, no matter where it is, is a telehealth-eligible area and a telehealth item can be claimed. This means nursing homes are in and GP practices in non-telehealth eligible areas are out!

Remember, you can solve most telehealth conundra by asking one simple question: Where is the patient physically located at the time the service is provided? But even that can be baffling sometimes. Consider this second example.

CASE STUDY 2

A patient attends the emergency department of a rural hospital in a telehealth-eligible area. The doctor seeing the patient would like some specialist assistance in dealing with the patient, so rapidly sends a referral to a specialist and then conducts a video consultation with the specialist. The patient, at this point, has not been admitted to the hospital. Can the specialist claim a telehealth-consultation item number?

Medicare has always provided health-sector funding across two distinct domains. The first subsidises private services rendered by health practitioners on a fee-for-service basis, and the second is the provision of free public-hospital services by federal grants made to state and territory governments.

Since its inception, Medicare rebates have been available to two categories of patients – inpatients and outpatients. So, if a patient is located in the emergency department and has not been admitted to the hospital, the patient would be an outpatient and therefore potentially eligible for a telehealth consultation – right?

Wrong! Over many years our federal and state governments have concocted a magnificent interface between the *Health Insurance Act 1973* and three legal documents, which together have redefined the entire concept of an outpatient service and, consequently, who funds what.

DEFINING MOMENTS

The *National Healthcare Agreement 2012* is the latest iteration of the agreement between the federal and state governments to fund public hospitals. It sets out the shared and individual responsibilities of all parties to the agreement, upholds the general Medicare principles of equity and accessibility based on clinical need and cross-references to the *National Healthcare Reform Agreement*.

The *National Healthcare Reform Agreement* provides details of the shared intentions of all governments to deliver the COAG reform agenda, including Activity Based Funding, and features key operational provisions – known as 'business rules' – which are found in Schedule G.

Appendix A to the Agreement is the definitions section, which cross-references to the latest version of the *National Health Data Dictionary*, *v16 2012*.

Still with me?

For present purposes we can narrow down the relevant definitions:

- Outpatient department means any part of a hospital (excluding the Emergency department) that provides non-admitted patient care.
- Outpatient clinic service is described as 'non-admitted patient service activity', excluding emergency department.

As you can see, there are now two subdivisions under the outpatient banner – non-admitted patient service and emergency department.

Business rule G18 provides that eligible patients presenting at a public-hospital emergency department must be treated as public patients before a decision to admit is made, and business rule G17 prevents emergency department patients being referred to an outpatient department to

1stAvailable.com.au

Changing forever the way Australians book their health care appointments

First there was Wotif.com, Seek.com, Realestate.com.au, Carsales.com.au who have forever changed the way we book accommodation, find jobs, look for property and buy cars.

Now **1stAvailable.com.au** will change forever the way Australians book their health care appointments.

61% of Australian's find the current **appointment booking** process **frustrating and inconvenient**, often resulting in a delay to treatment and worsening condition.

Here we are in the modern age of the internet, but we require our patients to **telephone** our practice **during business hours** - their busy working day.

Are you **making it easy** for your patients to access your services?

Join Australia's **No. 1** Healthcare Appointment Booking Site. Patients book via the **1stAvailable.com.au** website portal, your practice website or the 1stAvailable mobile app.

We are **integrated** with your **practice management software** systems making front desk staff adoption seamless, quick and easy.

Free to patients.

Enables patients to book with their **preferred practitioner, 24x7**.

Reduce telephone load on your front desk and **improve patient customer service**.

Your front desk and patients will **love you** for it.

Contact us now on **info@1stavailable.com.au** and find out why we have rapidly become Australia's **No. 1** Healthcare Appointment Booking Site.

1st available .com.au
My Health First

receive private specialist treatment.

On the basis that emergency department clinicians are being paid by the hospital for the services they provide, their services will not generally give rise to eligibility for MBS rebates (of course there are exceptions, which I will come to) – to do otherwise would be to allow those clinicians to double dip.

Any temptation to move a patient quickly to an outpatient department to circumvent this provision would be a breach of the National Healthcare Reform Agreement. It's quite nicely stitched up when you look closely, and it effectively excludes all telehealth claiming in the emergency department environment. That's right – currently if the patient is in the emergency department they cannot be the subject of a telehealth claim, end of story.

Referring back to the case-study example, it is irrelevant that the urban medical specialist has received a valid referral and is ready on the end of the video. A patient's location determines what happens next and, as we have seen, in a public emergency department the patient cannot have MBS charges raised against them. The exceptions are described in business rules G21 and G22, which create specific exemptions for GPs who provide emergency medical services in the emergency departments of small rural hospitals or other approved facilities. However, this does not impact or alter anything else telehealth related.

The correct answer to case-study 2 is therefore 'No'. The specialist cannot claim a telehealth item and, as a consequence, neither can the GP. The GP may be able to claim a consultation (though not a telehealth consultation) if a specific remote exemption applies.

LIFE SAVING

When considering the bigger health-funding picture, a Medicare-claiming avalanche could certainly result from opening up telehealth claiming to all state hospital emergency departments. Yet numerous examples do spring to mind whereby a specific exemption would save lives and millions in healthcare costs, such as this example:

"Patient presents to a remote public hospital emergency department with a developing stroke. CT scanning is required and the clot busting drug TPA, if administered within four hours of symptom onset, may be lifesaving. The local GP has access to a CT scanner at the hospital but needs specialist support and advice to make the decision to use TPA safely."

Aren't examples like this why we introduced telehealth in the first place?

Make no mistake, the federal government wants clinicians to use telehealth, and substantial incentives are still available both for getting on board (currently $3900) and for each claim.

Here's what a standard physician consultation currently looks like:

- $128.30 – the usual 85% rebate for item 110
- $64.13 – telehealth item 112 (50% x schedule fee for item 110 x 85%)
- $192.43 – subtotal paid overnight if claimed electronically
- $39 – claim incentive paid quarterly
  Total = $231.43

Telehealth is a rational approach to addressing specialist shortages in rural and remote Australia. It will boost specialist care for those living in aged-care facilities, as well as providing much needed specialist support for our indigenous population.

It is supported by cash incentives and, while the claiming can seem complex, it really boils down to one question – where is the patient?