

# NUMBER C

Medicare provider numbers can prove to be a minefield for anyone practising in more than one location. By deciphering fact from fiction, **Margaret Faux** provides some clarity.

Studying Medicare sometimes feels a bit like conducting a study of the Flat Earth Society. There's a lot of myth and not a lot of substance, and woe betide anyone who dares to travel beyond the horizon.

Much of the confusion derives from the very nature of the Medicare Benefits Schedule (MBS) itself, which is a departmental publication, very much a hybrid work, containing law, fact and plenty of fiction. As Paul Keating might say, it is the 'fiction that we have to have'. The legal literature and reported cases refer to the MBS very simply as 'a book'.

In this article I will outline why the issues surrounding provider numbers are so confusing by considering them in the context of some of the many queries I have received from doctors. I will then provide some answers and some rules of thumb.

## Why is Medicare so confusing?

The enabling legislation for the Medicare scheme is the *Health Insurance Act 1973* (the Act), and its associated regulations and tables. Some components of this complex legal scheme are directly copied and pasted into the MBS, such as the items described in the *General Medical Services Table*. But the explanatory notes in the MBS reveal something entirely different and are probably

best described as an interpretation by the Department of Human Services as to how the scheme should be administered.

It's obviously an interpretation that clinicians would do well to adopt, though it is important to note that some of the explanatory notes throughout the MBS bare no relationship at all to anything that can be found anywhere in the law.

It makes for interesting work, but problems occur when MBS matters end up in court. Australian courts apply and interpret law, not books. So, while medical practitioners are advised to read, understand and apply the MBS book, if they get it wrong and end up in a court of law, the court will ultimately apply and interpret the law rather than the book.

## ON A SERIOUS NOTE

In *Suman SOOD v Regina* [2006] NSWCCA 114 (12 April 2006), ADAMS J, sitting on the court of criminal appeal, remarked that Dr Sood was in a position where she was being required to interpret a point of law and apply it to the facts which, as a medical practitioner, she had neither the training nor the skills to do.

He went on to make this comment regarding the confusing language contained in the Act:



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# R U N C H

*"This, however, is merely a function of the lack of clarity of the language of the Act. No entirely satisfactory interpretation of the Act is as it seems to me, available."*

And in dissenting from the Chief Justice, he went on to say:

*"I do not accept that the legislature intended to place doctors in the position where a not unreasonable interpretation of the Act leads them to make a claim which ex post facto a judge (or, for that matter, a jury) will find to be wrong and render them liable to criminal prosecution."*

Dr Sood was found guilty by a jury of 96 counts of Medicare fraud in circumstances where she bulk billed and also charged an additional fee. She maintained from the outset that she did not know that what she was doing was wrong, and ample evidence was provided in support of this view. Applying the reasoning of Adams J, Dr Sood had made a 'not unreasonable' interpretation of the MBS, yet it landed her in a criminal court facing a jail term.

Clearly, medical claiming can be very serious stuff. Medicare is a taxpayer funded scheme, the integrity of which is the responsibility of the

Federal Government. So it's not something any clinician wants to get wrong. But how do you get it right? In the absence of a national curriculum on the subject, where can anyone go for reliable information and support?

## AROUND IN CIRCLES

Perhaps not surprisingly, Medicare has always maintained that ample information and support is available to providers. However there is evidence to suggest that some clinicians disagree. Consider this submission to the 2011 Senate Committee enquiry, which investigated the operations of the Medicare Professional Standards Review committee:

*"I was concerned to get the Medicare numbers right for this clinic. They are not straightforward. So I sent quite a lot of information to Medicare asking for help. I said: 'Are these odd numbers right? Is what I am going to charge right?' It took months to get a reply. I got a reply saying: 'We cannot give you an answer, Dr Masters. We suggest you contact the AMA and the college of GPs.' I contacted the AMA and the college of GPs...and they said: 'We are not here to interpret*

*the Medicare schedule. That should be done by Medicare.' Medicare will not do it. The PSR will not do it. The AMA will not do it. The college of GPs will not do it. And we get fined."*

The collective buck-passing eloquently expressed by Dr Masters leaves providers with little option other than to try and work it out themselves or ask their peers, who themselves are in no greater position to know the answers. It serves only to perpetuate MBS myths, misunderstandings and, ultimately, claiming errors.

## QUESTIONS & THE ISSUES THEY RAISED

Let's have a look at provider numbers, where it really shouldn't be too hard to work out which one to use when. After all, provider numbers are a cornerstone of the Medicare scheme and a pre-requisite for enabling patients to be reimbursed for medical expenses they have incurred.

If the practitioner doesn't have a Medicare provider number, patients can't claim Medicare benefits – simple. Yet I am asked questions such as the following almost daily.



THE QUESTIONS	THE ISSUES RAISED
I saw a patient today at a location where I do not have a currently open provider number. Can I claim using one of my other provider numbers?	No provider number for a new location. Can I use a different one?
I have a contract with a private hospital which stipulates that my private billings for certain procedures I undertake at that location must be done by the hospital. However, I am permitted to do my own billing for other services I provide at that location, such as seeing patients on the ward. But I can only have one provider number at that location (as there is only one street address), so how can I share that provider number between the two different billing arrangements and systems?	Can I get two provider numbers for the same location?
I'm an anaesthetist, so I don't have rooms and I don't have set lists at the moment. I'm covering for colleagues at various locations and I don't know from day to day which location I may be at tomorrow. Do I need a provider number at each location, or should I just have one linked to my home? That's what my colleagues have told me to do. And what do I do if I am at a completely new hospital tomorrow where I had never thought to obtain a provider number because I didn't know?	Moving locations daily while I do locums – can I use a home provider number?
I currently have a few provider numbers, one of which is at my rooms. From time to time I may see private patients at the public hospital, where I don't currently have a provider number. Can I just use my rooms provider number, or do I need to get one at the public hospital? And if I want you to do that billing for me, how will that affect my rooms billing?	Rare visits to another location – do I need another provider number?  If billing service X uses a provider number linked to practice Y, what will happen?
I use a room in the hospital twice a week to see my outpatients and it does my claiming for the patients I see on the day. If you do my inpatient claiming at that location, what do I do about my provider number? I have another one at the other local private hospital – can I use that?	Can I regularly use my provider number at location X for services I provide at location Y?
Under the terms of my contract at the public hospital, the hospital has linked my public-hospital provider number to its system and uses it to claim on my behalf for certain clinics. But what do I do about the private patients I see at that location, where I am entitled to retain the income? I will have to use one of my other provider numbers, won't I? Otherwise the claimed benefits will be deposited into the hospital's bank account rather than mine.	The public hospital has the use of my provider number but now I can charge private patients at the same location – is another provider number necessary?

## PROCEED WITH CARE

The problems are twofold. Firstly, Medicare provider numbers are linked to street addresses and currently it is only possible to have one provider number per doctor and per street address, and each Medicare provider number can only be linked to one electronic-claiming system.

As a result, the answer to many of the above dilemmas is that it is simply not possible to 'share' one provider number on two different software systems to lodge claims for services provided at one street address. It just can't be done – end of story.

And it can all go terribly wrong if care is not taken when managing provider numbers. I once witnessed \$40,000 of claims for one provider get 'stuck' in the crossfire when the day after they had been transmitted, but before they had been paid, the practice was taken offline due to a careless administrative error.

On another occasion, a provider inadvertently linked his public-hospital provider number to a new billing system, whereby the public hospital's revenue stream for his private patients suddenly dried up as it was now being diverted to the provider's own bank account, much to chagrin of the hospital!

You'll be pleased to know that these types of errors can always be rectified, but not without administrative pain and sometimes significant delays in cash flow. So it's prudent to always pause before signing any Medicare form for any hospital or practice. Ask yourself if the provider number to which the form relates is currently in use and by whom, and is it linked to claiming software? Sometimes alternative

solutions are the only option.

In a conversation with Medicare earlier this year, where I was explaining some of these recurrent issues faced by providers, I was advised that it was now possible to have two provider numbers for the same doctor linked to the same address. All I needed to do was prepare a letter, signed by the provider, setting out the reasons for requiring the second provider number at the same address, and attach it to an application for an additional provider number.

Wonderful, I thought – a watershed. Yet when I tried to assist a client to organise this, by drafting a carefully worded letter and submitting it as instructed, I was advised that it was not possible. Back to square one.

## RULES & REGULATIONS

So, are provider numbers location specific, and what exactly does the legislation say?

Before we look at the Act and Regulations, I just want to quickly clarify a point of terminology that can sometimes add to the confusion. LSPN is an acronym for 'location specific practice number', not 'provider number'.

LSPNs attach to the premises, not the provider, and relate to diagnostic-imaging services. Any machine used to provide diagnostic-imaging services must be registered under an LSPN to enable the payment of Medicare benefits at designated rates. LSPNs exist on a national register, which is accessible online.

The Medicare scheme does not describe 'location specific provider numbers' as such, though it is true that provider numbers are attached to locations.

The relevant law pertaining to

provider numbers (all underlining added) is found in Section 19 of the Act and Regulation 13, the relevant sections of which are copied below:

### HEALTH INSURANCE ACT 1973 – SECT 19

*Medicare benefit not payable in respect of certain professional services*  
(6) A Medicare benefit is not payable in respect of a professional service unless the person by or on behalf of whom the professional service was rendered, or an employee of that person, has recorded on the account, or on the receipt, for fees in respect of the service or, if an assignment has been made, or an agreement has been entered into, in accordance with section 20A, in relation to the Medicare benefit in respect of the service, on the form of the assignment or agreement, as the case may be, such particulars as are prescribed in relation to professional services generally or in relation to a class of professional services in which that professional service is included.

The prescribed particulars referred to in Section 19 are found in Regulation 13 as follows:

### HEALTH INSURANCE REGULATIONS 1975 – REG 13

*Particulars to be recorded on accounts, receipts and bulk billing agreement*

(1) For the purposes of subsection 19(6) of the Act, the following particulars are prescribed in relation to professional services generally:

- (a) the name of the patient to whom the service was given;
- (b) the date on which the service was given;
- (c) the amount charged in respect of the service;
- (d) the total amount paid in respect of the service;



(e) any amount outstanding in respect of the service.

(1A) For the purposes of subsection 19(6) of the Act, the following particulars are prescribed in relation to professional services rendered by a person who has been determined to be a medical practitioner under subsection 3J(1) of the Act:

(a) the name and the address of the medical practitioner;

(b) the provider number of the medical practitioner.

(1B) For the purposes of subsection 19(6) of the Act, the particulars prescribed in relation to professional services rendered by a medical practitioner other than a medical practitioner referred to in subregulation (1A) are:

(a) the name and the address of the medical practitioner; and

(b) the provider number of the medical practitioner;

either or both of which may be given.

And the relevant definitions of 'provider number' and 'practice location' are also contained in the regulations:

## HEALTH INSURANCE REGULATIONS

### 1975 – definitions

**"Provider number"** means the number that:

(a) is allocated by the Chief Executive Medicare to a practitioner, approved pathology practitioner, optometrist, participating midwife or participating nurse practitioner; and

(b) identifies the person and the places where the person practises his or her profession.

**"Practice location"**, for the provision of a medical service, means the place of practice in relation to which the medical practitioner by whom, or on whose behalf, the service is provided, has been allocated a provider number by the Chief Executive Medicare.

There are no cases or reports to assist in interpreting these sections of the scheme, which itself may indicate that it is not something that has been of significant concern to Medicare. However, like so much of the scheme, the drafting is broad (and quite inconsistent if you look closely) but the interpretation is narrow. Have a look at the following extracts taken from the Medicare and MBS Online websites, which make clear the departmental view of the above sections of the legislation:

The name and practice address or name and provider number of the practitioner who actually rendered the service (where the practitioner has more than one practice location recorded with Medicare Australia, the provider number used should be that which is applicable to the practice location at or from which the service was given).
For Medicare claiming purposes, the Health Insurance Regulations provide that a valid account or receipt must contain the medical practitioner's name and either: <ul style="list-style-type: none"> <li>• The address of the place of practice from which the service was provided; or</li> <li>• The provider number for the place of practice where the service was provided.</li> </ul>
A provider number uniquely identifies the medical practitioner and the location from which a service is rendered.
You cannot transfer a provider number for one address to another address, as this has an adverse impact on Medicare claims and prescriptions issued from the previous address.
Practitioners eligible to have Medicare benefits payable for their services and/or who for Medicare purposes wish to raise referrals for specialist services and requests for pathology or diagnostic imaging services, may apply in writing to Medicare Australia for a Medicare provider number for the locations where these services/referrals/requests will be provided.
When a practitioner ceases to practice at a given location they must inform Medicare promptly. Failure to do so can lead to the misdirection of Medicare cheques and Medicare information.
Practitioners at practices participating in the Practice Incentives Program (PIP) should use a provider number linked to that practice. Under PIP, only services rendered by a practitioner whose provider number is linked to the PIP will be considered for PIP payments.
Where a locum tenens will be in a practice for more than two weeks or in a practice for less than two weeks but on a regular basis, the locum should apply for a provider number for the relevant location. If the locum will be in a practice for less than two weeks and will not be returning there, they should contact Medicare Australia (provider liaison – 132 150) to discuss their options (for example, use one of the locum's other provider numbers).

## LOCATION, LOCATION

It is apparent that much of Medicare's broad interpretation of the legislation on this topic is not contained, or at least not with any clarity, in the legislation.

Specifically, neither the Act nor the regulations contain Medicare's statement, being that: '*A provider number uniquely identifies the medical practitioner and the location from which a service is rendered*'.

The legislation says a provider number identifies the person and the places where that person practices. The scheme clearly refers to the person (being the medical practitioner) not the place where the service was rendered, and nowhere is there a clause indicating that a medical

practitioner is prohibited from using a different provider number than that attached to the service location.

Of course, much of this is a non-issue for many practitioners and specifically for many GPs, who will usually practice in one location. For them it is simple enough, as they will obtain a provider number for that location and it will often be the only provider number they will ever need.

But I've even had GPs ask similar questions to those above when they have started providing inpatient services as CMOs, or are moving around for other reasons. And with Telehealth services now being on the increase, more and more provider numbers will be attached to home addresses or even corporate offices,

where the clinician physically sits to undertake the Telehealth consultation.

Many specialists are simply choosing to use one of their existing provider numbers for Telehealth consultations, just as GPs do when they conduct home visits. Still, some practitioners, mostly those providing inpatient services, are not sure which provider number to use when.

## SITE SPECIFIC

General practice is almost exclusively made up of outpatient services and, as I have mentioned, it's usually fairly straightforward in that environment. The practitioner should have a provider number linked to that location. Nowhere in the scheme is there any indication that you



could not use a provider number attached to a different location while you were, for example, waiting for a new one to be issued.

Sometimes the issuing of provider numbers can take much longer than the stated timeframes on Medicare's website. Earlier this year there was a significant backlog, causing even the simplest applications to take over a month.

So, if you look at the contents of a standard GP invoice, you will find that only one provider number will usually be included, being that of the servicing GP. In contrast, with the exception of anaesthetists (who don't need referrals to claim most of their services), specialist invoices will always include a minimum of two provider numbers, and three if an inpatient service has been provided.

In the outpatient context, a specialist invoice will include the servicing doctor's provider number and the referring doctor's provider number. Inpatient specialist invoices will include a third provider number, being that of the hospital or registered healthcare facility.

As to whether this last invoice containing three provider numbers complies with the legislation or not, it would be difficult to suggest that it doesn't – even if the provider number used by the specialist was not the provider number linked to the service location.

The two clear requirements of the scheme are met by providing the servicing providers name and address. However, it is also standard practice and most software requires that, in addition, the provider number of the location at which the service was provided is included on the claim.

After all of that, all you need is your name and address. But, according to Medicare, 'the fiction that we have to have' includes a provider number linked to the service location.

If you think about it from the department's point of view for a moment, Medicare does need to keep its legislative drafting style broad to allow doctors to exercise their clinical discretion. To do otherwise would result in lawyers and bureaucrats determining how doctors should practice medicine, something

clearly not in the best interests of the health of the nation. But this is cold comfort for doctors who want and deserve certainty and freedom from fear of a Medicare audit.

## ROLL WITH IT

In stark contrast to Medicare's interpretation of the Act, Adams J in Sood's case adopted a narrow view and basically said it (the Act) means what it says, and to suggest otherwise would create *"...considerable uncertainty in a context where precision of scope is of considerable importance..."*

*Although the Regulations comprise a distinct statutory instrument, it forms part of a detailed, comprehensive scheme. In my respectful opinion, the acceptance of the Crown submission would, in effect, surround each item with a penumbra of indeterminate meaning inconsistent with the structure of the legislative scheme and unfair to the medical practitioners attempting to work within its boundaries."*

Medicare will need to adapt to modern medical practice, where providers have changing needs as they become more mobile and the traditional model of medical practice becomes a thing of the past. Virtual medical practices are here to stay, and this will impact the way provider numbers are used.

But because no-one wants to end up facing criminal prosecution, the best advice is to obtain a provider number at each place where you intend to practice and always use the provider number attached to the location where the service is provided, if you can. But if you simply can't, use another provider number and include additional information on your invoices to inform Medicare of the location at which the service was provided.

Always ensure you can tick off the legislative requirements, of which there are only two, and if you have specific limitations or restrictions on your provider number, speak with Medicare and follow its instructions on exactly what you can and can't do.

It's one of those situations where it's better to just roll with the Flat Earth Society – don't fall off the horizon and accept that this is a fiction we just have to have. 