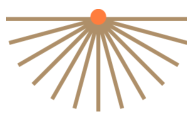
The Better Access Workbook

Medicare Training for Mental Health Professionals in Private Practice

TessCrawley



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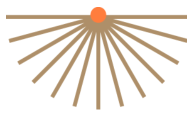

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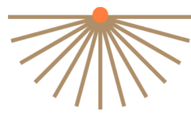


Introduction

The thought of being audited by Medicare scares all of us. And rest assured, you're not the only one frustrated by not getting consistent answers when you call the Medicare Helpline! It's okay, we're all in the same boat.

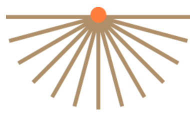
When Better Access was first released back in 2007, I was one of the original Better Access trainers, providing training to psychologists, psychiatrists, GPs, and others eligible to provide services under that new (at the time) initiative. I started my private practice well before Better Access came along, so I've had a front row seat in the changes as they have unfolded over the past 15 years.

More recently, I've made it my priority to ensure clinicians can access Better Access training through my own training program, because it is still an incredibly difficult program to navigate alone. I've also made it my business to stay on top of changes to Better Access as they've occurred (especially recently!). I hope you'll find this training program easy to digest, and that it will help you and your team to stay compliant within the Better Access system.

If you need more information, such as Item Numbers, have a look at the Better Access Education Guide (Google this phrase and you'll end up right there), or the MBS Better Access Fact Sheet. These documents are occasionally updated by Medicare, so it's best to go to the online source for these.

In the meantime, know that you're not the only one to find it mind boggling at times!

Best wishes,
Tess.



Section/Video 1 - MHCPs vs Referrals

So You've Received a Referral ... What Now?

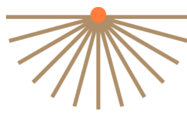
In this first section of the training, you'll learn the difference between a Mental Health Care Plan (MHCP, also known as a Mental Health Treatment Plan, or MHTP) and a referral. The terms "referral" and "MHCP" are often used interchangeably, but it's important to know that they are different, how they differ, and what purpose each serves.

What is A Mental Health Care Plan?

The full name of a MHCP is a GP Mental Health Care (or Treatment) Plan. It is a GP generated document and GP's are required to do specific training around this to be able to bill the relevant item numbers associated with producing a MHCP. A GP completes a MHCP (a formal process) in order to formulate a specific treatment plan around a patient's mental health needs. A specific item number is processed to Medicare by the GP, and it is the processing of this item number that triggers their patient's eligibility to have rebates attached to sessions with you. They must then write a REFERRAL (the plan alone is not enough).

NOTE: There is no specific item number for referrals, on the other hand.

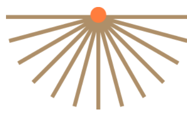
Unlike GPs, psychiatrists and pediatricians are deemed specialists, so they can refer clients to you directly without a MHCP.



You do not need to have a copy of the MHCP on file. All you require from the GP is a valid referral. In fact, you never need to even see the MHCP, a valid referral is sufficient.

NOTE: Mental Health Care Plans DO NOT EXPIRE.

A new MHCP may be completed by the GP (once 12 months has elapsed since the previous plan). This does not mean the GP must complete a new one after 12 months. MHCPs do not expire. Once processed, the original MHCP is always valid (unlike referrals). A GP may choose to complete a new MHCP if the clinical picture has changed significantly, but this is at the GP's discretion and is not essential. In other words, clients never NEED a new MHCP, but GPs may CHOOSE to do one if they feel it's appropriate (just not within 12 months of a previous plan).



What Constitutes a Valid Referral Under Better Access?

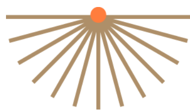
Unlike a MHCP, there is no set structure or item number associated with a referral. It is simply a letter requesting psychological intervention for the referrer's patient. It does need to contain some elements to make it valid (see below), but other than that there is no formal template for referrals. It could be written on the back of a chip packet and still be valid!

In order for your client to receive rebates under Better Access, you need to have a valid referral, which should contain:

- A description of symptoms (or provisional diagnosis)
- The type of therapy required
- The referral must be signed and dated by the GP.

  NOTE: While a referral *should* specify the number of sessions a client is being referred for, it does not have to in order to be considered valid. If the number of sessions is not specified, you can use your clinical judgment to provide sessions up to the maximum amount allowed for that course of treatment.

A valid referral identifies the client and their details, but does not have to be addressed to you. The client can choose who they want to see for their own treatment. It does not matter whose name the referral is made out to; the client is within their rights to see a different (eligible) mental health professional without needing to get another referral letter.



The referral must specify an appropriate mental health condition (ICD-10 and the DSM 5, mental health conditions). Many areas of psychological practice are not eligible under Better Access. For example, developmental disorders, cognitive assessment, relationship counselling, forensic assessment, or disability support letters do not fall under eligible categories.

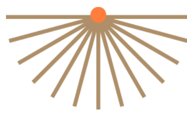
If the GP has sent you a MHCP but no referral letter, you will need to look closely at what is written in the plan, as it could actually be a valid referral on its own *IF* it contains all the requirements of a referral.

If you receive an incomplete referral letter, but ALSO have a copy of the plan which includes the missing elements (e.g, provisional diagnosis), you can look at these as one complete document and therefore treat it as a valid referral.

If all you have is a MHCP and it does not tick all the boxes to constitute a referral as well, you will have to call the GP practice and ask for a referral letter.

You must store copies of referrals for a minimum of two years. (This is a Medicare minimum requirement, other document storage laws still apply.) All documents can be stored as electronic copies in practice management software such as PowerDiary. You do not need to also store hard copies.

There is a myth that Better Access referrals are valid for a specific period of time such as 12 months. This is not true. Better Access referrals are valid for the number of sessions within that course of treatment. They can cross calendar years if needed. See page 11 under 'Course of Treatment' for more information.



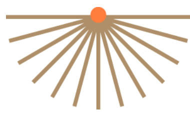
The Verbal Referral

If you already have the client in front of you for their first session and you do not yet have a written referral, you can proceed with a verbal referral. Call the GP and ask for their go-ahead, explaining the client has turned up, you know they have a MHCP but no referral has come through. Remember to make a note of the conversation and ask the GP to follow up by sending you through a written referral when they can. The better option is that they fax you a referral immediately with all the relevant information, but it is fine to proceed with a verbal referral as long as it is documented and preferably followed up in writing. You can also confirm this arrangement via your initial session letter.

Maximum Number of Sessions Per Year

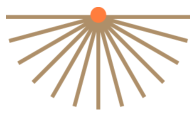
Session limits are based on a calendar year (i.e., 1 January to 31 December). At the time of writing, clients can access up to 20 sessions per calendar year for individual therapy. The first 10 sessions use item numbers beginning with 8**** for face-to-face therapy (and their counterparts beginning with 9**** for telehealth).

Referrals for individual therapy under the initial 10 sessions may be for a maximum of six sessions per referral (in any combination up to a maximum of 10 sessions per calendar year). These initial 10 sessions are typically made up of two courses of treatment (maximum 6 sessions per course of treatment). The standard approach is a 6+4 combination, but any combination is acceptable (up to a maximum of 6 per referral and 10 total initial sessions per calendar year).



The second block of 10 sessions is referred to as the “Extra 10”, with face-to-face and telehealth sessions using item numbers beginning with 9****. To access the Extra 10, clients must first have completed the initial 10 in that calendar year, must still be eligible for Better Access (diagnosable condition), and must have a specific referral (after recommendation from you) for the Extra 10. Referrals for the Extra 10 may request the 10 sessions in full, or any combination up to that total of 10 (total maximum of 20 sessions per calendar year as a combination of the initial 10 and the Extra 10). If the GP has specified fewer than 10 sessions in an Extra 10 referral, you must still write back making further recommendations at the end of the course of treatment specified in the referral.

Group therapy requires a separate referral letter, and has a maximum of six sessions per referral to a maximum of 10 group sessions per year.
All referrals can straddle calendar years, just to confuse matters!



What is a Course of Treatment?

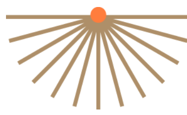
Each referral letter *should* specify the number of sessions covered by that referral. This is called the course of treatment.

If the number of sessions is not specified, use your clinical judgment to provide sessions up to the maximum amount allowed for that course of treatment.

The initial course of treatment is typically for six sessions, with the subsequent course of treatment typically being for four sessions. Then typically the third course of treatment will be for the Extra 10.

However, GPs may refer for any number of sessions (maximum of 6 per referral in the initial 10, and maximum of 10 per referral under the Extra 10). If a lower number is specified, you must respect this as the course of treatment and write back to the GP recommending further therapy (if required) at the end of that course of treatment. If a higher number is specified (e.g., GPs sometimes mistakenly refer for the full 10 initial sessions in one go), you are limited by the course of treatment limits (maximum 6 per referral for the initial 10, maximum of 10 for the Extra 10). In other words, if the GP refers for ten initially, you can only provide six sessions before writing back to the GP to ask for a re-referral for the remaining four. If they refer for less than 6 sessions, then you can only see the client for that number of sessions in the first course of treatment before requesting a re-referral.

It is your obligation to write after the final session of each course of treatment and make a recommendation for further treatment and request a rereferral for the same.



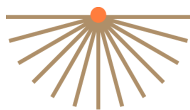
Letters to the GP

Medicare requires mental health practitioners to write to the GP at the conclusion of each course of treatment and when discharging a client. Although Medicare documentation refers to these as "reports", they are not psychological reports in the way we might assume reports to be. They only need to be brief letters. Their purpose is to update the GP on the progress of therapy, summarise any testing results, and provide a recommendation for additional sessions (if needed) and make a request for a rereferral for ongoing therapy (if required). A single page is sufficient (most GPs will struggle to find time to read anything longer than this).

TIP: The First Session Letter

Although Medicare does not require mental health practitioners to write a letter to the GP after the first session, it is beneficial to do so. Writing to the GP after your first session with a client is a matter of professional courtesy, and it is a good soft marketing tool (if you help referrers by communicating promptly and concisely, you are more likely be front of mind when they make their next referral - poor communication is the pet hate of referrers!).

You can use the initial session letter to confirm things that may not have been overly clear in the referral letter from the GP. For example, the referral may have referred to "stress" but you can clarify this in your initial session letter as "anxiety" (an eligible condition). Or the referral letter may have stated "psychological counselling", and your initial session letter can clarify this as trauma-informed CBT (an eligible treatment). If your initial impression is just that, an initial impression, say so. You can state that your assessment is ongoing and further diagnostic information will be provided in due course. In other words, if your diagnostic opinion changes over time, you'll be able to update the GP in future letters.



Remember, it’s a brief letter, not a forensic report!

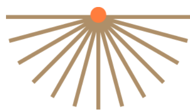
By using your initial session letter to clarify any ambiguities in the GP’s referral letter you are also confirming that this is an eligible referral. This is especially helpful when GPs don't know what the diagnosis is, especially if they have asked for opinion and management. They want to know what you think.
Keep these letters brief. For example:

Dear Tom,

Thanks for referring Sarah for treatment of perinatal anxiety. I've seen her today and will be seeing her again in two weeks' time. She's described a history consistent with your referral and her DASS results indicate she is in the severe range for anxiety but in the average range for depression. Treatment will incorporate CBT-based strategies plus some attachment-focussed work. I've provided her some start up strategies today and I'll be following up with her fortnightly.

I'll provide you with a progress report in due course.

Kind regards,
Tess.



The End-of-Course-of-Treatment (Re-referral) Letter

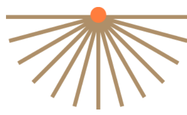
This letter is a Medicare requirement - you MUST write to the GP at the conclusion of each course of treatment. This may be after the initial six sessions if the client was referred for the maximum amount, otherwise it is after however many sessions the referral was for (maximum of six). You then need to write again at the conclusion of every subsequent course of treatment. These letters do not need to be any longer than a first session letter, but must include a statement on progress, any testing results, and MUST specify your recommendation for any further treatment. For example:

Dear Tom,

I saw Sarah for her sixth session this calendar year under her mental health treatment plan. She has made excellent progress with CBT for anxiety, however, there is some work needed around relapse prevention. DASS results remain in the moderate range for anxiety. Therefore, I recommend she has access to the remaining four sessions available to her under Better Access, and request a rereferral from you for the same.

I will provide an update in due course.

Kind regards,
Tess.



Writing to the GP before the course of treatment has ended

If you do have a relevant reason to write to the GP, you should do so, even outside of Medicare obligations. An example might be that a client has been on Zoloft but they are still really depressed, and your work with them is not making a dent. You may choose to write to the GP, as below:

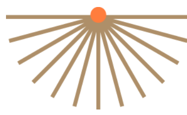
Dear Tom,

I've seen Sarah today. She reports that the Zoloft really hasn't made much of a difference to her. I've encouraged her to come and talk to you about this. I wonder if a psychiatric review of medication at this point might be helpful.

Kind regards,
Tess.

This could also just be written as an extra note in the next course of treatment letter, but certainly can be written separately if you are only up to session three of six, for example. Obviously, with any risk issues you will advise the GP asap.

Improving your communication with referrers represents excellent client care, and can also improve the marketing of your practice (by keeping you front of mind). So, if something changes and you want the GP to know, send them through a quick letter. Again, relevance and brevity are key here.



The discharge letter

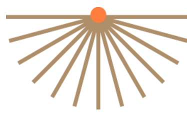
Mental health practitioners must write to the GP officially discharging the client once treatment has ended, either at completion of treatment or if the client has dropped out of treatment before completion. For example:

Dear Tom,

I saw Jane today for her 9th and final session. She has responded well to CBT for anxiety and now feels able to manage any future symptoms independently. Her final DASS scores indicated average results across all domains. We have agreed that no further sessions are needed at this time, as such I discharge her back into your care. Thank you again for your kind referral. I would welcome your rereferral in the future if Jane requires further assistance.

Kind regards,
Tess

TIP: If you have a referral on file with unaccessed sessions after the client has been discharged, it is a good idea to ask for a new referral should the client return if a significant period of time has elapsed. This will make it easier for you to be aware of any new concerns from the GP and also makes it easier for you to stay on top of reporting obligations.



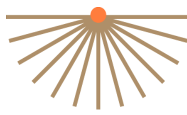
Clients on an as-needs basis:

If you and your client have agreed that there is no current need for therapy, but that they may return on an as-needs basis, then document this in a brief GP letter, stating that you'll provide them an update in due course if there's anything further to report.

Note: Clients on an as-needs basis are described in detail in video 7.

Section/Video 1 - Key Points & Tips:

- You don't have to write a letter to the GP after your first session with a client, but it is professional courtesy, clarifies referral validity, and has the bonus of being good marketing for you!
- You must write to the GP at the end of each course of treatment
- Your letters should include an update on progress, a recommendation for further treatment (if needed), and a request for a re-referral
- GPs are busy and so are you - keep your letters brief and to the point!
- If you are recommending further treatment under Better Access, request a re-referral, NOT a review.



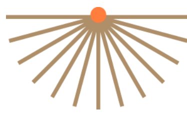
Section/Video 2- Rereferrals vs Reviews

What is a Review? How is it different from a Re-referral?

A Review is a specific process within Better Access, whereas a re-referral is a simple letter.
Reviews can be conducted at the GP's discretion (but not within three months of another Review) and they have a specific item number (whereas referrals/rereferrals do not). A formal review is NOT essential in order for you to continue therapy, whereas a re-referral IS. It is not up to us to advise the GP to conduct a formal Review, but you should feel free to request a re-referral any time. A direct quote from the Better Access education guide is that patients need a new referral for each course of treatment. Not a new review.

GPs may write a review every three months if they wish, but this has nothing to do with us, it is at their discretion. Do not ask for a review when you are recommending additional treatment, ask for a re-referral. Similarly, do not ask for a new mental health care plan either, as it is not necessary and is a lengthy process for the GP.

TIP: Unlike formal reviews, there is no specific item number associated with preparation of a referral or rereferral. GPs can use a standard consultation item number, or they can use a mental health consultation item number (if they are eligible to do so). There are no rules around how often they may use either of those two item numbers.



Does the GP need to see the client again for a rereferral?

The GP doesn't necessarily need to see the patient for a re-referral, although they might insist on doing so which is their prerogative. You can have a verbal rereferral over the phone if you haven't received one in writing by the time the client comes in for their first session on the new course of treatment.

By contrast, the GP must see the patient in person if they wish to conduct a formal review.

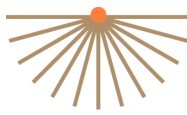
When you have reached the limit of rebates for the calendar year but still have a valid referral

Remember, the course of treatment ends when the number of sessions in the referral have been exhausted. The same rule applies for the subsequent course of treatment.

If you have already seen the client 16 times in the current calendar year, and a new referral for six sessions is received, you only have four rebates available from that referral within the current calendar year. The remaining two sessions can be used from January 1 in the following calendar year.

When Medicare rebates have been exhausted for the calendar year, you can continue to see the client without Medicare rebates if the client wishes.

TIP: It's a good idea to write to the GP stating that you have reached the limit of Medicare funding for the calendar year, the referral remains valid for the New Year and the client has opted to continue to see you without a Medicare rebate. This keeps the GP in the loop and clarifies what's going to happen next.



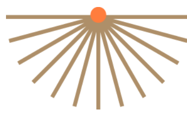
Medicare Helpline Tip:

Any time you are speaking to the Medicare helpline, get the name of the person you're speaking with, and document the time, the date, the question and the answer. The best way of contacting Medicare is via email, so you have everything in writing, however if your query is immediate, eg; your client is standing in front of you, document the conversation well.

One strategy might be to set up a "client" file in your practice management software (such as PowerDiary) called "Medicare Helpline", and copy every communication you have with them in there (as well as in the client's file), so you can keep your communication records easily accessible.

Session/Video 2 - Key Points & Tips:

- A review is a specific process conducted at the GP's discretion (must be three months apart)
- A rereferral is required at the end of each course of treatment (following your letter recommending same)
- A GP does not have to see the client for the rereferral (but they do for a formal review)
- Referrals expire when the course of treatment is complete (not based on timeframes)
- Document everything clearly when speaking with the Medicare helpline



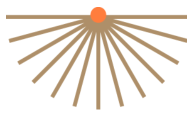
Session/Video 3 - New calendar year transition

A referral can cross calendar years. Imagine you are standing at the USA / Canada border. One foot in Canada, the other in the US. This is how calendar year transitions work too. If your referral is for six sessions and you conducted the fourth session in December, you would conduct the fifth session OF THAT REFERRAL in January, but this session would also be the FIRST session of the first set of 10 sessions available in that new calendar year.

TIP: Make sure you document session numbers in such a way that you can keep track of (a) the total number of sessions; (b) the number of sessions you are up to on the current course of treatment; and (c) the number of sessions you are up to within the current calendar year. It might look something like this:
Session Number: 23 (4/10) (14/20 - 2021)

Avoid "batch processing"

If you are bulk billing, avoid the practice known as "batch processing". This is where clinicians stockpile bulk bills and process them all at once in one big batch. (An example where this might seem useful is if you have practice administration only coming in on a part-time basis). Doing this is a bit of a red flag to Medicare as it can pop up as an anomaly and be a red flag for audit. See more information on audits below.

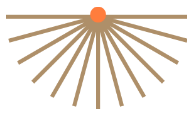


TIP: Change of GP

If you have got a client who's got a new GP, you must still communicate with the most recent referring GP to make your recommendation for a re-referral, but you can acknowledge that the client is now seeing a new GP. You can then cc the new GP into your letter and acknowledge that the rereferral will be coming from the new GP, and therefore, future communication will be with the new GP.

Section/Video 3 - Key Points:

- Referrals can cross calendar years
- Do not "batch process" bulk bills, process them as soon as possible.
- Keep a record of session numbers based on total sessions, course of treatment sessions, and calendar year sessions
- Always communicate with the most recent referring GP



Section/Video 4 - Audits

How are you selected for audit?

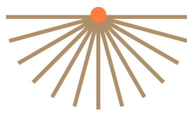
Medicare sees everything we do in terms of data. Each time we process an item number, it becomes part of an enormous data set. Conversely, if there is no item number processed, we are invisible to Medicare.

Think of all the professions that have access to Medicare provider numbers, across all of the MBS programs (i.e., Better Access is not the only one). Imagine all of the thousands of item numbers billed across all these programs every single day.

The data that Medicare gathers is useful for a number of reasons. It is used by the government to inform budgets in areas of need (such as aged care), identify defunct item numbers, and so on. This data forms one of the ways we can know how much money the government has spent on mental health care, for example.

Medicare will also look at the data to identify billing trends. This means there will be an average or "typical" billing pattern within each program. When an individual clinician's billing pattern sticks out as different to this typical pattern, they present as an outlier.

Each year, Medicare targets certain areas of MBS as targets for audit. They don't tend to conduct random audits (so you can breathe easy there), unless you've been 'dobbed in' by someone for being non-compliant or fraudulent.



Flags for Audit

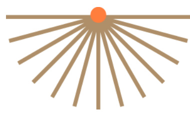
It's hard to predict what will be the next target for Medicare audits. In the past the following areas have been targeted:

- **Audit Flag: Overuse of the short session item numbers**

The average session conducted by most clinicians under Better Access is 50-60 minutes. There will also be an average number of 50-60 minute sessions billed each day. If you are exclusively using the short session number, this will mean you are seeing more clients per day, and will stand out as an outlier. This could therefore be a red flag for audit. Medicare would ask you to explain why (from a clinical best practice point of view) you've only used the short session item numbers. Making this your business choice is not a good enough reason. However, if you were working exclusively with a cohort where attention to therapy content was a challenge beyond 30 minutes, this might be valid. Medicare would want to see justification of this.

- **Audit Flag: Overuse of the out of rooms item numbers**

If you are running a mobile practice, it might make sense to you to use the Out-of-Rooms item number. However, this item number is intended to be used as a temporary measure when the client needs dictate that the session be in a place other than your normal consulting room. The item number also assumes you actually HAVE a normal consulting room. If your practice is 100% mobile, then you don't have a normal consulting room to justify the out-of-rooms item. Being a mobile practice is a business model, not an individually client-driven decision made on a session-by-session basis (which is what the item number is intended for). Therefore, being an outlier against the typical billing pattern for this item number could flag you for audit. Again, Medicare would want to see clinical justification for your perceived "overuse" of this item.



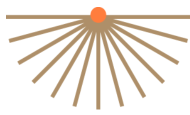
Remember, you need a provider number for any address you attend regularly to deliver MBS-funded services - even if this means an individual client's home! (I know, I don't make the rules!)

- **Audit Flag: Overbilling**

This is particularly the case where clinicians are seen to have billed significantly more items across a specified period of time than is common practice. Medicare may audit you to show that these sessions actually took place, especially if the sessions were bulk billed.

- **Audit Flag: You are dobbed in by somebody**

The most common examples of this that I'm aware of are when a student or provisional psych sees a client, and the practice uses the supervisor's provider number to apply a rebate to the session. This IS allowed if the supervisor is in the room for the whole session, but is absolutely NOT allowed if the supervisor is not in the room. Remember, by processing a rebate or an item number under your provider number, you are stating that you delivered that service yourself.



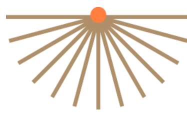
Non-Audited "Sweep" Target: Mismatch between REVIEW dates and new course of treatment

Recently Medicare conducted a sweep where clinicians were asked to show that they had a valid referral letter before commencing (typically) the seventh session of a client's treatment. Remember, Medicare doesn't see whether or not you've received a referral letter (as there are no specific item numbers associated with referrals or rereferrals).

This sweep picked up a mismatch for a number of clinicians where clients were seen for a seventh session, but the GPs had conducted formal reviews (who DO have a specific item number associated with them) after the date the seventh session rebates were processed. In some cases this mismatch occurred because the GPs decided to conduct formal reviews in addition to writing rereferral letters at an earlier date (and the clinicians were found not to be in the wrong).

Unfortunately, many clinicians were found to not have valid referral letters on file before commencing the seventh session. These clinicians were required to pay back all rebates associated with these non-compliant files. In some cases this amounted to tens of thousands of dollars, in other cases only a few errors were found and so only a small repayment was required.

ALWAYS make sure you have written your letter of recommendation/request at the end of one course of treatment AND have received a valid rereferral letter before commencing a new course of treatment (unless you and your client agree to continue without a rebate in the interim).



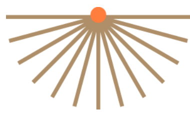
What Does Medicare Look For At Audit?

Typically, Medicare is looking for four key things at audit.

- Was there a valid referral?
- Were all the reporting obligations met? (Your letter to GP and subsequent re-referral, discharge letter)
- Was the service provided by the clinician claiming the item number?
- Was the therapy compliant with program requirements? (Eligible client, eligible practitioner, eligible intervention, and session was either face to face or a telehealth as per the item number used)

However, they may legally look beyond these things if they have grounds to suspect deliberate fraud.

Usually, if you are targeted for audit, Medicare will want to see a random sample of clients - typically 20 clients over a two year period. However, on occasion they will present you with a list of suspected non-compliant sessions (such as occurred in the above mentioned sweep).



TIP: Do your own internal audit of 20 randomly selected clients from the last two years' worth of files. Look at what's missing and then update your files accordingly. This will help you identify (and rectify) any regularly occurring problems. If, for example, you've got some clients that haven't been discharged officially, there is no harm in writing a letter to update the GP (even though significant time may have elapsed). Remember, formal discharge is a Medicare requirement.

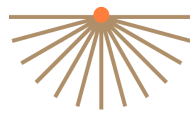
For example:

Dear Tom,

As the result of recently completed comprehensive file reviews, I note that Sarah was not formally discharged back into your care at the completion of her therapy program with me in December 2020.

I understand some time has elapsed, but please accept my belated formal discharge of Sarah into your care. Thank you again for your kind referral of Sarah, I would be happy to see her again upon your rereferral should the need arise.

Kind regards,
Tess



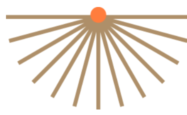
Shared liabilities between clinicians and practice owners

Medicare audits are conducted against individual provider numbers, not practices as a whole. If a clinician is audited and found to have processed rebates in a manner that is considered noncompliant, Medicare will require that the clinician pays back any rebates that are non-compliant. It is then up to the clinician to recoup any of these monies from clients (good luck with that!).

In more recent years, Medicare has updated their rules around liability such that both the clinician and the practice will share liability for the monies (and any fines) owed to Medicare, where the clinician is either an employee or subcontractor. Practice owners are not responsible if clinicians are room renters and they are independent from one another (ie, run their own practice management, billing etc). The degree that the liability is shared will depend on how the processed rebates were non-compliant. If it was a billing issue (e.g., processing of rebates before re-referral letters were received), the balance might swing more towards the practice owner. If it was a matter of failure to meet reporting obligations, the balance might swing more towards the clinician. This is determined on a case-by-case basis.

Medicare wants to ensure the items have been billed correctly, and by extension, that taxpayers' money is being spent appropriately and lawfully. If you've done something wrong, then you'll need to pay that back. If you become aware of an error in your processing, it is best to rectify that with Medicare as soon as possible, rather than risk audit later.

Medicare can penalize you for making their life difficult, but they can also reward you for making their life easier. If you are audited and refuse to comply with directions, they can increase financial penalties charged to you. Similarly if you



volunteer assistance with the process, they may choose to discount penalties charged to you. So if you know there is an issue with a file they are looking at, own up to it.

If you are found to be non-compliant at audit, Medicare has the power to garnish funds from your bank account if you refuse to comply with directions to repay rebates. Make sure you're aware of what your requirements are, and consider legal advice if selected for audit.

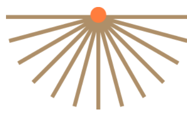
In addition to audits, Medicare can do "sweeps" where they pick up on anomalies and give you a chance to respond and rectify any problems (i.e., pay back money if you've made errors) without a full audit and associated penalties.

The amount of time given for you to produce documents may depend on the nature of the audit, and whether or not they suspect you of deliberate fraud.

Medicare can legally demand case notes as part of the documentation they require from you at audit. Whether or not they request case notes will depend on what they are looking for.

TIP: Have regular planning days at your practice where you include a quarterly file review so clinicians can spend time reviewing their own case loads and ensure any compliance issues are rectified as soon as they're identified.

TIP: Ensure all communication with Medicare is well documented. If selected for audit, seek legal advice, or contact the APS or your insurer about getting a lawyer.

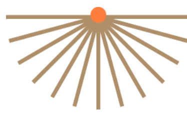


Audits and Telehealth:

Be mindful if you are temporarily providing Telehealth services from home and using your provider number linked to your office location. It is unclear how Medicare may audit the physical location for Telehealth services in the future. See page 34 for more information.

Section/Video 4 - Key Points:

- Medicare looks for outliers against the average within a huge set of data.
- Flags for audit:
    - Overuse of short session item numbers
    - Overuse of out of rooms item number
    - Overbilling
    - You are dobbed in by somebody
- Shared liability exists between the clinician and the practice owner
- Medicare can garnish funds
- Consider legal advice if you are selected for audit



Section/Video 5 & 6 - Covid19 Extensions to Better Access: Telehealth & The Extra 10

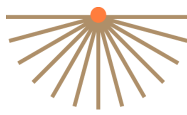
The Extra 10

Due to the ongoing impacts of Covid-19, the government made available an additional ten rebateable sessions per calendar year - making a total of 20 rebates instead of 10, using (typically) a 6+4+10 model.

In order to access the extra 10, clients must have completed the initial 10 sessions within the current calendar year and still be eligible for treatment under a MHCP.

1. You must write to the referrer upon completion of session 10 and make a specific recommendation for access to the extra 10.
2. You must have a rereferral specifically for the extra 10 before proceeding with a rebate for session 11.
3. The rereferral should specify how many sessions are required under that course of treatment. Unlike the initial 10, referrals for the extra 10 may specify the full 10 sessions in a single referral.

There are separate item numbers for the extra 10, which are listed at the end of the MBS Factsheet.



Eligibility Criteria for extra 10:

- Approved mental health care plan
- Must have already accessed all 10 of their initial 10 sessions within the current calendar year
- You must have written to the GP stating the client remains eligible, recommending ongoing therapy, and requesting a rereferral for the extra 10
- A re-referral from the GP for the extra 10

Example of recommendation letter to GP for Extra 10:

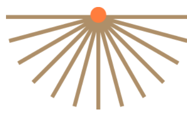
Dear Tom,

Sarah has completed her 10 sessions for the current calendar year. I note that she is still presenting with symptoms of anxiety, and DASS scores show her symptoms remain in the moderate range.

I recommend that she have access to the extra block of 10 sessions available under Better Access. If you are happy for therapy to continue, all I need from you is a letter of rereferral for the Extra 10 sessions. Otherwise, please feel free to contact me to discuss further if you have any concerns about this plan.

I'll provide you with an update in due course.

Kind regards,
Tess.



How closely do the client's psychological difficulties need to be related to COVID factors?

There is no longer any requirement that symptoms be related to Covid19. Make a clinical judgment about whether you feel the client requires continued therapy and remains eligible under Better Access. Make this clinical opinion clear in your letter of recommendation to the GP.

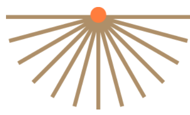
Telehealth

There are no changes to the rules that apply to the rural and remote item numbers, but as everyone is now eligible for the telehealth items initiated under Covid19 arrangements, there is little need to use these geographically-limited item numbers for the time being.

The guidelines around telehealth state a preference for video conferencing (e.g., Zoom or the telehealth function in PowerDiary), however, the guidelines also acknowledge that telephone services are available if video access is not available. There are separate item numbers for video conferencing versus telephone sessions.

Telehealth and Provider Numbers:

Your provider number should be linked to your location. For example, if you see all clients from home (face-to-face), the provider number should be linked to your home address. There has been some leeway during Covid that ensures people can temporarily continue to use their provider number linked to a practice address whilst they offer Telehealth services from home. However, there is limited information as to whether this practice is suitable long term.



Section/Video 5 & 6- Key Points:

- The government has made available an extra 10 rebatable sessions per calendar year under Better Access.
- The extra 10 sessions are only available once the initial 10 sessions have been used in that particular calendar year.
- A patient's symptoms do not have to be directly related to Covid19.
- Different item numbers for the extra 10 sessions apply. These are located at the end of the MBS Factsheet.
- There are guidelines suggesting a preference for video conferencing at this time.