



medicare

Substantiating that a patient attended a service

Guideline for responding to a Department of Human Services request to substantiate a Medicare Benefits Schedule (MBS) service.

This guideline relates to all MBS items that require a patient to be present. For example, items 23, 36, 104, 5020, 10960, and 85533.

This guideline is not exhaustive and an individual can respond to an audit using any document they believe substantiates the concern raised. However, the Department of Human Services may determine that further information is required and request additional documentation to substantiate the concern raised.

Documents you may require in the first instance to substantiate that a patient attended:

- **Payment receipt** — any type of receipt containing the patient's name or signature to confirm that the patient paid for the service.
- **Daybook or other note created during or as soon as practicable after patient attendance** — any record kept by a practitioner, third party or practice that is made at the time of a patient attendance indicating the name of the patient and the date of service.
- **Any document created during the attendance** — that includes the patient's name, the date of service and a comment on the service. For example, a copy of a referral, request, medical certificate or other document that contains the patient's name and the date of service.

- **An excerpt from the patient's clinical file** — clearly showing the patient's name and the date of service and sufficient information to verify the attendance of the patient. This may include history or examination findings entered into the clinical file during or as soon as practicable after the provision of the service.

You are not expected to produce clinical information relating to a patient unless those details are necessary to substantiate that the patient attended the service. Where clinical information is not necessary to substantiate this fact, that information should be censored in all documents provided.

If you are asked to produce documents containing clinical information, you can choose to only provide it to a medical practitioner employed by the Department of Human Services.

Notice to Produce Documents

Under subsection 129AAD of the *Health Insurance Act 1973*, the Department of Human Services can issue a formal notice for you to produce documents that substantiate your services under the Medicare program where there is a reasonable concern that a benefit has been paid that exceeds the amount that should have been paid.

A notice to produce documents can be issued if you do not voluntarily respond to a request by the Department of Human Services to provide substantiating documents for compliance audit purposes.

A notice to produce documents can be issued in relation to services rendered on or after 9 April 2011.

Additionally, subsection 129AAJ of the *Health Insurance Act 1973* gives you the ability to request a review of decision for any audit findings determined by a Department of Human Services — Medicare compliance audit.

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- The patient or clinical record must be contemporaneous. This means it must be completed at the time the service was rendered or initiated or as soon as practicable afterwards.
- Records produced to substantiate concerns raised by the Department of Human Services may be in paper or electronic form; however both forms must satisfy the requirements to be adequate and contemporaneous.
- Make sure you refer to any guidance provided by your relevant professional body in relation to records and record keeping.

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Record keeping

- All practitioners who provide or initiate a service for which a Medicare benefit is payable should ensure they maintain adequate and contemporaneous records.
- Records should clearly identify the name of the patient; contain a separate entry for each attendance by the patient for a service; indicate the date on which the service was rendered or initiated; contain information adequate to explain the type of service rendered or initiated; and be sufficiently comprehensible that another practitioner, relying on the record, could effectively undertake the patient's ongoing care.