

Reimbursement Rates for Medical Service Information

page

The Transport Accident Commission (TAC) can fund the reasonable cost of services provided by a medical practitioner to people injured in transport accidents.

The TAC has adopted the Medicare Benefits Schedule (MBS) items, explanations, definitions, rules and conditions for services provided by medical practitioners. When invoicing for medical services, medical practitioners are expected to adhere to the MBS rules unless otherwise specified by the TAC in this document or its medical policies.

Some of the key billing rules that are relevant to medical practitioners when invoicing the TAC are summarised below:

Multiple Operation Rule

Non-orthopaedic procedures

For all procedures (other than orthopaedic operations set out in Group T8, Subgroup 15) the MBS multiple operation rule applies using the fees within this document. For further information refer to Section T.N.8.2 “Multiple Operation Rule” of the MBS.

Orthopaedic Procedures

For orthopaedic operations set out in Group T8, Subgroup 15 of the MBS (other than fractures and dislocations), the fees for two or more operations performed on a patient on the one occasion should be calculated using the following rules:

- 100 per cent for the item with the greatest TAC fee; plus 75 per cent of each other item.

Fractures and Dislocations

For the treatment of dislocations and fractures, the fees for two or more operations performed on a patient on the one occasion should be calculated using the following rules:

- For multiple dislocations or fractures requiring an operative or manipulative procedure, the fee for each dislocation or fracture shall be 100% of the TAC fee.
- For multiple dislocations or fractures where the second or subsequent conditions do not require operative or manipulative treatment, the fee for the second and each subsequent procedure shall be 75% of the TAC fee.
- When dislocations and fractures are associated with a compound (open) wound, an additional fee of 50% of the dislocation or fracture fee shall apply. The additional 50% applies only to the dislocation or fracture fee and does not apply to the fees for any other procedures that may be performed during the surgery. The medical practitioner must state on their invoice ‘**Open**’ or ‘**Compound**’ next to the procedure item number.

Except where otherwise specified by the TAC, the fee for a fracture-dislocation to the same site shall be the fee for the fracture or dislocation, whichever is the greater, plus 50% of the TAC fee for the lesser procedure.

Assistance at Operations

The TAC adopts the principles as detailed in the MBS regarding “Assistance at Operations”. The TAC requires medical practitioners to identify the principal surgeon, the MBS item numbers (where assistance is payable), the total fee charged for the operation, and to indicate that these item numbers were for assistance at operations. For further details refer to Section T.N.9.1 “Assistance at Operations” of the MBS.

Aftercare

The TAC adopts the principles as detailed in the MBS regarding “Aftercare”. If an additional service is required within the “Aftercare Period”, the invoice should be marked “not normal aftercare”, with a brief explanation of the reason for this service. Adequate and contemporaneous records must also be kept to support this explanation. For further details refer to Section TN.8.4 “Aftercare (Post-operative Treatment)” of the MBS.

Complete Medical Service Principle

The TAC adopts the “Complete Medical Service” principle within the MBS. The MBS states that, each professional service listed in the MBS is a complete medical service. Where a listed service is also a component of a more comprehensive service covered by another item, the benefit for the latter service will cover the former. For example, surgical management of a limb fracture would

reasonably be expected to include release of haematoma. Therefore, billing for drainage of haematoma in addition to surgical treatment of the fracture is inappropriate. For further details refer to GN.14.34 “Principles of Interpretation” of the MBS.

Mutually Exclusive Services

The TAC adopts the descriptions of all items within the MBS, including those that are mutually exclusive; that is, where another service does not apply. The TAC also adopts the principle of clinical justification in the context of the use of the item descriptors. For instance, it is inappropriate to bill for both open and closed fracture item numbers for the one fracture or item numbers that include ‘cord involvement’ and ‘no cord involvement’ for the one spinal fracture. For further details refer to TN.8.1 “Surgical Operations” of the MBS.

Adequate and Contemporaneous Records

All medical practitioners are reminded that they should maintain adequate and contemporaneous records, which include clinical information explaining the service rendered, and are written at the time, or as close to the time as practicable, of the service. For further details refer to GN.15.39 “Practitioners should maintain adequate and contemporaneous records” of the MBS.

Medical Supervision

During surgical procedures, payment to specialists who are supervising specialist trainees is conditional based on the following:

- The medical practitioner claiming for a service performed under their supervision must be physically present and contribute during the procedure.
- The medical practitioner claiming for the service cannot claim for other procedures occurring during the time of the supervision. For example, if the procedure supervised is from 2pm to 4pm then no other procedures or services can be claimed during this period of time.
- Supervision of surgical assistance cannot be claimed.
- All contemporaneous hospital operation records or clinical notes should reflect the role of the specialist in directly supervising the trainee.

In non-surgical circumstances, the medical practitioner must personally undertake the service for which they are billing unless otherwise specified in the MBS. If the MBS allows services to be rendered on behalf of medical practitioners, the supervising medical practitioner must have a direct involvement in at least part of the service, unless the MBS guidelines allows for another arrangement.

For further details refer to GN.12.30 “Professional Services” and GN.12.31 “Services rendered on behalf of Medical Practitioners” of the MBS.

Hospital Medical Officers, Registrars and Fellows in Public Hospitals

Hospital Medical Officers, Registrars and Fellows are not entitled to bill the TAC for services to admitted patients, as these expenses are included in payments made directly to public hospitals under the WIES funding system (Casemix). Radiology, Pathology, Outpatient, non-admitted Emergency Department and Rehabilitation services in public hospitals are not funded by the TAC through the WIES system. These services can be billed independently.

Further Information

You can access the following publications or access more information about medical services by visiting tac.vic.gov.au or contacting the TAC customer service centre on 1300 654 329 or 1800 332 556 (if calling outside of Melbourne), or email info@tac.vic.gov.au

- [Doctors and diagnostics policy](#)
- [Medical practitioner provider guidelines](#)
- [How to Invoice the TAC](#)

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