Australian Government
Department of Health and Ageing

Medicare Benefits Schedule Book

Optometrical Services Schedule

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At the time of printing, the relevant legislation giving authority for the changes included in this edition of the book may still be subject to the approval of Executive Council and the usual Parliamentary scrutiny. This book is not a legal document, and, in cases of discrepancy, the legislation will be the source document for payment of Medicare benefits.

The latest Medicare Benefits Schedule information is available from *MBS Online* at http://www.health.gov.au/mbsonline

G.1.1. The Medicare Benefits Schedule - Introduction

Schedules of Services

Each professional service contained in the book has been allocated a unique item number. Located with the item number and description for each service is the Schedule fee and Medicare benefit, together with a reference to an explanatory note relating to the item (if applicable).

If the service attracts an anaesthetic, the word (Anaes.) appears following the description. Where an operation qualifies for the payment of benefits for an assistant, the relevant items are identified by the inclusion of the word (Assist.) in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

In some cases two levels of fees are applied to the same service in General Medical Services, with each level of fee being allocated a separate item number. The item identified by the letter "S" applies in the case where the procedure has been rendered by a recognised specialist in the practice of his or her specialty and the patient has been referred. The item identified by the letter "G" applies in any other circumstance.

Higher rates of benefits are also provided for consultations by a recognised consultant physician where the patient has been referred by another medical practitioner or an approved dental practitioner (oral surgeons).

Differential fees and benefits also apply to services listed in Category 5 (Diagnostic Imaging Services). The conditions relating to these services are set out in Category 5.

Explanatory Notes

Explanatory notes relating to the Medicare benefit arrangements and notes that have general application to services are located at the beginning of the schedule, while notes relating to specific items are located at the beginning of each Category. While there may be a reference following the description of an item to specific notes relating to that item, there may also be general notes relating to each Group of items.

G.1.2. Medicare - an outline

The Medicare Program ('Medicare') provides access to medical and hospital services for all Australian residents and certain categories of visitors to Australia. **Medicare Australia** administers Medicare and the payment of Medicare benefits. The major elements of Medicare are contained in the *Health Insurance Act 1973*, as amended, and include the following:

(a). Free treatment for public patients in public hospitals.

(b). The payment of 'benefits', or rebates, for professional services listed in the Medicare Benefits Schedule (MBS). In general, the Medicare benefit is 85% of the Schedule fee, otherwise the benefits are

i. 100% of the Schedule fee for services provided by a general practitioner to non-referred, non-admitted patients;

ii. 100% of the Schedule fee for services provided on behalf of a general practitioner by a practice nurse or registered Aboriginal Health Worker;

iii. 75% of the Schedule fee for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients);

iv. 75% of the Schedule fee for professional services rendered as part of a privately insured episode of hospital-substitute treatment.

Medicare benefits are claimable only for 'clinically relevant' services rendered by an appropriate health practitioner. A 'clinically relevant' service is one which is generally accepted by the relevant profession as necessary for the appropriate treatment of the patient.

When a service is not clinically relevant, the fee and payment arrangements are a private matter between the practitioner and the patient.

Services listed in the MBS must be rendered according to the provisions of the relevant Commonwealth, State and Territory laws. For example, medical practitioners must ensure that the medicines and medical devices they use have been supplied to them in strict accordance with the provisions of the *Therapeutic Goods Act 1989.*

Where a Medicare benefit has been inappropriately paid, Medicare Australia may request its return from the practitioner concerned.

G.1.3. Medicare benefits and billing practices

Key information on Medicare benefits and billing practices

The *Health Insurance Act 1973* stipulates that Medicare benefits are payable for professional services. A professional service is a clinically relevant service which is listed in the MBS. A medical service is clinically relevant if it is generally accepted in the medical profession as necessary for the appropriate treatment of the patient.

Medical practitioners are free to set their fees for their professional service. However, the amount specified in the patient's account must be the amount charged for the service specified. The fee may not include a cost of goods or services which are not part of the MBS service specified on the account.

Billing practices contrary to the Act

A *non-clinically relevant service* must not be included in the charge for a Medicare item. The non-clinically relevant service must be separately listed on the account and not billed to Medicare.

Goods supplied for the patient's home use (such as wheelchairs, oxygen tanks, continence pads) must not be included in the consultation charge. Medicare benefits are limited to services which the medical practitioner provides at the time of the consultation – any other services must be separately listed on the account and must not be billed to Medicare.

Charging part of all of an episode of hospital treatment or a hospital substitute treatment to a non-admitted consultation is prohibited. This would constitute a false or misleading statement on behalf of the medical practitioner and no Medicare benefits would be payable.

An account may not be re-issued to include charges and out-of-pocket expenses excluded in the original account. The account can only be reissued to correct a genuine error.

Potential consequence of improperly issuing an account

The potential consequences for improperly issuing an account are

(a). No Medicare benefits will be paid for the service;

(b). The medical practitioner who issued the account, or authorised its issue, may face charges under sections 128A or 128B of the *Health Insurance Act 1973*.

(c). Medicare benefits paid as a result of a false or misleading statement will be recoverable from the doctor under section 129AC of the *Health Insurance Act 1973*.

Providers should be aware that Medicare Australia is legally obliged to investigate doctors suspected of making false or misleading statements, and may refer them for prosecution if the evidence indicates fraudulent charging to Medicare. If Medicare benefits have been paid inappropriately or incorrectly, Medicare Australia will take recovery action.

G.2.1. Provider eligibility for Medicare

To be eligible to provide medical service which will attract Medicare benefits, or to provide services for or on behalf of another practitioner, practitioners must meet one of the following criteria:

(a) be a recognised specialist, consultant physician or general practitioner; or

(b) be in an approved placement under section 3GA of the *Health Insurance Act 1973*; or

(c) be a temporary resident doctor with an exemption under section 19AB of the *Health Insurance Act 1973*, and working in accord with that exemption .

Any practitioner who does not satisfy the requirements outlined above may still practice medicine but their services will not be eligible for Medicare benefits.

NOTE: New Zealand citizens entering Australia do so under a special temporary entry visa and are regarded as temporary resident doctors.

NOTE: It is an offence under Section 19CC of the *Health Insurance Act 1973* to provide a service without first informing a patient where a Medicare benefit is not payable for that service (i.e. the service is not listed in the MBS).

Non-medical practitioners
To be eligible to provide services which will attract Medicare benefits under MBS items 10950-10977 and MBS items 80000-89000, allied health professionals, dentists, and dental specialists must be
(a) registered according to State or Territory law or, absent such law, be members of a professional association with uniform national registration requirements; and
(b) registered with Medicare Australia to provide these services.

G.2.2. Provider Numbers
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. The form may be downloaded from www.medicareaustralia.gov.au

For Medicare purposes, an account/receipt issued by a practitioner must include the practitioner's name and ***either*** the provider number for the location where the service was provided ***or*** the address where the services were provided.

Medicare provider number information is released in accord with the secrecy provisions of the *Health Insurance Act 1973* (section 130) to authorized external organizations including private health insurers, the Department of Veterans' Affairs and the Department of Health and Ageing.

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.

G.2.3. Locum tenens
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).

A locum must use the provider number allocated to the location if
(a) they are an approved general practice or specialist trainee with a provider number issued for an approved training placement; or
(b) they are associated with an approved rural placement under Section 3GA of the *Health Insurance Act 1973*; or
(c) they have access to Medicare benefits as a result of the issue of an exemption under section 19AB of the *Health Insurance Act 1973* (i.e. they have access to Medicare benefits at specific practice locations); or
(d) they will be at a practice which is participating in the Practice Incentives Program; or
(e) they are associated with a placement on the MedicarePlus for Other Medical Practitioners (OMPs) program, the After Hours OMPs program, the Rural OMPs program or Outer Metropolitan OMPs program.

G.2.4. Overseas trained doctor
Ten year moratorium

Section 19AB of the *Health Insurance Act 1973* states that services provided by overseas trained doctors (including New Zealand trained doctors) and former overseas medical students trained in Australia, will not attract Medicare benefits for 10 years from ***either***

(a) their date of registration as a medical practitioner for the purposes of the *Health Insurance Act 1973; **or***
(b) their date of permanent residency (the reference date from will vary from care to case).

Exclusions - Practitioners who **before 1 January 1997** had

(a) registered with a State or Territory medical board ***and*** retained a continuing right to remain in Australia; ***or***
(b) lodged a valid application with the Australian Medical Council (AMC) to undertake examinations whose successful completion would normally entitle the candidate to become a medical practitioner.

The Minister of Health and Ageing may grant an overseas trained doctor (OTD) or occupational trainee (OT) an exemption to the requirements of the ten year moratorium, with or without conditions. When applying for a Medicare provider number, the OTD or OT must

(a) demonstrate that they need a provider number and that their employer supports their request; and
(b) provide the following documentation:
    i. Australian medical registration papers; and
    ii. a copy of their personal details in their passport and all Australian visas and entry stamps; and
    iii. a letter from the employer stating why the person requires a Medicare provider number and/or prescriber number is required; and
    iv. a copy of the employment contract.

G.2.5. Addresses of Medicare Australia, Schedule Interpretation and Changes to Provider Details

Medicare Australia,
GPO Box 9822,
in the Capital City in each State

Phone:132-150 for all States and Territories (local call cost)

NEW SOUTH WALES **Medicare Australia Paramatta Office** 130 George Street PARRAMATTA NSW 2165	**VICTORIA** **Medicare Australia Melbourne Office** 595 Collins Street MELBOURNE VIC 3000	**QUEENSLAND** **Medicare Australia Brisbane Office** 143 Turbot Street BRISBANE QLD 4000
SOUTH AUSTRALIA **Medicare Australia Adelaide Office** 209 Greenhill Road EASTWOOD SA 5063	**WESTERN AUSTRALIA** **Medicare Australia Perth Office** Bank West Tower 108 St. George's Terrace PERTH WA 6000	**TASMANIA** **Medicare Australia Hobart Office** 242 Liverpool Street HOBART TAS 7000
NORTHERN TERRITORY As per South Australia	**AUSTRALIAN CAPITAL TERRITORY** **Medicare Australia National Office** 134 Reed Street TUGGERANONG ACT 2901	

Schedule Interpretations

The day-to-day administration and payment of benefits under the Medicare arrangements is the responsibility of Medicare Australia. Inquiries concerning matters of interpretation of Schedule items should be directed to Medicare Australia and not to the Department of Health and Ageing. The following telephone number 132 150 have been reserved by Medicare Australia exclusively for inquiries relating to the Schedule.

Changes to Provider Details

It is important that Medicare Australia be notified promptly of changes to practice addresses to ensure correct provider details for each practice location. Changes to practice address details can be made in writing to the Medicare Australia office, listed above, in the State of the practice location.

G.3.1. Patient eligibility for Medicare

An "eligible person" is a person who resides permanently in Australia. This includes New Zealand citizens and holders of permanent residence visas. Applicants for permanent residence may also be eligible persons, depending on circumstances. Eligible persons must enrol with Medicare before they can receive Medicare benefits.

Medicare covers services provided only in Australia. It does not refund treatment or evacuation expenses overseas.

G.3.2. Medicare cards

The **green** Medicare card is for people permanently in Australia. Cards may be issued for individuals or families.

The **blue** Medicare card bearing the words “INTERIM CARD” is for people who have applied for permanent residence.

Visitors from countries with which Australia has a Reciprocal Health Care Agreement receive a card bearing the words "RECIPROCAL HEALTH CARE"

G.3.3. Visitors to Australia and temporary residents

Visitors and temporary residents in Australia are not eligible for Medicare and should therefore have adequate private health insurance.

G.3.4. Reciprocal Health Care Agreements

Australia has Reciprocal Health Care Agreements with New Zealand, Ireland, the United Kingdom, the Netherlands, Sweden, Finland, Norway, Italy and Malta.

Visitors from these countries are entitled to medically necessary treatment while they are in Australia, comprising public hospital care (as public patients), Medicare benefits and drugs under the Pharmaceutical Benefits Scheme (PBS). Visitors must enrol with Medicare Australia to receive benefits. A passport is sufficient for public hospital care and PBS drugs.

Exceptions:

- Visitors from Ireland and New Zealand are entitle to public hospital care and PBS drugs, and should present their passports before treatment as they are not issued with Medicare careds.
- Visitors from Italy and Malta are covered for a period of six months only.

The Agreements do not cover treatment as a private patient in a public or private hospital. People visiting Australia for the purpose of receiving treatment are not covered.

G.4.1. General Practice

Some MBS items may only be used by general practitioners. For MBS purposes a general practitioner is a medical practitioner who is

(a) vocationally registered under section 3F of the *Health Insurance Act 1973* (see General Explanatory Note below); or

(b) a Fellow of the Royal Australian College of General Practitioners (FRACGP), who participates in, and meets the requirements for the RACGP Quality Assurance and Continuing Medical Education Program; or

(c) a Fellow of the Australian College of Rural and Remote Medicine (FACRRM) who participates in, and meets the requirements for the ACRRM Quality Assurance and Continuing Medical Education Program; or

(d) is undertaking an approved general practice placement in a training program for ***either*** the award of FRACGP ***or*** a training program recognised by the RACGP being of an equivalent standard; or

(e) is undertaking an approved general practice placement in a training program for ***either*** the award of FACRRM ***or*** a training program recognised by ACRRM as being of an equivalent standard.

A medical practitioner seeking recognition as an FRACGP should apply to Medicare Australia, having completed an application form available from Medicare Australia's website. A general practice trainee should apply to General Practice Education and Training Limited (GPET) for a general practitioner trainee placement. GPET will advise Medicare Australia when a placement is approved. General practitioner trainees need to apply for a provider number using the appropriate provider number application form available on Medicare Australia's website.

Vocational recognition of general practitioners

The only qualifications leading to vocational recognition are FRACGP and FACRRM. The criteria for recognition as a GP are:

(a) certification by the RACGP that the practitioner
- is a Fellow of the RACGP; and
- practice is, or will be within 28 days, predominantly in general practice; and
- has met the minimum requirements of the RACGP for taking part in continuing medical education and quality assurance programs.

(b) certification by the General Practice Recognition Eligibility Committee (GPREC) that the practitioner
- is a Fellow of the RACGP; and
- practice is, or will be within 28, predominantly in general practice; and
- has met minimum requirements of the RACGP for taking part in continuing medical education and quality assurance programs.

(c) certification by ACRRM that the practitioner
- is a Fellow of ACRRM; and
- has met the minimum requirements of the ACRRM for taking part in continuing medical education and quality assurance programs.

In assessing whether a practitioner's medical practice is predominantly in general practice, the practitioner must have at least 50% of clinical time and services claimed against Medicare. Regard will also be given as to whether the practitioner provides a comprehensive primary medical service, including treating a wide range of patients and conditions using a variety of accepted medical skills and techniques, providing services away from the practitioner's surgery on request, for example, home visits and making appropriate provision for the practitioner's patients to have access to after hours medical care.

Further information on eligibility for recognition should be directed to:

Program Relations Officer, RACGP
Tel: (03) 8699 0494 Email at: qacpd@racgp.org.au

Secretary, General Practice Recognition Eligibility Committee:
Tel: (02) 6124 6753 Email at co.medicare.eligibility@medicareaustralia.gov.au

Executive Assistant, ACRRM:
Tel: (07) 3105 8200 Email at acrrm@acrrm.org.au

How to apply for vocational recognition

Medical practitioners seeking vocational recognition should apply to Medicare Australia using the approved Application Form available on the Medicare Australia website: www.medicareaustralia.gov.au. Applicants should forward their applications, as appropriate, to

Chief Executive Officer
The Royal Australian College of General Practitioners
College House
1 Palmerston Crescent
SOUTH MELBOURNE VIC 3205

Chief Executive Officer
Australian College of Rural and Remote Medicine
GPO Box 2507
BRISBANE QLD 4001

Secretary
The General Practice Recognition Eligibility Committee
Medicare Australia
PO Box 1001
TUGGERANONG ACT 2901

The relevant body will forward the application together with its certification of eligibility to the Medicare Australia CEO for processing.

Continued vocational recognition is dependent upon:

(a) the practitioner's practice continuing to be predominantly in general practice (for medical practitioners in the Register only); and

(b) the practitioner continuing to meet minimum requirements for participation in continuing professional development programs approved by the RACGP or the ACRRM.

Further information on continuing medical education and quality assurance requirements should be directed to the RACGP or the ACRRM depending on the college through which the practitioner is pursuing, or is intending to pursue, continuing medical education.

Medical practitioners refused certification by the RACGP, the ACRRM or GPREC may appeal in writing to the General Practice Recognition Appeal Committee (GPRAC), Medicare Australia, PO Box 1001, Tuggeranong, ACT, 2901.

Removal of vocational recognition status

A medical practitioner may at any time request Medicare Australia to remove their name from the Vocational Register of General Practitioners.

Vocational recognition status can also be revoked if the RACGP, the ACRRM or GPREC certifies to Medicare Australia that it is no longer satisfied that the practitioner should remain vocationally recognised. Appeals of the decision to revoke vocational recognition may be made in writing to GPRAC, at the above address.

A practitioner whose name has been removed from the register, or whose determination has been revoked for any reason must make a formal application to re-register, or for a new determination.

G.5.1. Recognition as a Specialist or Consultant Physician

A medical practitioner who:

- is registered as a specialist under State or Territory law; or
- holds a fellowship of a specified specialist College and has obtained, after successfully completing an appropriate course of study, a relevant qualification from a relevant College

and has formally applied and paid the prescribed fee, may be recognised by the Minister as a specialist or consultant physician for the purposes of the *Health Insurance Act 1973*.

A relevant specialist College may also give Medicare Australia's Chief Executive Officer a written notice stating that a medical practitioner meets the criteria for recognition.

A medical practitioner who is training for a fellowship of a specified specialist College and is undertaking training placements in a private hospital or in general practice, may provide services which attract Medicare rebates. Specialist trainees should consult the information available at www.medicareaustralia.gov.au.

Once the practitioner is recognised as a specialist or consultant physician for the purposes of the *Health Insurance Act 1973*, Medicare benefits will be payable at the appropriate higher rate for services rendered in the relevant speciality, provided the patient has been appropriately referred to them.

Further information about applying for recognition is available at www.medicareaustralia.gov.au.

G.5.2. Emergency Medicine

A practitioner will be acting as an emergency medicine specialist when treating a patient within 30 minutes of the patient's presentation, and that patient is

(a) at risk of serious morbidity or mortality requiring urgent assessment and resuscitation; or
(b) suffering from suspected acute organ or system failure; or
(c) suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or
(d) suffering from a drug overdose, toxic substance or toxin effect; or
(e) experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or
(f) suffering acute severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or
(g) suffering acute significant haemorrhage requiring urgent assessment and treatment; and
(h) treated in, or via, a bona fide emergency department in a hospital.

Benefits are not payable where such services are rendered in the accident and emergency departments or outpatient departments of public hospitals.

G.6.1. Referral Of Patients To Specialists Or Consultant Physicians

For certain services provided by specialists and consultant physicians, the Medicare benefit payable is dependent on acceptable evidence that the service has been provided following referral from another practitioner.

A reference to a referral in this Section does not refer to written requests made for pathology services or diagnostic imaging services.

What is a Referral?

A "referral" is a request to a specialist or a consultant physician for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s).

Subject to the exceptions in the paragraph below, for a valid "referral" to take place

(i) the referring practitioner must have undertaken a professional attendance with the patient and turned his or her mind to the patient's need for referral and have communicated relevant information about the patient to the specialist or consultant physician (this need not mean an attendance on the occasion of the referral);
(ii) the instrument of referral must be in writing as a letter or note to a specialist or to a consultant physician and must be signed and dated by the referring practitioner; and
(iii) the specialist or consultant physician to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

The exceptions to the requirements in paragraph above are that

(a) sub-paragraphs (i),(ii) and (iii) do not apply to
- a pre-anaesthesia consultation by a specialist anaesthetist (items 16710-17625);

(b) sub-paragraphs (ii) and (iii) do not apply to
- a referral generated during an episode of hospital treatment, for a privately insured service provided or arranged by that hospital, where the hospital records provide evidence of a referral (including the referring practitioner's signature); or
- an emergency where the referring practitioner or the specialist or the consultant physician was of the opinion that the service be rendered as quickly as possible; and

(c) sub-paragraph (iii) does not apply to instances where a written referral was completed by a referring practitioner but was lost, stolen or destroyed.

Examination by Specialist Anaesthetists

A referral is not required in the case of pre-anaesthesia consultation items 17610-17625. However, for benefits to be payable at the specialist rate for consultations, other than pre-anaesthesia consultations by specialist anaesthetists (items 17640 -17655) a referral is required.

Who can Refer?
The general practitioner is regarded as the primary source of referrals. Cross-referrals between specialists and/or consultant physicians should usually occur in consultation with the patient's general practitioner.

Referrals are to be made as follows:-

(a) to a recognised consultant physician -
  (i) by another medical practitioner; or
  (ii) by an approved dental practitioner [1] (oral surgeon), where the referral arises out of a dental service;

(b) to a recognised specialist -
  (i) by another medical practitioner; or
  (ii) by a registered dental practitioner [2], where the referral arises out of a dental service; or
  (iii) by a registered optometrist where the specialist is an ophthalmologist.

[1] See paragraph OB.1 for the definition of an approved dental practitioner.

[2] A registered dental practitioner is a dentist registered with the Dental Board of the State or Territory where s/he practices. A registered dental practitioner may or may not be an approved dental practitioner.

Billing

Routine Referrals

In addition to providing the usual information required to be shown on accounts, receipts or assignment forms, specialists and consultant physicians must provide the following details (unless there are special circumstances as indicated in paragraph below):-

- name and either practice address or provider number of the referring practitioner;
- date of referral; and
- period of referral (when other than for 12 months) expressed in months, eg "3", "6" or "18" months, or "indefinitely" should be shown.

Special Circumstances

(i) Lost, stolen or destroyed referrals.

If a referral has been made but the letter or note of referral has been lost, stolen or destroyed, benefits will be payable at the referred rate if the account, receipt or the assignment form shows the name of the referring medical practitioner, the practice address or provider number of the referring practitioner (if either of these are known to the consultant physician or specialist) and the words 'Lost referral'. This provision only applies to the initial attendance. For subsequent attendances to attract Medicare benefits at the referred rate a duplicate or replacement letter of referral must be obtained by the specialist or the consultant physician.

(ii) Emergencies

If the referral occurred in an emergency, benefit will be payable at the referred rate if the account, receipt or assignment form is endorsed 'Emergency referral'. This provision only applies to the initial attendance. For subsequent attendances to attract Medicare benefits at the referred rate the specialist/consultant physician must obtain a letter of referral.

(iii) Hospital referrals.

Private Patients - Where a referral is generated during an episode of hospital treatment for a privately insured service provided or arranged by that hospital, benefits will be payable at the referred rate if the account, receipt or assignment form is endorsed 'Referral within (name of hospital)' and the patient's hospital records show evidence of the referral (including the referring practitioner's signature). However, in other instances where a medical practitioner within a hospital is involved in referring a patient (e.g. to a specialist or a consultant physician in private rooms) the normal referral arrangements apply, including the requirement for a referral letter or note and its retention by the specialist or the consultant physician billing for the service.

Public Hospital Patients

Under the 2003-2008 Australian Health Care Agreements, State and Territory Governments were responsible for the provision of public hospital services to eligible persons in accordance with the terms and conditions of the Agreements. On expiry of the Agreements on 30 June 2008, the Minister for Health and Ageing made a series of determinations after an amendment to the Health Care (Appropriation) Act 1998. These determinations, known as 2008-09 Health Care Determinations, effectively rolled over the terms and conditions of the 2003-08 Agreements to 30 June 2009.

Bulk Billing

Bulk billing assignment forms should show the same information as detailed above. However, faster processing of the claim will be facilitated where the provider number (rather than the practice address) of the referring practitioner is shown.

Period for which Referral is Valid
The referral is valid for the period specified in the referral which is taken to commence on the date of the specialist's or consultant physician's first service covered by that referral.

Specialist Referrals
Where a referral originates from a specialist or a consultant physician, the referral is valid for 3 months, except where the referred patient is an admitted patient. For admitted patients, the referral is valid for 3 months or the duration of the admission whichever is the longer.

As it is expected that the patient's general practitioner will be kept informed of the patient's progress, a referral from a specialist or a consultant physician must include the name of the patient's general practitioners and/or practice. Where a patient is unable or unwilling to nominate a general practitioner or practice this must be stated in the referral.

Referrals by other Practitioners
Where the referral originates from a practitioner other than those listed in *Specialist Referrals*, the referral is valid for a period of 12 months, unless the referring practitioner indicates that the referral is for a period more or less than 12 months (eg. 3, 6 or 18 months or valid indefinitely). Referrals for longer than 12 months should only be used where the patient's clinical condition requires continuing care and management of a specialist or a consultant physician for a specific condition or specific conditions.

Definition of a Single Course of Treatment
A single course of treatment involves an initial attendance by a specialist or consultant physician and the continuing management/treatment up to the stage where the patient is referred back to the care of the referring practitioner. It also includes any subsequent review of the patient's condition by the specialist or the consultant physician that may be necessary. Such a review may be initiated by either the referring practitioner or the specialist/consultant physician.

The presentation of an unrelated illness, requiring the referral of the patient to the specialist's or the consultant physician's care would initiate a new course of treatment in which case a new referral would be required.

The receipt by a specialist or consultant physician of a new referral following the expiration of a previous referral for the same condition(s) does not necessarily indicate the commencement of a new course of treatment involving the itemisation of an initial consultation. In the continuing management/treatment situation the new referral is to facilitate the payment of benefits at the specialist or the consultant physician referred rates rather than the unreferred rates.

However, where the referring practitioner:-
(a) deems it necessary for the patient's condition to be reviewed; and
(b) the patient is seen by the specialist or the consultant physician outside the currency of the last referral; and
(c) the patient was last seen by the specialist or the consultant physician more than 9 months earlier
the attendance following the new referral initiates a new course of treatment for which Medicare benefit would be payable at the initial consultation rates.

Retention of Referral Letters
The prima facie evidence that a valid referral exists is the provision of the referral particulars on the specialist's or the consultant physician's account.

A specialist or a consultant physician is required to retain the instrument of referral (and a hospital is required to retain the patient's hospital records which show evidence of a referral) for 18 months from the date the service was rendered.

A specialist or a consultant physician is required, if requested by the Managing Director of Medicare Australia, to produce to a Medical Adviser, who is an officer of Medicare Australia, the instrument of referral within seven days after the request is received. Where the referral originates in an emergency situation or in a hospital, the

specialist or consultant physician is required to produce such information as is in his or her possession or control relating to whether the patient was so treated.

Attendance for Issuing of a Referral
Medicare benefit is attracted for an attendance on a patient even where the attendance is solely for the purpose of issuing a referral letter or note. However, if a medical practitioner issues a referral without an attendance on the patient, no benefit is payable for any charge raised for issuing the referral.

Locum-tenens Arrangements
It should be noted that where a non-specialist medical practitioner acts as a locum-tenens for a specialist or consultant physician, or where a specialist acts as a locum-tenens for a consultant physician, Medicare benefit is only payable at the level appropriate for the particular locum-tenens, eg, general practitioner level for a general practitioner locum-tenens and specialist level for a referred service rendered by a specialist locum tenens.

Medicare benefits are not payable where a practitioner is not eligible to provide services attracting Medicare benefits acts as a locum-tenens for any practitioner who is eligible to provide services attracting Medicare benefits.

Fresh referrals are not required for locum-tenens acting according to accepted medical practice for the principal of a practice ie referrals to the latter are accepted as applying to the former and benefit is not payable at the initial attendance rate for an attendance by a locum-tenens if the principal has already performed an initial attendance in respect of the particular instrument of referral.

Self Referral
Medical practitioners may refer themselves to consultant physicians and specialists and Medicare benefits are payable at referred rates.

Referrals by Dentists or Optometrists
For Medicare benefit purposes, a referral may be made to

(i) a recognised specialist:
  (a) by a registered dental practitioner, where the referral arises from a dental service; or
  (b) by a registered optometrist where the specialist is an ophthalmologist; or

(ii) a consultant physician, by an approved dental practitioner (oral surgeon), where the referral arises out of a dental service.

In any other circumstances (i.e. a referral to a consultant physician by a dentist, other than an approved oral surgeon, or an optometrist, or a referral by an optometrist to a specialist other than a specialist ophthalmologist), it is <u>not</u> a valid referral. Any resulting consultant physician or specialist attendances will attract Medicare benefits at unreferred rates.

Registered dentists and registered optometrists may refer themselves to specialists in accordance with the criteria above, and Medicare benefits are payable at the levels which apply to their referred patients.

G.7.1. Billing procedures
Itemised Accounts
Where the doctor bills the patient for medical services rendered, the patient needs a properly itemised account/receipt to claim Medicare benefits.

Under the provisions of the *Health Insurance Act 1973* and *Regulations*, a Medicare benefit is not payable for a professional service unless it is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of the service, the following particulars

(i) patient's name;
(ii) the date the professional service was rendered;
(iii) the amount charged for the service;
(iv) the total amount paid in respect of the service;
(v) any amount outstanding in respect of the service;
(vi) for professional services rendered to a patient as part of a privately insured episode of hospital treatment; an asterisk '*' directly after an item number where used; or a description of the professional service sufficient to identify the item that relates to that service, preceded by the word 'admitted patient' ;

(vii) for professional services rendered as part of a privately insured episode of hospital-substitute treatment and the patient who receives the treatment chooses to receive a benefit from a private health insurer, the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service sufficient to identify the item that relates to that service, preceded by the words 'hospital-substitute treatment';

(viii) 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);

(ix) the name and practice address or name and provider number of the practitioner claiming or receiving payment of benefits, or assignment of benefit:-

-for services in Groups A1 to A14, D1, T1, T4 to T9 of the General Medical Services, Groups O1 to O7 (Oral and Maxillofacial services), and Group P9 of Pathology - where the person claiming payment is NOT the person who rendered the service;

-for services in Groups D2, T2, T3, I2, to I5 - for every service;

(x) if the service was a Specified Simple Basic Pathology Test (listed in Category 6 - Pathology, Group P9 of the Schedule) that was determined necessary by a practitioner who is another member of the same group medical practice, the surname and initials of that other practitioner;

(xi) where a practitioner has attended the patient on more than one occasion on the same day and on each occasion rendered a professional service to which an item in Category 1 of the Medicare Benefits Schedule relates (i.e. professional attendances), the time at which each such attendance commenced; and

(xii) where the professional service was rendered by a consultant physician or a specialist in the practice of his/her speciality to a patient who has been referred:- (a) the name of the referring medical practitioner; (b) the address of the place of practice or provider number for that place of practice; (c) the date of the referral; and (d) the period of referral (where other than for 12 months) expressed in months, e.g. "3", "6" or "18" months, or "indefinitely".

NOTE: If the information required to be recorded on accounts, receipts or assignment of benefit forms is included by an employee of the practitioner, the practitioner claiming payment for the service bears responsibility for the accuracy and completeness of the information.

Practitioners should note that payment of claims could be delayed or disallowed where it is not possible from account details to clearly identify the service as one which qualifies for Medicare benefits, or the practitioner as a registered medical practitioner at the address the service was rendered. Practitioners are therefore encouraged to provide as much detail as possible on their accounts, including Medicare Benefits Schedule item number and provider number.

The *Private Health Insurance Act 2007* provides for the payment of private health insurance benefits for hospital treatment and general treatment. Hospital treatment is treatment that is intended to manage a disease, injury or condition that is provided to an insured person by a hospital or arranged with the direct involvement of a hospital. General treatment is treatment that is intended to manage or prevent a disease, injury or condition and is not hospital treatment. Hospital-substitute treatment is a sub-set of General Treatment and a direct substitute for an episode of hospital treatment. Health insurers can cover specific professional services as hospital-substitute treatment in accordance with the *Private Health Insurance (Health Insurance Business) Rules*.

Claiming of Benefits

The patient, upon receipt of a doctor's account, has three courses open for paying the account and receiving benefits.

Paid Accounts

The patient may pay the account and subsequently present the receipt at a Medicare customer service centre for assessment and payment of the Medicare benefit in cash.

In these circumstances, where a claimant personally attends a Medicare office to obtain a cash or EFT deposit for the payment of Medicare benefits, the claimant is not required to complete a Medicare Patient Claim Form (PC1).

A Medicare patient claim form (PC1) must be completed where the claimant is mailing his/her claim for a cheque or EFT payment of Medicare benefits or arranging for an agent to collect cash on the claimant's behalf at a Medicare office.

Alternatively a patient may lodge their claim electronically from the doctors' surgery using Medicare Australia's Online claiming.

Claims for professional services rendered as part of an episode of hospital-substitute treatment should be submitted to the health insurer in the first instance for the payment of private health insurance benefits. The insurer of the patient will forward the claim to Medicare Australia for the payment of Medicare benefits

Unpaid and Partially Paid Accounts
Where the patient has not paid the account, the unpaid account may be presented to Medicare with a Medicare claim form. In this case Medicare will forward to the claimant a benefit cheque made payable to the doctor.

It will be the patient's responsibility to forward the cheque to the doctor and make arrangements for payment of the balance of the account if any. "Pay doctor" cheques involving Medicare benefits, must (by law), not be sent direct to medical practitioners or to patients at a doctor's address (even when the claimant requests this). "Pay doctor" cheques are required to be forwarded to the claimant's last known address.

When issuing a receipt to a patient for an account that is being paid wholly or in part by a Medicare "pay doctor" cheque the medical practitioner should indicate on the receipt that a "Medicare" cheque for $..... was included in the payment of the account.

Where a patient has reached the relevant extended Medicare safety net threshold, the Medicare benefit payable is the Medicare rebate for the service plus 80% of the out-of-pocket cost of the service (ie difference between the fee charged by the doctor and the Medicare rebate). The patient must pay at least 20% of the out-of-pocket cost of the account before extended Medicare safety net benefits become payable for the out-of-pocket cost. Medicare will apportion the benefit accordingly.

Claims for professional services rendered as part of an episode of hospital-substitute treatment should be submitted to the health insurer in the first instance for the payment of private health insurance benefits. The insurer of the patient will forward the claim to Medicare Australia for the payment of Medicare benefits.

Assignment of Benefit (Direct – Billing) Arrangements
Under the Health Insurance Act an Assignment of Benefit (direct-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need.

If a medical practitioner direct-bills, he/she undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient, with the exception of certain vaccines.

Under these arrangements:-

- the patient's Medicare number must be quoted on all direct-bill assignment forms for that patient;
- the assignment forms provided are loose leaf to enable the patient details to be imprinted from the Medicare Card;
- the forms include information required by Regulations under Section 19(6) of the Health Insurance Act;
- the doctor must cause the particulars relating to the professional service to be set out on the assignment form, before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it;
- where a patient is unable to sign the assignment form, the signature of the patient's parent, guardian or other responsible person (other than the doctor, doctor's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff) is

acceptable. The reason the patient is unable to sign should also be stated. In the absence of a "responsible person" the patient signature section should be left blank and in the section headed 'Practitioner's Use', an explanation should be given as to why the patient was unable to sign (e.g. unconscious, injured hand etc.) and this note should be signed or initialled by the doctor. If in the opinion of the practitioner the reason is of such a "sensitive" nature that revealing it would constitute an unacceptable breach of patient confidentiality or unduly embarrass or distress the recipient of the patient's copy of the assignment of benefits form, a concessional reason "due to medical condition" to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases it is expected that the reason given will be more specific.

- where the patient is direct-billed, an additional charge can **ONLY** be raised against the patient by the practitioner where the patient is provided with a vaccine/vaccines from the practitioner's own supply held on the practitioner's premises. This exemption only applies to general practitioners and other non-specialist practitioners in association with attendance items 3 to 96, 5000 to 5267 (inclusive) and item 10993 and only relates to vaccines that are not available to the patient free of charge through Commonwealth or State funding arrangements or available through the Pharmaceutical Benefits Scheme. The additional charge must only be to cover the supply of the vaccine.

Use of Medicare Cards in Direct Billing

The Medicare card plays an important part in direct billing as it can be used to imprint the patient details (including Medicare number) on the assignment forms. A special Medicare imprinter is used for this purpose and is available free of charge, on request, from Medicare.

The patient details can, of course, be entered on the assignment forms by hand, but the use of a card to imprint patient details assists practitioners and ensures accuracy of information. The latter is essential to ensure that the processing of a claim by Medicare is expedited.

The Medicare card number must be quoted on assignment forms. If the number is not available, then the direct-billing facility should not be used. To do so would incur a risk that the patient may not be eligible and Medicare benefits not payable.

Where a patient presents without a Medicare card and indicates that he/she has been issued with a card but does not know the details, the practitioner may contact a Medicare telephone enquiry number to obtain the number.

It is important for the practitioner to check the eligibility of patients to Medicare benefits by reference to the card, as enrolees have entitlement limited to the date shown on the card and some enrolees, eg certain visitors to Australia, have restricted access to Medicare (see paragraphs 3.4 and 3.5).

Assignment of Benefit Forms

To meet varying requirements the following types of stationery are available from Medicare Australia. Note that these are approved forms under the Health Insurance Act, and no other forms can be used to assign benefits without the approval of Medicare Australia.

(1) Form DB2-GP. This form is designed for the use of optical scanning equipment and is used to assign benefits for General Practitioner Services other than requested pathology, specialist and optometrical services. It is loose leaf for imprinting and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Practitioner copy and a Patient copy. There are 4 pre-printed items with provision for two other items. The form can also be used as an "offer to assign" when a request for pathology services is sent to an approved pathology practitioner and the patient does not attend the laboratory.

(2) Form DB2-OP. This form is designed for the use of optical scanning equipment and is used to assign benefits for optometrical services. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2-GP, except for content variations. This form may not be used as an offer to assign pathology services.

(3) Form DB2-OT. This form is designed for the use of optical scanning equipment and is used to assign benefits for all specialist services. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2-GP, except for content variations. There are no pre-printed items on this form.

(4) Form DB3. This is used to assign or offer to assign benefits for pathology tests rendered by approved pathology practitioners. It is loose leaf to enable imprinting of patient details from

the Medicare card and is similar in most respects to Form DB2, except for content variations. The form may not be used for services other than pathology.

(5) Form DB4. This is a continuous stationery version of the DB2, and has been designed for use on most office accounting machines.

(6) Form DB5. This is a continuous stationery form for pathology services which can be used on most office machines. It cannot be used to assign benefits and must therefore be accompanied by an offer to assign (Form DB2, DB3 or DB4) or other form approved by Medicare Australia for that purpose.

The Claim for Assigned Benefits (Form DB1N, DB1H)

Practitioners who accept assigned benefits must claim from Medicare using either Claim for Assigned Benefits form DB1N or DB1H. The DB1N form should be used where services are rendered to persons for treatment provided out of hospital or day hospital treatment. The DB1H form should be used where services are rendered to persons while hospital treatment is provided in a hospital or day hospital facility (other than public patients). Both forms have been designed to enable benefit for a claim to be directed to a practitioner other than the one who rendered the services. The facility is intended for use in situations such as where a short term locum is acting on behalf of the principal doctor and setting the locum up with a provider number and pay-group link for the principal doctor's practice is impractical. Practitioners should note that this facility cannot be used to generate payments to or through a person who does not have a provider number.

Each claim form must be accompanied by the assignment forms to which the claim relates.

The DB1N and DB1H are also loose leaf to enable imprinting of practitioner details using the special Medicare imprinter. For this purpose, practitioner cards, showing the practitioner's name, practice address and provider number are available from Medicare on request.

Direct-Bill Stationery (Forms DB6Ba & DB6Bb)

Medical practitioners wishing to direct-bill may obtain information on direct-bill stationery by telephoning 132150.

- Form DB6Ba. This form is used to order larger stocks of forms DB3, DB4 and DB5 (and where a practitioner uses these forms, DB1N and DB1H), kits for optical scanning stationery (which comprises DB2's (GP, OP and OT)), DB1's pre addressed envelopes and an instruction sheet for the use of direct-bill scanning stationery.
- Form DB6Bb. This form is used to order stocks of forms and additional products (including Medicare Safety Net forms and promotional material). These forms are available from Medicare.

Time Limits Applicable to Lodgement of Claims for Assigned Benefits

A time limit of two years applies to the lodgement of claims with Medicare under the direct-billing (assignment of benefits) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than two years earlier than the date the claim was lodged with Medicare.

Provision exists whereby in certain circumstances (eg hardship cases, third party workers' compensation cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the processing centre to which assigned claims are directed.

G.8.1. Provision for review of individual health professionals

The Professional Services Review (PSR) reviews and investigates service provision by health practitioners to determine if they have engaged in inappropriate practice when rendering or initiating Medicare services, or when prescribing or dispensing under the PBS.

Section 82 of the *Health Insurance Act 1973* defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude that it would be unacceptable to the general body of the members of the profession in which the practitioner was practicing when they rendered or initiated the services under review. It is also an offence under Section 82 for a person or officer of a body corporate to knowingly, recklessly or negligently cause or permit a practitioner employed by the person to engage in such conduct.

Medicare Australia monitors health practitioners' claiming patterns. Where Medicare Australia detects an anomaly, it may request the Director of PSR to review the practitioner's service provision. On receiving the request, the Director must decide whether to a conduct a review and in which manner the review will be conducted. The Director is authorized to require that documents and information be provided.

Following a review, the Director must:
(a) decide to take no further action; or
(b) enter into an agreement with the person under review (which must then be ratified by an independent Determining Authority); or
(c) refer the matter to a PSR Committee.

A PSR Committee normally comprises three medically qualified members, two of whom must be members of the same profession as the practitioner under review. However, up to two additional Committee members may be appointed to provide wider range of clinical expertise.

The Committee is authorized to:
(a) investigate any aspect of the provision of the referred services, and without being limited by the reasons given in the review request or by a Director's report following the review;
(b) hold hearings and require the person under review to attend and give evidence;
(c) require the production of documents (including clinical notes).

The methods available to a PSR Committee to investigate and quantify inappropriate practice are specified in legislation:
(a) Patterns of Services - The *Health Insurance (Professional Services Review) Regulations 1999* specify that when a general practitioner or other medical practitioner reaches or exceeds 80 or more attendances on each of 20 or more days in a 12-month period, they are deemed to have practiced inappropriately.

(i) A professional attendance means a service of a kind mentioned in group A1, A2, A5, A6, A7, A9, A11, A13, A14, A15, A16, A17, A18, A19, A20, A21, A22 or A23 of Part 3 of the General Medical Services Table.

(ii) If the practitioner can satisfy the PSR Committee that their pattern of service was as a result of exceptional circumstances, the quantum of inappropriate practice is reduce accordingly. Exceptional circumstances include, but are not limited to, those set out in the *Regulations*. These include:

a. an unusual occurrence;
b. the absence of other medical services for the practitioner's patients (having regard to the practice location); and
c. the characteristics of the patients.

(b) Sampling - A PSR Committee may use statistically valid methods to sample the clinical or practice records.

(c) Generic findings - If a PSR Committee cannot use patterns of service or sampling (for example, there are insufficient medical records), it can make a 'generic' finding of inappropriate practice.

Additional Information
A PSR Committee may not make a finding of inappropriate practice unless it has given the person under review notice of its intention to review them, the reasons for its findings, and an opportunity to respond. In reaching their decision, a PSR Committee is required to consider whether or not the practitioner has kept adequate and contemporaneous patient records (See general explanatory note G15.1 for more information on adequate and contemporaneous patient records).

The practitioner under review is permitted to make submissions to the PSR Committee before key decisions or a final report is made.

If a PSR Committee finds that the person under review has engaged in inappropriate practice, the findings will be reported to the Determining Authority to decide what action should be taken:
(i) a reprimand;
(ii) counselling;
(iii) repayment of Medicare benefits; and/or
(iv) complete or partial disqualification from Medicare benefit arrangements for up to three years.

Further information is available from the PSR website - www.psr.gov.au

G.8.2. Medicare Participation Review Committee

The Medicare Participation Review Committee determines what administrative action should be taken against a practitioner who:

(a) has been successfully prosecuted for relevant criminal offences;
(b) has breached an Approved Pathology Practitioner undertaking;
(c) has engaged in prohibited diagnostic imaging practices; or
(d) has been found to have engaged in inappropriate practice under the Professional Services Review scheme and has received Final Determinations on two (or more) occasions.

The Committee can take no further action, counsel or reprimand the practitioner, or determine that the practitioner be disqualified from Medicare for a particular period or in relation to particular services for up to five years.

Medicare benefits are not payable in respect of services rendered by a practitioner who has been fully disqualified, or partly disqualified in relation to relevant services under the *Health Insurance Act 1973* (Section 19B applies).

G.8.3. Referral of professional issues to regulatory and other bodies

The *Health Insurance Act 1973* provides for the following referral, to an appropriate regulatory body:

i. a significant threat to a person's life or health, when caused or is being caused or is likely to be caused by the conduct of the practitioner under review; or
ii. a statement of concerns of non-compliance by a practitioner with 'professional standards'.

G.8.4. Medicare Benefits Consultative Committee

The Medicare Benefits Consultative Committee (MBCC) is an informal consultative forum established by agreement between the Department of Health and Ageing and the Australian Medical Association (AMA) to facilitate discussion on reviews of the Medicare Benefits Schedule (MBS). (Note that reviews of the Diagnostic Imaging and Pathology Services are conducted under other arrangements.) Representation is drawn from the Department of Health and Ageing, Medicare Australia, the AMA and relevant craft groups of the medical profession.

The major function of the consultative process is to review particular services or groups of services within the Schedule, including consideration of new items and appropriate fee levels, to ensure that the Schedule reflects and encourages appropriate clinical practice.

It is Government policy that reviews of Schedule items conducted under the auspices of the MBCC will be on a **cost neutral basis**, except for genuinely new items where consideration will be given to providing additional funding.

Proposals for listing of new procedures

A specific item for a new procedure is not included in the Schedule until the safety, efficacy and cost effectiveness of the procedure have been established. Through a government initiative to strengthen the evidence base of the Schedule, the Medicare Services Advisory Committee (MSAC) has been established to advise the Minister for Health and Ageing on the strength of evidence pertaining to new and emerging medical technologies and procedures in relation to their safety, effectiveness and cost effectiveness, and under what circumstances public funding should be supported for these services.

MSAC's activities complement the MBCC process. Accordingly, applications for the inclusion of new services in the MBS should be referred to MSAC for independent evaluation. The MSAC application process differs from the requirements for submissions to MBCC in that applications for evaluation of new procedures are accepted from individuals and medical industry, as well as the medical profession.

Following approval by the Minister of an MSAC recommendation for public funding of a new procedure, an appropriate MBS listing for the service will be negotiated through the MBCC process.

Proposals for revised or new item descriptors

Individual practitioners seeking changes to the MBS should seek the support of their relevant craft group or association which can pursue the matter on their behalf through the AMA to the Medicare Benefits Branch of the Department.

An MBCC submission has the capacity to impact significantly on government outlays and must provide information to allow informed decisions to be made. While this can often be seen as bureaucratic to the profession, it is a necessary part of the accountability process for public funds.

While the complexity of information provided will reflect the extent of the review being requested, submissions for amendment to items of service already listed in the MBS should generally include details as listed below.

While reviews, in the main, relate to therapeutic procedures, the Schedule items covering diagnostic and non-procedural therapeutic items on the Schedule may also require review from time to time.

Requirements for submissions

- The rationale for the change - For example, the change may be a result of developments in medical practice.
- An outline of surgical procedures to be covered - Advice should include a description of the procedure, procedural times, and duration and complexity of aftercare required.
- Supporting evidence of the safety and efficacy of procedures - Relevant journal or review articles, or literature references, should be attached. This will assist in assessing whether a particular procedure may need to be evaluated by MSAC. Identification of approval by relevant regulatory authorities where relevant must be included.
- Revised item descriptors - Suggestions for new/revised descriptors should provide an accurate description of the service covered. Definitions such as 'wide' or 'deep', 'minor' or 'major, 'short' or 'long' etc. should be avoided. Necessary restrictions between the new and existing items must be identified. Relevant clinical standards or additional specialist qualification must be identified.
- Advice as to whether surgical assistance for a procedure is warranted - The justification for a surgical assistant should be included.
- An estimate of annual utilisation of the proposed new/revised item - This should be based on expected or actual assessment of utilisation of the new item.
- A proposed fee (if a revised fee is being considered) - The derivation of the fee should be explained, eg. based on costing data or fee relativity to existing items. Any offsets should be identified, eg. other items that would not be claimed if the new/revised item was introduced.
- An outline of consultations already undertaken with other relevant craft groups.

Many areas of the Schedule are utilised by more than one craft group, and the MBCC process is designed to ensure that all relevant groups are involved in the consultative process.

Any consultation that has taken place should be outlined, and if possible, a statement indicating the level of agreement to the proposal among the relevant craft groups should be provided.

G.8.5. Medical Services Advisory Committee

The Medical Services Advisory Committee (MSAC) advises the Minister on the strength of evidence relating to the safety, effectiveness and cost effectiveness of new and emerging medical services and technologies and under what circumstances public funding, including listing on the MBS, should be supported.

MSAC members are appointed by the Minister and include specialist practitioners, general practitioners, health economists, a health consumer representative, health planning and administration experts and epidemiologists.

For more information on the MSAC refer to their website – www.msac.gov.au or email on msac.secretariat@health.gov.au or by phoning the MSAC secretariat on (02) 6289 6811.

G.8.6. Pathology Services Table Committee

This Pathology Services Table Committee comprises six representatives from the interested professions and six from the Australian Government. Its primary role is to advise the Minister on the need for changes to the structure and content of the Pathology Services Table (except new medical services and technologies) including the level of fees.

G.8.7. Medicare Claims Review Panel

There are MBS items which make the payment of Medicare benefits dependent on a 'demonstrated' clinical need. Services requiring prior approval are those covered by items 11222, 11225, 12207, 12215, 12217, 14124, 21965, 21997, 30214, 32501, 42771, 42783, 42786, 42789, 42792, 45019, 45020, 45528, 45557, 45558, 45559, 45585, 45586, 45588, 45639, 50125.

Claims for benefits for these services should be lodged with Medicare Australia for referral to the National Office of Medicare Australia for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable Medicare Australia to determine the eligibility of the service for the payment of benefits.

Practitioners may also apply to Medicare Australia for prospective approval for proposed surgery.

Applications for approval should be addressed to:
The MCRP Officer
PO Box 1001
Tuggeranong ACT 2901

G.9.1. Penalties and Liabilities

Penalties of up to $10,000 or imprisonment for up to five years, or both, may be imposed on any person who makes a statement (oral or written) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used with a claim for benefits. In addition, any practitioner who is found guilty of such offences by a court shall be subject to examination by a Medicare Participation Review Committee and may be counselled or reprimanded or may have services wholly or partially disqualified from the Medicare benefit arrangements.

A penalty of up to $1,000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on a direct-billing form without the obligatory details having been entered on the form before the person signs, or who fails to cause a patient to be given a copy of the completed form.

G.10.1. Schedule fees and Medicare benefits

Medicare benefits are based on fees determined for each medical service. The fee is referred to in these notes as the "Schedule fee". The fee for any item listed in the MBS is that which is regarded as being reasonable on average for that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered.

In some cases two levels of fees are applied to the same service in General Medical Services, with each level of fee being allocated a separate item number. The item identified by the letter "S" applies in the case where the procedure has been rendered by a recognised specialist in the practice of his or her speciality and the patient has been referred. The item identified by the letter "G" applies in any other circumstances.

As a general rule Schedule fees are adjusted on an annual basis, usually in November.

The Schedule fee and Medicare benefit levels for the medical services contained in the MBS are located with the item descriptions. Where appropriate, the calculated benefit has been rounded to the nearest higher 5 cents. However, in no circumstances will the Medicare benefit payable exceed the fee actually charged.

There are presently three levels of Medicare benefit payable:

(a) **75% of the Schedule fee:**
   i. for professional services rendered to a privately insured patient as part of an episode of hospital treatment (other than public patients). Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '*' directly after an item number where used; or a description of the professional service, preceded by the word 'patient';
   ii. for professional services rendered as part of an episode of hospital-substitute treatment, and the patient who receives the treatment chooses to receive a benefit from a private health insurer. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service, preceded by the words 'hospital-substitute treatment'.

(b) **100% of the Schedule fee** for non-referred attendances by general practitioners to non-admitted patients and services provided by a practice nurse or registered Aboriginal Health Worker on behalf of a general

practitioner.

(c) **85% of the Schedule fee,** or the Schedule fee less $69.10 (indexed annually), whichever is the greater, for all other professional services.

Public hospital services are available free of charge to eligible persons who choose to be treated as public patients.

A medical service rendered to a patient on the day of admission to, or day of discharge from hospital, *but prior to admission or subsequent to discharge*, will attract benefits at the 85% or 100% level, not 75%. This also applies to a pathology service rendered to a patient prior to admission. Attendances on patients at a hospital (other than patients covered by paragraph (i) above) attract benefits at the 85% level.

The 75% benefit level applies even though a portion of the service (eg. aftercare) may be rendered outside the hospital. With regard to obstetric items, benefits would be attracted at the 75% level where the confinement takes place in hospital.

Pathology tests performed after discharge from hospital on bodily specimens taken during hospitalisation also attract the 75% level of benefits.

It should be noted that private health insurers can cover the "patient gap" (that is, the difference between the Medicare rebate and the Schedule fee) for services attracting benefits at the 75% level. Patient's may insure with private health insurers for the gap between the 75% Medicare benefits and the Schedule fee or for amounts in excess of the Schedule fee where the doctor has an arrangement with their health insurer.

G.10.2. Medicare safety nets

'Out-of-pocket' expenses are the difference between the fee the practitioner charges and the Medicare benefit paid to the patient. Patients are protected against high out-of-pocket expenses for non-admitted services listed in the MBS, by the 'original' Medicare safety net and the 'extended' Medicare safety net:

(a). Under the extended Medicare safety net, Medicare rebates 80% of out-of-pocket expenses for non-admitted Medicare services, once an annual threshold of out-of-pocket expenses is reached. In 2009, concession cardholders, families receiving Family Tax Benefit (Part A) and families that qualify for notional Family Tax Benefit (Part A) are eligible for the extended Medicare safety net when their cumulative out-of-pocket expenses reach $555.70; all other singles, couples and families are eligible when their cumulative out-of-pocket expenses reach $1,111.60. The extended Medicare safety net operates with the original safety net.

(b). Under the original safety net, the Medicare benefit for non-admitted services increases to 100% of the Schedule fee, once the cumulative 'gap amounts' reach an annual threshold. In 2009 the threshold amount is $383.90. The 'gap amount' refers to the amount between the Medicare benefit and the Schedule fee. Thereafter, any remaining out-of-pocket expenses count towards meeting the extended Medicare safety net threshold.

The thresholds for the original and extended Medicare safety nets are indexed on 1 January each year.

While individuals are automatically registered with Medicare Australia for the safety nets, couples and families must register themselves to be eligible. Registration forms can be obtained from Medicare Australia offices or completed online at www.medicareaustralia.gov.au

G.11.1. Services not listed in the MBS

Benefits are not generally payable for services not listed in the MBS. However, there are some procedural services which are not specifically listed because they are regarded as forming part of a consultation or else attract benefits on an attendance basis. For example, intramuscular injections, aspiration needle biopsy, treatment of sebhorreic keratoses and less than 10 solar keratoses by ablative techniques and closed reduction of the toe (other than the great toe).

Enquiries about services not listed or on matters of interpretation should be directed to Medicare Australia on 132 150.

G.11.2. Ministerial Determinations

Section 3C of the *Health Insurance Act 1973* empowers the Minister to determine an item and Schedule fee (for the purposes of the Medicare benefits arrangements) for a service not included in the health insurance legislation. This provision may be used to facilitate payment of benefits for new developed procedures or techniques where close monitoring is desirable. Services which have received section 3C approval are located in their relevant Groups in the MBS with the notation "**(Ministerial Determination)**".

G.12.1. Professional services

Professional services which attract Medicare benefits include medical services rendered by or "on behalf of" a medical practitioner. The latter include services where a part of the service is performed by a technician employed by or, in accordance with accepted medical practice, acting under the supervision of the medical practitioner.

The H*ealth Insurance Regulations 1975* specify that the following medical services will attract benefits only if they have been personally performed by a medical practitioner on not more than one patient on the one occasion (i.e. two or more patients cannot be attended simultaneously, although patients may be seen consecutively), unless a group session is involved (i.e. Items 170-172). The requirement of "personal performance" is met whether or not assistance is provided, according to accepted medical standards:-

(a) All Category 1 (Professional Attendances) items (except 170-172, 342-346);
(b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11212, 11304, 11500, 11600, 11601, 11627, 11701, 11712, 11724, 11921, 12000, 12003;
(c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13709, 13750-13760, 13915-13948, 14050, 14053, 14218, 14221 and 14224);
(d) Item 15600 in Group T2 (Radiation Oncology);
(e) All Group T3 (Therapeutic Nuclear Medicine) items;
(f) All Group T4 (Obstetrics) items (except 16400 and 16514);
(g) All Group T6 (Anaesthetics) items;
(h) All Group T7 (Regional or Field Nerve Block) items;
(i) All Group T8 (Operations) items;
(j) All Group T9 (Assistance at Operations) items;
(k) All Group T10 (Relative Value Guide for Anaesthetics) items.

For the group psychotherapy and family group therapy services covered by Items 170, 171, 172, 342, 344 and 346, benefits are payable only if the services have been conducted personally by the medical practitioner.

Medicare benefits are not payable for these group items or any of the items listed in (a) - (k) above when the service is rendered by a medical practitioner employed by the proprietor of a hospital (not being a private hospital), except where the practitioner is exercising their right of private practice, or is performing a medical service outside the hospital. For example, benefits are not paid when a hospital intern or registrar performs a service at the request of a staff specialist or visiting medical officer.

G.12.2. Services rendered on behalf of medical practitioners

Medical services in Categories 2 and 3 not included in the list above and Category 5 (Diagnostic Imaging) services continue to attract Medicare benefits if the service is rendered by:-

(a) the medical practitioner in whose name the service is being claimed;
(b) a person, other than a medical practitioner, who is employed by a medical practitioner or, in accordance with accepted medical practice, acts under the supervision of a medical practitioner.

See Category 6 Notes for Guidance for arrangements relating to Pathology services.

So that a service rendered by an employee or under the supervision of a medical practitioner may attract a Medicare rebate, the service must be billed in the name of the practitioner who must accept full responsibility for the service. Medicare Australia must be satisfied with the employment and supervision arrangements. While the supervising medical practitioner need not be present for the entire service, they must have a direct involvement in at least part of the service. Although the supervision requirements will vary according to the service in question, they will, as a general rule, be satisfied where the medical practitioner has:-

(a) established consistent quality assurance procedures for the data acquisition; and
(b) personally analysed the data and written the report.

Benefits are not payable for these services when a medical practitioner refers patients to self-employed medical or paramedical personnel, such as radiographers and audiologists, who either bill the patient or the practitioner requesting the service.

G.12.3. Mass immunisation

Medicare benefits are payable for a professional attendance that includes an immunisation, provided that the actual administration of the vaccine is not specifically funded through any other Commonwealth or State Government program, nor through an international or private organisation.

The location of the service, or advertising of it, or the number of patients presenting together for it, normally do not indicate a mass immunisation.

G.13.1. Services which do not attract Medicare benefits

Services not attracting benefits

- telephone consultations;
- issue of repeat prescriptions when the patient does not attend the surgery in person;
- group attendances (unless otherwise specified in the item, such as items 170, 171, 172, 342, 344 and 346);
- non-therapeutic cosmetic surgery;
- euthanasia and any service directly related to the procedure. However, services rendered for counselling/assessment about euthanasia will attract benefits.

Medicare benefits are not payable where the medical expenses for the service

- are paid/payable to a public hospital;
- are for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability. (Please note that if the medical expenses relate to a compensable injury/illness for which the insurer/compensation agency is disputing liability, then Medicare benefits are payable until the liability is accepted.);
- are for a medical examination for the purposes of life insurance, superannuation, a provident account scheme, or admission to membership of a friendly society;
- are incurred in mass immunisation (see General Explanatory Note 12 for further explanation).

Unless the Minister otherwise directs

Medicare benefits are not payable where:

- the service is rendered by or on behalf of, or under an arrangement with the Australian Government, a State or Territory, a local government body or an authority established under Commonwealth, State or Territory law;
- the medical expenses are incurred by the employer of the person to whom the service is rendered;
- the person to whom the service is rendered is employed in an industrial undertaking and that service is rendered for the purposes related to the operation of the undertaking; or
- the services is a health screening service.

Current regulations preclude the payment of Medicare benefits for professional services rendered in relation to or in association with:

(a) chelation therapy (that is, the intravenous administration of ethylenediamine tetra-acetic acid or any of its salts) other than for the treatment of heavy-metal poisoning;
(b) the injection of human chorionic gonadotrophin in the management of obesity;
(c) the use of hyperbaric oxygen therapy in the treatment of multiple sclerosis;
(d) the removal of tattoos;
(e) the transplantation of a thoracic or abdominal organ, other than a kidney, or of a part of an organ of that kind; or the transplantation of a kidney in conjunction with the transplantation of a thoracic or other abdominal organ, or part of an organ of that kind;
(f) the removal from a cadaver of kidneys for transplantation;
(g) the administration of microwave (UHF radio wave) cancer therapy, including the intravenous injection of drugs used in the therapy.

Pain pumps for post-operative pain management

The cannulation and/or catheterisation of surgical sites associated with pain pumps for post-operative pain management cannot be billed under any MBS item.

The filling or re-filling of drug reservoirs of ambulatory pain pumps for post-operative pain management cannot be billed under any MBS items.

Non Medicare Services
An item in the range 1 to 10943 does not apply to the service described in that item if the service is provided at the same time as, or in connection with, any of the services specified below

(a) Endoluminal gastroplication, for the treatment of gastro-oesophageal reflux disease;
(b) Endovenous laser treatment, for varicose veins;
(c) Gamma knife surgery;
(d) Intradiscal electro thermal arthroplasty;
(e) Intravascular ultrasound (except where used in conjunction with intravascular brachytherapy);
(f) Intro-articular viscosupplementation, for the treatment of osteoarthritis of the knee;
(g) Low intensity ultrasound treatment, for the acceleration of bone fracture healing, using a bone growth stimulator;
(h) Lung volume reduction surgery, for advanced emphysema;
(i) Photodynamic therapy, for skin and mucosal cancer;
(j) Placement of artificial bowel sphincters, in the management of faecal incontinence;
(k) Sacral nerve stimulation, for urinary incontinence;
(l) Selective internal radiation therapy for any condition other than hepatic metastases that are secondary to colorectal cancer;
(m) Specific mass measurement of bone alkaline phosphatase;
(n) Transmyocardial laser revascularisation;
(o) Vertebral axial decompression therapy, for chronic back pain.

Health Screening Services
Unless the Minister otherwise directs Medicare benefits are not payable for health screening services. A health screening service is defined as a medical examination or test that is not reasonably required for the management of the medical condition of the patient. Services covered by this proscription include such items as:

- multiphasic health screening;
- mammography screening (except as provided for in Items 59300/59303);
- testing of fitness to undergo physical training program, vocational activities or weight reduction programs;
- compulsory examinations and tests to obtain a flying, commercial driving or other licence;
- entrance to schools and other educational facilities;
- for the purposes of legal proceedings;
- compulsory examinations for admission to aged persons' accommodation and pathology services associated with clinical ecology.

The Minister has directed that Medicare benefits be paid for the following categories of health screening:

- a medical examination or test on a symptomless patient by that patient's own medical practitioner in the course of normal medical practice, to ensure the patient receives any medical advice or treatment necessary to maintain their state of health. Benefits would be payable for the attendance and tests which are considered reasonably necessary according to patients individual circumstances (such as age, physical condition, past personal and family history). For example, a Papanicolaou test in a woman (see General Explanatory note 13.6.4 for more information), blood lipid estimation where a person has a family history of lipid disorder. However, such routine check up should not necessarily be accompanied by an extensive battery of diagnostic investigations;
- a pathology service requested by the National Heart Foundation of Australia, Risk Evaluation Service;
- age or health related medical examinations to obtain or renew a licence to drive a private motor vehicle;
- a medical examination of, and/or blood collection from persons occupationally exposed to sexual transmission of disease, in line with conditions determined by the relevant State or Territory health authority, (one examination or collection per person per week). Benefits are not paid for pathology tests resulting from the examination or collection;
- a medical examination being a condition of child adoption or fostering;
- a medical examination being a requisite for Social Security benefits or allowances;
- a medical or optometrical examination provided to a person who is an unemployed person (as defined by the *Social Security Act 1991)*, as the request of a prospective employer.

The National Policy on screening for the Prevention of Cervical Cancer (endorsed by the Royal Australian College of General Practitioners, the Royal Australian College of Obstetricians and Gynaecologists, the Royal College of Pathologists of Australasia, the Australian Cancer Society and the National Health and Medical Research Council) is as follows:-

- an examination interval of two years for women who have no symptoms or history suggestive of abnormal cervical cytology, commencing between the ages of 18 to 20 years, or one or two years after first sexual intercourse, whichever is later;
- cessation of cervical smears at 70 years for women who have had two normal results within the last five years. Women over 70 who have never been examined, or who request a cervical smear, should be examined.

Note 1: As separate items exist for routine examination of cervical smears, treating practitioners are asked to clearly identify on the request form to the pathologist, if the smear has been taken as a routine examination or for the management of a previously detected abnormality (see paragraph PP.11 of Pathology Services Explanatory Notes in Category 6).

Note 2: See items 2501 to 2509, and 2600 to 2616 in Group A18 and A19 of Category 1 – Professional Attendances and the associated explanatory notes for these items in Category 1 – Professional Attendances.

Services rendered to a doctor's dependants, practice partner, or practice partner's dependants

Generally, Medicare benefits are not paid for professional services rendered by a medical practitioner to dependants or partners or a partner's dependants.

A 'dependant' person is a spouse or a child. The following provides definitions of these dependant persons:

a spouse, in relation to a dependant person means:
(a) a person who is legally married to, and is not living, on a permanent basis, separately and apart from, that person; and
(b) a de facto spouse of that person.

a child, in relation to a dependant person means:
(a) a child under the age of 16 years who is in the custody, care and control of the person or the spouse of the person; and
(b) a person who:
(i) has attained the age of 16 years who is in the custody, care and control of the person of the spouse of the person; or
(ii) is receiving full time education at a school, college or university; and
(iii) is not being paid a disability support pension under the Social Security Act 1991; and
(iv) is wholly or substantially dependent on the person or on the spouse of the person.

G.14.1. Principles of interpretation of the MBS

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.

Where a service is rendered partly by one medical practitioner and partly by another, only the one amount of benefit is payable. For example, where a radiographic examination is started by one medical practitioner and finalised by another.

G.14.2. Services attracting benefits on an attendance basis

Some services are not listed in the MBS because they are regarded as forming part of a consultation or they attract benefits on an attendance basis. Some of these services are identified in the indexes to this book with an (*).

G.14.3. Consultation and procedures rendered at the one attendance

Where, during a single attendance, a consultation (under Category 1 of the MBS) and another medical service (under any other Category of the Schedule) occur, benefits are payable subject to certain exceptions, for both the consultation and the other service. Benefits are not payable for the consultation in addition to an item rendered

on the same occasion where the item is qualified by words such as "each attendance", "attendance at which", “including associated attendances/consultations", and all items in Group T6 and T9. In the case of radiotherapy treatment (Group T2 of Category 3) benefits are payable for both the radiotherapy and an initial referred consultation.

Where the level of benefit for an attendance depends upon the consultation time (for example, in psychiatry), the time spent in carrying out a procedure which is covered by another item in the MBS, may not be included in the consultation time.

A consultation fee may only be charged if a consultation occurs; that is, it is not expected that consultation fee will be charged on every occasion a procedure is performed.

G.14.4. Aggregate items

The MBS includes a number of items which apply only in conjunction with another specified service listed in the MBS. These items provide for the application of a fixed loading or factor to the fee and benefit for the service with which they are rendered.

When these particular procedures are rendered in conjunction, the legislation provides for the procedures to be regarded as one service and for a single patient gap to apply. The Schedule fee for the service will be ascertained in accordance with the particular rules shown in the relevant items.

G.14.5. Residential aged care facility

A residential aged care facility is defined in the *Aged Care Act 1997*; the definition includes facilities formerly known as nursing homes and hostels.

G.15.1. Practitioners should maintain adequate and contemporaneous records

All practitioners who provide, or initiate, a service for which a Medicare benefit is payable, should ensure they maintain **adequate** and **contemporaneous** records.

Note: 'Practitioner' is defined in Section 81 of the *Health Insurance Act 1973* and includes: medical practitioners, dentists, optometrists, chiropractors, physiotherapists, podiatrists and osteopaths.

Since 1 November 1999 PSR Committees determining issues of inappropriate practice have been obliged to consider if the practitioner kept adequate and contemporaneous records. It will be up to the peer judgement of the PSR Committee to decide if a practitioner’s records meet the prescribed standards.

The standards which determine if a record is adequate and contemporaneous are prescribed in the *Health Insurance (Professional Services Review) Regulations 1999*.

To be ***adequate***, the patient or clinical record needs to:

- clearly identify the name of the patient; and
- contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated; and
- each entry needs to provide clinical information adequate to explain the type of service rendered or initiated; and
- each entry needs to be sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the patient’s ongoing care.

To be ***contemporaneous***, the patient or clinical record should be completed at the time that the service was rendered or initiated or as soon as practicable afterwards. Records for hospital patients are usually kept by the hospital and the practitioner could rely on these records to document in-patient care.

Optometrical Services Schedule

SUMMARY OF CHANGES

There has been no change to the Optometrical benefits schedule for 1 January 2010.

O.1.. Benefits For Services By Participating Optometrists

All Australian residents and certain categories of visitors to Australia can claim Medicare benefits for services with participating optometrists. The Health Insurance Act contains legislation covering the major elements of the Medicare program.

Responsibility for regulating the Medicare program lies with the Australian Government through the Department of Health and Ageing. Medicare Australia is responsible for consideration of applications for the acceptance of optometric undertakings and for the day to day operation of Medicare and the payment of benefits. Addresses of the Department and Medicare Australia (Medicare offices) are located at the end of these Notes.

O.2.. Participation By Optometrists

Medicare pays benefits for services provided by optometrists who have signed an agreement to participate in arrangements with the Commonwealth Government. This agreement is formally known as the "Common Form of Undertaking - Participating Optometrists" and is often referred to as the Participating Agreement. A copy of the Undertaking is contained in Section 3 of this book.

An optometrist registered or licensed under a law in any State or Territory of Australia, who wishes to become a participating optometrist, is required to sign the Common Form of Undertaking and an employer of optometrists must sign a separate common form of undertaking except where the optometrist and the owner of the business are the same person.

Where the optometric practice is conducted in a corporate form, such as a company or partnership, it is necessary for the corporation to become a "participating optometrist", and an additional undertaking must be signed by a person who has authority to give the undertaking on behalf of the organisation.

The undertaking sets out the obligations to be met under the arrangements. Copies of the undertaking may be obtained from the Provider Liaison Section, Medicare Australia at the addresses listed at the end of these Notes.

Where an employer of optometrists completes an undertaking, that undertaking must identify premises owned by them or in their possession. The relevant details are to be included in schedules 2 and 3 of the undertaking. An undertaking completed by an individual optometrist does not need to identify the premises from which services are to be provided as the Common Form of Undertaking applies to all premises from which the optometrists will provide services.

When completed, the undertaking should be returned to:

Manager (Eligibility)
Medicare Australia
PO Box 1001
Tuggeranong, ACT 2901.

The Minister may refuse to accept an undertaking given by an optometrist. In these circumstances the optometrist will be notified in writing of the refusal and is given 30 days to forward a written request to the Minister, to have the matter reviewed.

After acceptance by the Minister, or his delegate, of the completed undertaking, a letter of acceptance of the undertaking will be forwarded to the optometrist. At the same time, Medicare Australia will send the optometrist a supply of assignment forms and claim forms for assignment of Medicare benefits, together with the necessary instructions for direct-billing purposes.

The Manager (Eligibility) must be notified in writing of any changes to the details furnished by an optometrist in schedule 2 and schedule 3 of the undertaking.

Participating optometrists may at any time terminate undertakings either wholly or as they relate to particular premises, by notifying:

Manager (Eligibility)
Medicare Australia

PO Box 1001
Tuggeranong, ACT 2901.

The date of termination may not be earlier than 30 days after the date on which the notice is served.

The names and addresses of participating optometrists may be obtained from:

Manager (Eligibility)
Medicare Australia
PO Box 1001
Tuggeranong, ACT 2901.

Only if the Minister or the Minister's delegate certifies in writing that this is necessary in the public interest.

O.3.. Provider Numbers
To ensure that benefits are paid only for services provided by optometrists registered in a State or Territory of Australia, each optometrist providing services for which a Medicare benefit is payable requires an individual provider number.

Provider numbers will be issued only to individual participating optometrists registered in a State or Territory of Australia. Corporations, other business entities and individuals who are not registered optometrists will not be issued with provider numbers.

Provider numbers are allocated to practitioners to enable claims for Medicare benefits to be processed and cheques to be correctly drawn in favour of the practitioner where applicable. The number may be up to eight characters. The second last character identifies the practice location, the last being a check character.

Optometrists can obtain a provider number from Medicare. A separate provider number is issued for each location at which an optometrist practises and has current State/Territory registration. Provider numbers for additional practice locations may also be obtained from Medicare following confirmation of State/Territory registration. Optometrists cannot use another optometrist's provider number.

If a practitioner wishes Medicare benefits cheques, which would normally be drawn in favour of the practitioner, to be made payable to another payee and/or another address, written authority can be given to Medicare to do this. This payment to another party is known as a pay group link. There can only be one pay group link for an individual practice location but multiple practitioners and practice locations can be linked to one pay group. Further information on pay group links may be obtained from Medicare (addresses at the end of the Notes).

Locum Tenens
An optometrist who has signed a Common Form of Undertaking and is to provide services at a practice location as a locum for more than 2 weeks or will return to the practice on a regular basis for short periods should apply for a provider number for that location.

If the locum is to provide services at a practice for less than 2 weeks, the locum can use their own provider number or can obtain an additional provider number for that location.

Normally, Medicare benefits are payable for services rendered by an optometrist only when the optometrist has completed a Common Form of Undertaking. However, benefits may be claimed for services provided by an optometrist who has not signed the Undertaking if the optometrist has provided them on behalf of an optometrist who has signed the Undertaking.

To ensure benefits are payable when a locum practises in these circumstances, the locum optometrist should:

- Check that they will be providing optometry services on behalf of a participating optometrist ie their employer has a current Common Form of Undertaking

- Notify Medicare Australia in writing, before commencing the locum arrangement of the name and address of the participating optometrist on whose behalf they will be providing services.

Locums can direct Medicare payments to a third party eg the principal of the practice, by either arranging a pay group link and/or by nominating the principal as the payee provider on direct bill stationery.

O.4.. Patient Eligibility

Eligible persons

For the purposes of the optometric arrangements, an eligible person is:

- A person who holds the normal Medicare card as issued to Australian residents; or
- A person who holds a Medicare card which shows "INTERIM CARD" and the period of eligibility; or
- A person who holds a Medicare card which shows “VISITOR RHCA" (Reciprocal Health Care Agreements).

Medicare cards

An eligible person who applies to enrol in Medicare (using a Medicare Enrolment/Amendment Application) will be issued with a uniquely numbered Medicare Card (green in colour). Cards may be issued for individuals or families.

Medicare cards (blue in colour), with the words "INTERIM CARD" are issued in certain circumstances to persons who have applied for permanent resident status.

Medicare cards with the words "RECIPROCAL HEALTH CARE” are issued to visitors from countries with which Australia has Reciprocal Health Care Agreements. Visitors from New Zealand and the Republic of Ireland are **NOT** entitled to optometric treatment under RHCA and all other RHCA visitors are only entitled to immediately necessary treatment.

O.5.. Benefits For Services By Participating Optometrists

What services are covered

The services coming within the scope of the optometric benefit arrangements are those clinically relevant services ordinarily rendered by the optometrist in relation to consultation on ocular or vision problems or related procedures.

Benefits may only be claimed when:

(a) a service has been performed and a clinical record of the service has been made;
(b) a significant consultation or examination procedure has been carried out;
(c) the service has been performed at premises listed in an undertaking;
(d) the service has involved the personal attendance of both the patient and the optometrist; and
(e) the service is "clinically relevant" (as defined in the Health Insurance Act) ie a service rendered by an optometrist that is generally accepted in the optometric profession as being necessary for the appropriate treatment of the patient to whom it is rendered.

Where Medicare benefits are not payable

Medicare benefits may not be claimed for attendances for:

(a) delivery, dispensing, adjustment or repairs of visual aids;
(b) filling of prescriptions written by other practitioners

Benefits are not payable for optometric services associated with:

(a) cosmetic surgery
(b) refractive surgery
(c) tests for fitness to undertake sporting, leisure or vocational activities
(d) compulsory examinations or tests to obtain any commercial licence (eg flying or driving)
(e) entrance to schools or other educational facilities
(f) compulsory examinations for admissions to aged care facilities
(g) vision screening

Medicare benefits are not payable for services in the following circumstances:

(a) where the expenses for the service are paid or payable to a recognised (public) hospital;
(b) where the service is provided by teaching institutions to patients of supervised students;
(c) where the service is not "clinically relevant" (as described in the Health Insurance Act, ie a service rendered by an optometrist that is generally accepted in the optometric profession as being necessary for the appropriate treatment of the patient to whom it is rendered).

Unless the Minister otherwise directs, a benefit is not payable in respect of an optometric service where:
(a) the service has been rendered by or on behalf of, or under an arrangement with, the Commonwealth, a State or a local governing body or an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory; or
(b) the service was rendered in one or more of the following circumstances –
    (i) the employer arranges or requests the consultation
    (ii) the results are provided to the employer by the optometrist
    (iii) the employer requires that the employee have their eyes examined
    (iv) the account for the consultation is sent to the employer
    (v) the consultation takes place at the patient's workplace or in a mobile consulting room at the patient's workplace.

Services rendered to an optometrist's dependants, employer or practice partner or dependants
A condition of the participating arrangement is that the optometrist agrees not to submit an account or a claim for services rendered to any dependants of the optometrist, to his or her employer or practice partner or any dependants of that employer or partner.

O.6.. Schedule Fees and Medicare Benefits

Schedule fees and Medicare benefits
Optometrists participating in the scheme agree not to charge more than the Schedule fees for services covered by Medicare, and also, that charges for appliances shall not include any amount related to consultation procedures for which benefits are payable. The only exceptions are for Item 10907 and in relation to domiciliary visits.
The services provided by participating optometrists which attract benefits are set out in the Health Insurance Regulations.

Medicare benefits are payable at 85% of the Schedule fee for services rendered with a maximum gap payment for any one service of $69.10 (indexed annually) between the Medicare rebate and the Schedule fee.

Where it can be established that payments of $388.80 (effective from 1 January 2010 and indexed annually from 1 January each year) have been made by a family or an individual during a calendar year regarding the difference between the Medicare benefit and the Schedule fee for out-of-hospital services, benefits will thereafter be paid for the rest of that year up to 100% of the Schedule fee. A family group includes a spouse and dependent children under 16 years of age or dependent students under the age of 25.

Limiting rule for patient claims
Where a fee charged for a service is less than the Medicare benefit, the benefit will be reduced to the amount of the fee actually charged. In no case will the benefit payable exceed the fee charged.

Multiple attendances
Payment of benefit may be made for several attendances on a patient on the same day by the same optometrist provided that the subsequent attendances are not a continuation of the initial or earlier attendances. However, there should be a reasonable lapse of time between the services before they can be regarded as separate attendances.

Where two or more attendances are made on the one day by the same optometrist the time of each attendance should be stated on the account (eg 10.30 am and 3.15 pm) in order to assist in the payment of benefits, except where a perimetry item is performed in association with a consultation item where times do not need to be specified.

In some circumstances a subsequent consultation on the same day may be judged to be a continuation of an earlier attendance and a second benefit is not payable. For example, a preliminary eye examination may be concluded with the instillation of mydriatic or cycloplegic drops and some time later additional examination procedures are undertaken. These sessions are regarded as being one attendance for benefit purposes.

Referred comprehensive initial consultations (Item 10905) - Read in conjunction with 09.1 - 09.13
For the purposes of Item 10905, the referring optometrist, having considered the patient's need for the referred consultation, is required to provide a written referral, dated and signed, and setting out the patient's condition and the reason for the referral.

Benefits will be paid at the level of Item 10905 providing the referral is received before the provision of the service, and providing the account, receipt or bulk-billing form contains the name and provider number of the referring optometrist. Referrals from medical practitioners do not attract benefit under item 10905.

The optometrist claiming the Item 10905 service is obliged to retain the written referral for a period of twenty-four months.

Referrals must be at "arms length". That is to say, no commercial arrangements or connections should exist between the optometrists.

Second comprehensive initial consultation within 24 months of a previous comprehensive consultation (Item 10907)
Where a patient receives a comprehensive initial consultation within 24 months of a previous comprehensive consultation provided by another optometrist an additional fee may be charged provided that the service is not direct-billed. The actual additional amount charged is a matter between the optometrist and the patient but it must not exceed an amount equal to the difference between the Schedule fees for Item 10900 and Item 10907.

In circumstances where an additional fee is charged the optometrist must inform the patient of the benefit payable for Item 10907 at the time of the consultation and that the additional fee will not attract benefits.

Where it is necessary for the optometrist to seek patient information from Medicare in order to determine appropriate itemisation of accounts, receipts or bulk-billed claims, the optometrist must ensure that:-
(a) the patient is advised of the need to seek the information and the reason the information is required;
(b) the patient's informed consent to the release of information has been obtained; and
(c) the patient's records verify the patient's consent to the release of information.

Significant change in visual function requiring comprehensive re-evaluation (Item 10912)
Significant changes in visual function which justify the charging of Item 10912 include documented changes of:

- vision or visual acuity of 2 lines (0.2 logMAR) or more (corrected or uncorrected)
- visual fields or previously undetected field loss
- binocular vision
- contrast sensitivity or previously undetected contrast sensitivity loss.

New Signs or symptoms/progressive disorder requiring comprehensive re-evaluation (Items 10913 and 10914)
When charging Item 10913 and Item 10914, the optometrist must document the new signs or symptoms or the nature of the progressive disorder suffered by the patient on the patient's record card. Progressive disorders may include conditions such as maculopathy (including age related maculopathy) cataract, corneal dystrophies, glaucoma etc.

Examination of the eyes of a patient with diabetes mellitus (Item 10915)
Where an examination of the eyes, with the instillation of a mydriatic, of a patient with diabetes mellitus is being conducted, where possible this item should be billed rather than item 10914 to assist in identifying whether such patients are receiving appropriate eye care.

Domiciliary visits
Where patients are unable to travel to an optometrist’s practice for treatment, and where the request for treatment is initiated by the patient, a domiciliary visit may be conducted, which involves the optometrist

travelling to the patient's place of residence, transporting the necessary equipment. Where possible, it is preferable that the patient travel to the practice so that the full range of equipment is available for the examination of the patient.

Benefits are payable under items 10931 – 10933 to provide some financial assistance in the form of a loading to the optometrist, in recompense for travel costs and packing and unpacking of equipment. The loading is in addition to the consultation item. For the purposes of the loading, acceptable places of residence for domiciliary visits are the patient's home, a residential aged care facility as defined by the *Aged Care Act 1997*, or an institution which means a place (other than a residential aged care facility or hospital) at which residential accommodation and/or day care is made available to any of the following categories: disadvantaged children, juvenile offenders, aged persons, chronically ill psychiatric patients, homeless persons, unemployed persons, persons suffering from alcoholism, persons addicted to drugs, or physically or intellectually disabled persons.

Visits to a hospital are not covered by the new loading, but are covered by the previous arrangements, that is, where a visit to a hospital is provided at the patient's request, an extra fee not exceeding the fee for item 10900 may be charged, in addition to the Schedule fee, providing the service is not bulk-billed. Benefits are not payable in respect of the private charge.

Items 10931 – 10933 may be used whether or not the optometrist chooses to bulk-bill but it is important that if the consultation is bulk-billed the loading is also, and no private charge can then be levied. If the consultation is not bulk-billed, the loading should also not be bulk-billed and a private charge may be levied. The additional private charge must be calculated so that the **total** charges for the basic service, loading and private charge do not exceed an amount which equals twice the fee for item 10900. The usual requirement that the patient must have requested the domiciliary visit applies.

The choice of appropriate item in the range 10931 - 10933 depends on how many patients are seen at the one location. Benefits are payable under item 10931 where the optometrist travels to see one patient at a single location. Item 10931 can be billed in addition to the consultation item. If the optometrist goes on to see another single patient **at a different location**, that patient can also be billed an item 10931 plus the consultation. However, if two patients are visited at a single location on the same occasion, each of the two patients should be billed item 10932 as well as the consultation item applying to each patient. Similarly, if three patients are visited at a single location on the same occasion, each of the three patients should be billed item 10933 as well as the consultation item applying to each patient.

Where more than three patients are seen at the same location, additional benefits for domiciliary visits are not payable for the fourth, fifth etc patients. On such occasions, the first three patients should be billed item 10933 as well as the appropriate consultation item, and all subsequent patients may only be billed the appropriate consultation item. Where multiple patients are seen at one location on one occasion, there is no provision for patients to be 'grouped' into twos and threes for billing purposes.

Where a private charge is levied for a domiciliary visit, bulk-billing is precluded. Benefits are not payable in respect of the private charge and the patient should be informed of this. Private charges should be shown separately on accounts issued by optometrists and must not be included in the fees for the service.
Domiciliary visit loading items may not be claimed in conjunction with brief initial consultation item 10916, or with computerised perimetry items 10940 or 10941.

Release of prescription
Where a spectacle prescription is prepared for the patient, it becomes the property of the patient, who is free to have the spectacles dispensed by a person of the patient's choice. The optometrist will ensure that the patient is made aware that he or she is entitled to a copy of the spectacle prescription.

Contact lens prescriptions are excluded from the above provision, although the prescription remains the property of the patient and should be available to the patient at the completion of the prescription and fitting process.

Reminder notices
The optometrist will ensure that any notice sent to a patient suggesting re-examination is sent solely on the basis of the clinical needs of the patient.

Aftercare period following surgery
Medicare schedule items that apply to surgery include all professional attendances necessary for the post-operative treatment of the patient. The aftercare period includes all post-operative treatment, whether provided by a medical practitioner or an optometrist. The amount and duration of the aftercare may vary but includes all attendances until recovery from the operation. Attendances provided by an optometrist in the aftercare period do not attract a Medicare benefit.

The rebate for cataract surgery includes payment for aftercare attendances so payment for aftercare services provided by an optometrist on behalf of a surgeon should be arranged with the surgeon. The optometrist should not charge the patient. In the case of cataract surgery, the first visit following surgery for which the optometrist can charge a rebatable fee is generally the attendance at which a prescription for spectacles or contact lenses is written.

Medicare benefits are not available for refractive surgery, consultations in preparation for the surgery or consultations in the aftercare period. Charges for attendances by optometrists may be made directly to the patient or to the surgeon depending on the arrangements made prior to surgery. Accounts and receipt issued to the patient should clearly indicate the fee is non-rebatable.

Computerised Perimetry Services (Items 10940 and 10941)
Benefit under items 10940 and 10941 is payable where full quantitative computerised perimetry (automated absolute static threshold but not including multifocal multichannel objective perimetry) has been performed by an optometrist on both eyes (item 10940) or one eye (item 10941) where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain. Item 10940 for bilateral procedures cannot be claimed for patients who are totally blind in one eye. In this instance, item 10941 for unilateral procedures should be claimed, where appropriate.

These items can be billed either in association with comprehensive consultation items 10900, 10905, 10907, 10912, 10913, 10914 or 10915, or independently, but they cannot be billed with items 10916 or 10918. An assessment and report is required and, where referral to an ophthalmologist for further treatment is required, the printed results of the perimetry should be provided to the ophthalmologist to discourage repetition of perimetry unless clinically necessary. If Medicare benefits are to be claimed, a maximum of 2 perimetry services in any 12 month period may be provided.

Low Vision Assessment (Item 10942)
A benefit is payable under item 10942 where one or more of the tests outlined in the item description are carried out on a patient who has already been established during a comprehensive consultation as having low vision, as specifically defined in the item. This item is not intended for patients expected to undergo cataract surgery in the near future who may temporarily meet the criteria for having low vision.

Item 10942 may be claimed on the same day as either a comprehensive initial consultation or a subsequent consultation, but only where the additional low vision testing has been carried out on an eligible patient. Item 10942 is not intended to be claimed with a brief initial consultation, or with any of the contact lens items.

Children's vision assessment (Item 10943)
Children aged 0 to 2 years, and 15 years and over, are not eligible for item 10943 and may be treated under appropriate attendance items.

A benefit is payable under item 10943 where one or more of the assessment and testing procedures outlined in the item description are carried out on a patient aged 3 - 14 years inclusive, and where a finding of significant binocular or accommodative dysfunction is the outcome of the consultation and assessment/testing. The conditions to be assessed under this item are primarily amblyopia and strabismus, but dysfunctions relating to vergences are also covered, providing well established and evidence based optometry practice is observed.
A benefit is not payable under item 10943 for the assessment of learning difficulties or learning disabilities.

Item 10943 may be claimed on the same day as either a comprehensive consultation or a subsequent consultation, but only where the additional assessment/testing has been carried out on an eligible child. Item 10943 is not intended to be claimed with a brief initial consultation, or with any of the contact lens items.

O.7.. Billing Procedures
There are three ways benefits may be paid for optometric services:

(a) the patient may pay the optometrist's account and then claim benefits from a Medicare office by submitting the account and the receipt;
(b) the patient may submit the unpaid account to Medicare which will then draw a cheque in favour of the optometrist; or
(c) the optometrist may bill Medicare instead of the patient for the consultation. This mechanism is known as direct billing. If an optometrist direct-bills, he/she undertakes to accept the relevant Medicare benefit as full payment for the consultation. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient.

Note: Additional charges must not be levied in respect of domiciliary visits and consultations covered by Item 10907 if the services are direct-billed.

Claiming of benefits
The patient, upon receipt of an optometrist's account, has two courses open for paying the account and receiving benefits.

Paid accounts
If the account has been paid, the claimant can obtain a cash benefit (up to certain limits) from a Medicare office. Alternatively they may lodge a claim by post, by fax in selected pharmacies and Rural Transaction Centres, or telephone (in rural areas throughout Australia) for a payment by Electronic Funds Transfer (EFT) or cheque.

Unpaid accounts
Where the patient has not paid the account the unpaid account may be presented to Medicare with a Medicare claim form. In this case Medicare will forward to the claimant a benefit cheque made payable to the optometrist.

It is the patient's responsibility to forward the cheque to the optometrist and make arrangements for payment of the balance of the account, if any. "Pay optometrist cheques" involving Medicare benefits cannot be sent direct to optometrists, or to patients at an optometrist's address (even if requested by the patient to do so). "Pay optometrist cheques" will be forwarded to the patient's normal address.

When issuing a receipt to a patient for an account that is being paid wholly or in part by a Medicare "pay optometrist cheque" the optometrist should indicate on the receipt that a "Medicare" cheque for $..... was involved in the payment of the account.

Itemised accounts
When an optometrist bills a patient for a service, the patient should be issued with a properly itemised account and receipt to enable him/her to claim Medicare benefits. Where both a consultation and computerised perimetry occur, these may be itemised on the same account.

Medicare benefits are not payable in respect of an optometric service unless there is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of each service to each patient, the following information:-
(a) patient's name;
(b) date on which the service(s) was rendered;
(c) a description of the service(s) (eg "initial consultation, "subsequent consultation" or "contact lens consultation" and/or “computerised perimetry” in those cases where it is performed);
(d) Medicare Benefits Schedule item number(s);
(e) the name and practice address or name and provider number of the optometrist who actually rendered the service(s). Where the optometrist has more than one practice location, the provider number used should be that which is applicable to the practice location where the service(s) was given;
(f) the fee charged for the service(s);
(g) the time each service began if the optometrist attended the patient on more than one occasion on the same day and on each occasion rendered a professional service relating to an optometric item, except where a perimetry item is performed in association with a consultation item, where times do not need to be specified.

The optometrist billing for the service bears responsibility for the accuracy and completeness of the information included on accounts, receipts and assignment of benefits forms even where such information has been recorded by an employee of the optometrist.

Payment of benefits could be delayed or disallowed if the account does not clearly identify the service as one which qualifies for Medicare benefits or that the practitioner is a registered optometrist practising at the address where the service was rendered. It is important to ensure that an appropriate description of the service, the item number and the optometrist's provider number are included on accounts, receipts and assignment forms. Details of any charges made other than for services, eg a dispensing charge, a charge for a domiciliary visit, should be shown separately either on the same account or on a separate account.

Patients must be eligible to receive Medicare benefits and must also meet the clinical requirements outlined in the relevant item descriptors.

Duplicate accounts
Only one original itemised account per service should be issued, except in circumstances where both a consultation and computerised perimetry occur, in which case these may be itemised on the same original account. Duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for “accounts rendered”.

Assignment of benefit (direct billing) arrangements
Under the Health Insurance Act an Assignment of Benefit (direct-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need.

If an optometrist direct-bills, he/she undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:-

- the patient's Medicare number must be quoted on all direct-bill assignment forms for that patient;
- the assignment forms provided are loose leaf to enable the patient details to be imprinted from the Medicare Card;
- the forms include information required by Regulations under Section 19(6) of the Health Insurance Act;
- the doctor must cause the particulars relating to the professional service to be set out on the assignment form, before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it;
- where a patient is unable to sign the assignment form, the signature of the patient's parent, guardian or other responsible person (other than the doctor, doctor's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff) is acceptable. The reason the patient is unable to sign should also be stated. In the absence of a "responsible person" the patient signature section should be left blank and in the section headed 'Practitioner's Use', an explanation should be given as to why the patient was unable to sign (e.g. unconscious, injured hand etc.) and this note should be signed or initialled by the doctor. If in the opinion of the practitioner the reason is of such a "sensitive" nature that revealing it would constitute an unacceptable breach of patient confidentiality or unduly embarrass or distress the recipient of the patient's copy of the assignment of benefits form, a concessional reason "due to medical condition" to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases it is expected that the reason given will be more specific.

Use of Medicare cards in direct billing
The Medicare card plays an important part in direct-billing as it can be used to imprint the patient details (including Medicare number) on the basic direct-billing forms. A special Medicare imprinter is used for this purpose and is available free of charge, on request, from Medicare.

The patient details can, of course, be entered on the direct-bill forms by hand, but the use of the card to imprint patient details assists optometrists and ensures accuracy of information. The latter is essential to ensure that the processing of a claim by Medicare is expedited.

The Medicare card number must be quoted on direct-bill forms. If the number is not available, then the assignment of benefit facility should not be used. To do so would incur a risk that the patient may not be eligible and Medicare benefits not payable.

Where a patient presents without a Medicare card and indicates that he/she has been issued with a card but does not know the details, the optometrist may contact a Medicare telephone enquiry number to obtain the number.

It is important for the optometrist to check the eligibility of patients for Medicare benefits by reference to the card, as entitlement is limited to the "valid to" date shown on the bottom of the card. Additionally the card will show if a person is enrolled through a Reciprocal Health Care Agreement.

Assignment of benefit forms

Only the approved forms available from Medicare Australia can be used to direct bill patients for optometric services and no other form can be used without its approval.

(a) **Form DB2-OP**
This form is designed for the use of optical scanning equipment and is used to assign benefits for optometrical services. It is loose leaf to enable imprinting of patient details from the Medicare card and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Practitioner copy and a Patient copy.

(b) **Form DB4**
This is a continuous stationery version of Form DB2 and has been designed for use on most office accounting machines.

The Claim for Assigned Benefits (Form DB1N, DB1H)

Practitioners who accept assigned benefits must claim from Medicare using either Claim for Assigned Benefits form DB1N or DB1H. The DB1N form should be used where services are rendered to persons for treatment provided out of hospital or day hospital treatment. The DB1H form should be used where services are rendered to persons while hospital treatment is provided in a hospital or day hospital facility (other than public patients). Both forms have been designed to enable benefit for a claim to be directed to a practitioner other than the one who rendered the services. The facility is intended for use in situations such as where a short term locum is acting on behalf of the principal doctor and setting the locum up with a provider number and pay-group link for the principal doctor's practice is impractical. Practitioners should note that this facility cannot be used to generate payments to or through a person who does not have a provider number.

Each claim form must be accompanied by the assignment forms to which the claim relates.

The DB1N and DB1H are also loose leaf to enable imprinting of practitioner details using the special Medicare imprinter. For this purpose, practitioner cards, showing the practitioner's name, practice address and provider number are available from Medicare on request.

Time limits applicable to lodgement of claims for Medicare benefits

A time limit of two years applies to the lodgement of claims with Medicare under the direct-billing (Assignment of Benefits) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than two years earlier than the date the claim was lodged with Medicare.

Provision exists whereby in certain circumstances (eg hardship cases, third party or workers' compensation cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the processing centre to which assigned claims are directed.

O.8.. Limitations on Benefits

Single Course of Attention

A reference to a single course of attention means:-

(a) In the case of Items 10900 to 10918 - a course of attention by one or more optometrists in relation to a specific episode of optometric care.

(b) In relation to Items 10921 to 10930 - a course of attention, including all associated attendances, by one or more optometrists for the purpose of prescribing and fitting of contact lenses.

Initial consultations

The initial consultation item (Item 10900) is payable once only within 24 months of the previous standard consultation (Item 10900, 10905, 10907, 10912, 10913, 10914 or 10915). However, a benefit is payable under

Item 10912, 10913, 10914 or 10915 where the patient has an ocular condition which necessitates a further course of attention being started within 24 months of the previous initial consultation. The conditions which qualify for a further course of attention are contained in the descriptions of these items (see paragraphs 06.16, O6.17 and O6.18).

Where an attendance would have been covered by Item 10900,10905, 10907, 10912, 10913, 10914 or 10915 but is of 15 minutes duration or less, Item 10916 (Short consultation) applies.

Second or subsequent consultations (Item 10918)
Each consultation, apart from the initial consultation, in a single course of attention, other than a course of attention involving the fitting and prescription of contact lenses, is covered by Item 10918.

Contact lens consultations (Items 10921 to 10930)
In the case of contact lens consultations, benefit is payable only where the patient is one of the prescribed classes of patient entitled to benefit for contact lens consultations as described in Items 10921 to 10929.
For claims under Items 10921,10922,10923,10925 and 10930, eligibility is based on the patient's distance spectacle prescription, determining the spherical equivalent by adding to the spherical prescription, half the cylindrical correction.

Medicare benefits are not payable for Item 10929 in circumstances where patients want contact lenses for:
(a) reasons of appearance (because they do not want to wear spectacles);
(b) sporting purposes;
(c) work purposes; or
(d) psychological reasons (because they cannot cope with spectacles).

All attendances subsequent to the initial consultation in a course of attention involving the prescription and fitting of contact lenses are collectively regarded as a single service under Items 10921 to 10930, as appropriate. The date of service is deemed to be the date on which the contact lenses are delivered to the patient. Any visits related to the prescribing and fitting of lenses are regarded to be covered by the relevant item in the range 10921 to 10930. The bulk item includes those aftercare visits necessary to ensure the satisfactory performance of the lenses. This interpretation is unaltered by the frequency of aftercare visits associated with various lens types including extended wear lenses. Consultations during the aftercare period that are unrelated to the prescription and fitting of contact lenses or that are not part of normal aftercare may be billed under other appropriate items (not Items 10921 to 10930).

For patients not eligible for Medicare rebates for contact lens care, fees charged for contact lens consultations are a matter between the practitioner and the patient. Any account for consultations involving the fitting and prescription of contact lenses issued to a patient who does not fall into the specified categories should be prepared in such a way that it cannot be used to obtain benefits. No Medicare item number should be attached to any service that does not attract benefits and the optometrist should annotate the account with wording such as "Medicare benefits not payable".

Where an optometrist wishes to apportion the total fee to show the appropriate optometric consultation benefit and the balance of the fee, he or she should ensure that the balance is described in such a way (eg balance of account) that it cannot be mistaken as being a separate consultation. In particular no Medicare item number should be shown against the balance.

When a patient receives a course of attention involving the prescription and fitting of contact lenses an account should not be issued (or an assignment form completed) until the date on which the patient takes delivery of the lenses.

Benefit under Items 10921-10929 is payable once only in any period of 36 consecutive months except where circumstances are met under Item 10930 within a 36 month period.

Additional payments for optometrists visiting remote and very remote locations (Visiting Optometrists Scheme)
Special arrangements exist under the provisions of Section 129A of the Health Insurance Act 1973 to provide financial incentives to optometrists to deliver outreach optometric services to remote and very remote locations, which would not otherwise have ready access to primary eye care, without additional charge to patients. Optometrists are encouraged to provide outreach services to national priority locations, particularly remote and

very remote communities, Indigenous communities and rural communities with an identified need for optometric services.

Under these arrangements, financial assistance may be provided to approved participating optometrists to cover the costs of travel, accommodation, meals and incidentals, lease of equipment, facility fees, administrative support at the outreach location, and external locum support at the optometrist's principal practice. Approved participating optometrists may also be eligible to receive an Absence from Practice Allowance to compensate for 'loss of business opportunity' due to the time spent travelling to and from an approved outreach location to deliver optometric services.

This assistance is provided because the participating nature of the benefit arrangements does not permit optometrists to charge fees higher than Medicare Schedule fees to offset the additional costs involved in visiting remote and very remote locations.

A national call for expressions of interest will be undertaken on an annual basis, although applications for priority areas may be considered on a needs basis at any time. Optometrists interested in providing an outreach optometric service should contact the relevant State or Northern Territory Office of the Australian Government Department of Health and Ageing. Addresses of State and Northern Territory offices are located at the end of these Notes.

Visiting optometrists should also note that Regional Eye Health Coordinators located in several Aboriginal Community Controlled Health Services in each State and Territory may be able to assist in arranging and establishing ongoing visits. Optometrists are advised to contact their relevant State or Northern Territory Office of the Australian Government Department of Health and Ageing.

O.9.. Referrals (Read in connection with O6.9 to O6.12)

General

Optometrists are required to refer a patient for medical attention when it becomes apparent to them that the patient's condition is such that it would be more appropriate for treatment to be undertaken by a medical practitioner.

Optometrists may refer patients directly to specialist ophthalmologists with the patient being able to claim benefits for the ophthalmologist's services at the referred specialist rate.

Optometrists may refer patients directly to another optometrist, based on the clinical needs of the patient.

A referral letter or note must have been issued by the optometrist for all such services provided by specialist ophthalmologists or optometrists in order for patients to be eligible for Medicare benefit at the referred rate. Unless such a letter or note has been provided, benefits will be paid at the unreferred rate.

Medicare benefits at the referred rate are not paid for patients referred by optometrists to consultant physicians or to specialists other than ophthalmologists. See paragraph O9.15 regarding emergency situations.

What is a referral

For the purposes of the optometric arrangements, a "referral" is a request to a specialist ophthalmologist or another optometrist for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s).

Subject to the exceptions in paragraph O9.8 below, for a valid "referral" to take place:

(a) the referring optometrist must have turned his or her mind to the patient's need for referral and communicate relevant information about the patient to the specialist ophthalmologist or optometrist to whom the patient is referred (but this does not necessarily mean an attendance on the occasion of the referral);

(b) the instrument of referral must be in writing by way of a letter or note and must be signed and dated by the referring optometrist; and

(c) the practitioner to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

The exceptions to the requirements in paragraph O9.7 are that:

(a) sub-paragraphs (ii) and (iii) do not apply to an emergency situation where the specialist ophthalmologist was of the opinion that the service be rendered as quickly as possible (see para O9.15); and
(b) sub-paragraph (iii) does not apply to instances where a written referral was completed by a referring optometrist but was lost, stolen or destroyed.

Period for which referral is valid
A referral from an optometrist to an ophthalmologist is valid for 12 months unless the optometrist specifies on the referral that the referral is for a different period (eg 3, 6 or 18 months or valid indefinitely).

The referral applies for the period specified in the referral from the date that the ophthalmologist provides the first service to the patient. If there is no period specified in the referral then the referral is valid for 12 months from the date of the first service provided by the ophthalmologist.

Referrals for longer than 12 months should be made only when the patient's clinical condition requires continuing care and management.

An optometrist may write a new referral when a patient presents with a condition unrelated to the condition for which the previous referral to an ophthalmologist was written. In these circumstances Medicare benefits for the consultation with the ophthalmologist would be payable at initial consultation rates.

A new course of treatment for which Medicare benefits would be payable at the initial consultation rates will also be paid where the referring optometrist:-
(a) deems it necessary for the patient's condition to be reviewed; and
(b) the patient is seen by the ophthalmologist outside the currency of the previous referral; and
(c) the patient was last seen by the specialist ophthalmologist more than 9 months earlier the attendance following a new referral.

Self referral
Optometrists may refer themselves to specialist ophthalmologists or other optometrists and Medicare benefits are payable at referred rates.

Emergency situations
Medicare benefits are payable even though there is no written referral in an emergency situation (as defined in the regulations). The specialist or the consultant physician should be of the opinion that the service must be rendered as quickly as possible and endorses the account, receipt or assignment form "Emergency referral".

A referral must be obtained from a medical practitioner or, in the case of a specialist ophthalmologist, a medical practitioner or an optometrist if attendances subsequent to the emergency attendance are to attract Medicare benefits at the referred rate.

O.10.. Provision for Review and Inquiry
Optometric Benefits Consultative Committee (OBCC)
The OBCC is an advisory committee established in 1990 by arrangement between the Minister and Optometrists Association Australia.

The OBCC's functions are:
(a) to consider the appropriateness of existing Medicare Benefits Schedule items, including the need to combine, delete or create items, and the need to amend item descriptions;
(b) to undertake reviews of particular services and to report on the appropriateness of the existing structure of the Schedule, having regard to current optometric practice;
(c) to provide a forum for discussion on fees and fee relativities for individual optometric items in the Medicare Benefits Schedule (but not so as to involve a general review of the overall level of optometric fees);
(d) to consider and advise on the appropriateness of the participating optometrists' arrangements and the Common Form of Undertaking (as specified in the Health Insurance Act and related legislation) and the administrative rules and interpretations which determine the payment of benefits for optometric services or the level of benefits;

(e) to investigate specific matters associated with the participating optometrists' arrangements and to advise on desirable changes.

The OBCC comprises two representatives from the Department of Health and Ageing, two representatives from Medicare Australia, and three representatives from Optometrists Association Australia.

Professional Services Review (PSR) Scheme
The Professional Services Review (PSR) Scheme is a scheme for reviewing and investigating the provision of services by a health practitioner to determine whether the practitioner has engaged in inappropriate practice in the rendering or initiating of Medicare services or in presribing under the Pharmaceutical Benefits Scheme (PBS). A health practitioner is a medical practitioner, a dentist, an optometrist, a chiropractor, physiotherapist or a podiatrist.

Section 82 of the *Health Insurance Act 1973* defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude that it would be unacceptable to the general body of the members of the profession in which the practitioner was practising when he or she rendered or initiated the services.
Medicare Australia monitors health practitioners' claiming patterns. Where an anomaly is detected, for which a satisfactory explanation cannot be provided, Medicare Australia can request that the Director of PSR review the provision of services by the practitioner.

From 1 January 2003, changes were introduced to clarify each stage in the PSR process, and to strengthen the procedural fairness provisions available to the person under review.

The revised PSR arrangements apply in relation to requests by Medicare Australia to the Director of PSR made after 1 January 2003.

O.11.. Penalties and Liabilities
Penalties
Penalties of up to $10,000 or imprisonment for up to five years may be imposed on any person who makes a statement (either orally or in writing) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used in connection with a claim for benefits. In addition, any practitioner who is found guilty of such offences shall be subject to examination by a Medicare Participation Review Committee and may be counselled or reprimanded or may have services wholly or partially disqualified from the Medicare benefit arrangements.

A penalty of up to $1,000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on a direct-billing form without necessary details having been entered on the form before the patient signs or who fails to give the patient a copy of the completed form.

Medicare Participation Review Committee (MPRC)
The Medicare Participation Review Committee determines what administrative action should be taken against a practitioner who has been successfully prosecuted for defrauding Medicare.

The Committees have a discretionary range of options from taking no action against the practitioner through counselling and reprimand to full or partial disqualification from participating in the Medicare benefit arrangements for up to five years.

SERVICES		SERVICES
	GROUP A10 - OPTOMETRIC SERVICES	
10900	**COMPREHENSIVE INITIAL CONSULTATION** Professional attendance of more than 15 minutes duration, being the first in a course of attention - not payable within 24 months of an attendance to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10915 applies *(See para O6 of explanatory notes to this Category)* **Fee:** $67.15 85% = $57.10	
10905	**REFERRED COMPREHENSIVE INITIAL CONSULTATION** Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has been **referred** by another optometrist who is not associated with the optometrist to whom the patient is referred *(See para O6 of explanatory notes to this Category)* **Fee:** $67.15 85% = $57.10	
10907	**COMPREHENSIVE INITIAL CONSULTATION BY ANOTHER PRACTITIONER WITHIN 24 MONTHS OF A PREVIOUS COMPREHENSIVE CONSULTATION** Professional attendance of more than 15 minutes duration being the first in a course of attention **where the patient has attended another optometrist** within the previous 24 months for an attendance to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10915 applies *(See para O6 of explanatory notes to this Category)* **Fee:** $33.60 85% = $28.60	
10912	**OTHER COMPREHENSIVE CONSULTATIONS** Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has suffered a **significant change of visual function** requiring comprehensive reassessment within 24 months of an initial consultation to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10915 at the same practice applies *(See para O6 of explanatory notes to this Category)* **Fee:** $67.15 85% = $57.10	
10913	Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has **new signs or symptoms**, unrelated to the earlier course of attention, requiring comprehensive reassessment within 24 months of an initial consultation to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10915 at the same practice applies *(See para O6 of explanatory notes to this Category)* **Fee:** $67.15 85% = $57.10	
10914	Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has a **progressive disorder** (excluding presbyopia) requiring comprehensive reassessment within 24 months of an initial consultation to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10915 applies *(See para O6 of explanatory notes to this Category)* **Fee:** $67.15 85% = $57.10	
10915	Professional attendance of more than 15 minutes duration, being the first in a course of attention involving the examination of the eyes, with the instillation of a mydriatic, of a patient with diabetes mellitus requiring comprehensive reassessment. *(See para O6 of explanatory notes to this Category)* **Fee:** $67.15 85% = $57.10	
10916	**BRIEF INITIAL CONSULTATION** Professional attendance, being the first in a course of attention, of not more than 15 minutes duration, not being a service associated with a service to which item 10931, 10932, 10933, 10940, 10941, 10942 or 10943 applies *(See para O6 of explanatory notes to this Category)* **Fee:** $33.60 85% = $28.60	
10918	**SUBSEQUENT CONSULTATION** Professional attendance being the second or subsequent in a course of attention not related to the prescription and fitting of contact lenses, not being a service associated with a service to which item 10940 or 10941 applies *(See para O6 of explanatory notes to this Category)* **Fee:** $33.60 85% = $28.60	

	CONTACT LENSES FOR SPECIFIED CLASSES OF PATIENTS - BULK ITEMS FOR ALL SUBSEQUENT CONSULTATIONS *Note: Benefits may not be claimed under Item 10929 where the patient wants the contact lenses for appearance, sporting, work or psychological reasons - see paragraph O8.5 - O8.11 of explanatory notes to this category.* All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention in respect of which the first attendance is a service to which item 10900, 10905, 10907, 10912, 10913, 10914, 10915 or 10916 applies - payable only once in a period of 36 months
10921	- patients with **myopia of 5.0 dioptres or greater** (spherical equivalent) in 1 eye **Fee:** $166.45 85% = $141.50
10922	- patients with **manifest hyperopia of 5.0 dioptres or greater** (spherical equivalent) in 1 eye **Fee:** $166.45 85% = $141.50
10923	- patients with **astigmatism of 3.0 dioptres or greater** in 1 eye **Fee:** $166.45 85% = $141.50
10924	- patients with **irregular astigmatism** in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3 logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens **Fee:** $210.05 85% = $178.55
10925	- patients with **anisometropia of 3.0 dioptres or greater** (difference between spherical equivalents) **Fee:** $166.45 85% = $141.50
10926	- patients with corrected **visual acuity of 0.7 logMAR (6/30) or worse** in both eyes, being patients for whom a contact lens is prescribed as part of a **telescopic system** **Fee:** $166.45 85% = $141.50
10927	- patients for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by: **(i) pathological mydriasis; or** **(ii) aniridia; or** **(iii) coloboma of the iris; or** **(iv) pupillary malformation or distortion; or** **(v) significant ocular deformity or corneal opacity** whether congenital, traumatic or surgical in origin **Fee:** $210.05 85% = $178.55
10928	- patients who, by reason of **physical deformity**, are unable to wear spectacles **Fee:** $166.45 85% = $141.50
10929	- patients who have a **medical or optical condition** (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10926, 10927 or 10928 applies) requiring the use of a contact lens for correction, where the **condition is specified** on the patient's account **Fee:** $210.05 85% = $178.55
10930	All professional attendances regarded as a single service in a single course of attention involving the prescription and fitting of contact lenses where the patient meets the requirements of an item in the range 10921-10929 and requires a **change in contact lens material or basic lens parameters**, other than a simple power change, because of a **structural or functional change in the eye or an allergic response** within 36 months of the fitting of a contact lens covered by item 10921 to 10929 **Fee:** $166.45 85% = $141.50

SERVICES		SERVICES
	DOMICILIARY VISITS An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10932, 10933, 10940 or 10941) applies (the applicable item) if the service is: a) rendered at a place other than consulting rooms, being at: (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on **one patient** at a single location on one occasion, and c) either: (i) bulk-billed in respect of the fees for both: - this item; and - the applicable item; or (ii) not bulk-billed in respect of the fees for both: - this item; and - the applicable item *(See para O6 of explanatory notes to this Category)*	
10931	**Fee:** $23.40 85% = $19.90	
	An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10931, 10933, 10940 or 10941) applies (the applicable item) if the service is: a) rendered at a place other than consulting rooms, being at: (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on **two patients** at the same location on one occasion, and c) either: (i) bulk-billed in respect of the fees for both: - this item; and - the applicable item; or (ii) not bulk-billed in respect of the fees for both: - this item; and - the applicable item *(See para O6 of explanatory notes to this Category)*	
10932	**Fee:** $11.65 85% = $9.95	
	An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10931, 10932, 10940 or 10941) applies (the applicable item) if the service is: a) rendered at a place other than consulting rooms, being at: (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on **three patients** at the same location on one occasion, and c) either: (i) bulk-billed in respect of the fees for both: - this item; and - the applicable item; or (ii) not bulk-billed in respect of the fees for both: - this item; and - the applicable item *(See para O6 of explanatory notes to this Category)*	
10933	**Fee:** $7.75 85% = $6.60	
	COMPUTERISED PERIMETRY Full quantitative computerised perimetry (automated absolute static threshold) not being a service involving multifocal multichannel objective perimetry, performed by an optometrist, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, bilateral - to a maximum of 2 examinations (including examinations to which item 10941 applies) in any 12 month period, not being a service associated with a service to which item 10916, 10918, 10931, 10932 or 10933 applies *(See para O6 of explanatory notes to this Category)*	
10940	**Fee:** $64.05 85% = $54.45	

SERVICES		SERVICES
10941	Full quantitative computerised perimetry (automated absolute static threshold) not being a service involving multifocal multichannel objective perimetry, performed by an optometrist, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, unilateral - to a maximum of 2 examinations (including examinations to which item 10940 applies) in any 12 month period, not being a service associated with a service to which item 10916, 10918, 10931, 10932 or 10933 applies *(See para O6 of explanatory notes to this Category)* **Fee:** $38.60 85% = $32.85	
10942	**LOW VISION ASSESSMENT** Testing of residual vision to provide optimum visual performance involving one or more of spectacle correction, determination of contrast sensitivity, determination of glare sensitivity and prescription of magnification aids in a patient who has best corrected visual acuity of 6/15 or N.12 or worse in the better eye, or horizontal visual field of less than 120 degrees within 10 degrees above and below the horizontal midline, not being a service associated with a service to which item 10916 or 10921 to 10930 applies, payable twice in a 12 month period *(See para O6 of explanatory notes to this Category)* **Fee:** $33.60 85% = $28.60	
10943	**CHILDREN'S VISION ASSESSMENT** Additional testing to confirm diagnosis of, or establish a treatment regime for, a significant binocular or accommodative dysfunction, including assessment of one or more of accommodation, ocular motility, vergences, or fusional reserves and/or cycloplegic refraction, in a patient aged 3 to 14 years, not to be used for the assessment of learning difficulties or learning disabilities, not being a service associated with a service to which item 10916 or 10921 to 10930 applies, payable once only in a 12 month period *(See para O6 of explanatory notes to this Category)* **Fee:** $33.60 85% = $28.60	

Common Form of Undertaking

Participating Optometrists

Sections 23A and 23B
Health Insurance Act 1973

For the purposes of section 23A of the ***Health Insurance Act 1973*** (the Act)

I, _____ (full name in BLOCK letters)

of _____ (address for correspondence)

being

__ an optometrist registered to practice optometry in a State or Territory of Australia; or

__ a person/s who employs optometrists to provide services in the course of the practice of their profession; or

__ both of the above

(Choose one of the above options by marking a cross in the appropriate box)

who wishes to become a Participating Optometrist, hereby give the following undertaking to the Minister for Health and Ageing for and on behalf of the Commonwealth of Australia.

(Where this undertaking is made on behalf of a company or partnership which employs optometrists, it should be signed by a person who has the authority to make such undertakings on behalf of the company or, in the case of a partnership, by one of the partners on behalf of the partnership)

INTRODUCTION

1 The Minister has, pursuant to subsection 23A(1) of the Act, after consultation with Optometrists Association Australia, drawn up a common form of Undertaking to be given by an optometrist who wishes to become a Participating Optometrist. Definitions, interpretation and other formalities relating to this Undertaking are at Schedule 1.

2 Date on which an Undertaking comes into force

2.1 An Undertaking comes into force on the day on which it is accepted by the Minister.

3 Services to which this Undertaking relates

3.1 This Undertaking relates to any clinically relevant service ordinarily rendered by an optometrist in relation to consultation on ocular or vision problems, but does not include:

(a) an attendance for the sole purpose of delivering a prescribed visual aid or appliance or adjusting or repairing such an aid or appliance;

(b) an attendance for the purpose of filling a prescription written by another practitioner;

(c) an attendance on behalf of teaching institutions on patients of supervised students of optometry;

(d) an attendance by an optometrist on:

(i) any dependant of the Optometrist;

(ii) a practice partner of the Optometrist or any dependants of that partner;

(iii) an employer of the Optometrist or any dependants of that employer;

(e) anything done or service provided at any premises other than those specified in this Undertaking.

4 Premises to which this Undertaking relates

4.1 Where this Undertaking is signed by a person/s who employs optometrists to provide services in the course of the practice of optometry, the premises to which this Undertaking relates are those:

(a) specified in Schedule 2; and

(b) any other premises at which a domiciliary visit is made.

5 Termination of Undertaking

5.1 This Undertaking shall continue to be in force until it is:

(i) terminated by the Optometrist under subsection 23B(6) of the Act; or

(ii) revoked by the Minister following a determination of fraudulent or inappropriate practice.

5.2 A Participating Optometrist may, at any time, terminate an Undertaking, either wholly or in so far as it covers particular premises, by serving, as prescribed, a notice of termination to the Managing Director, Medicare Australia, specifying a date of termination not earlier than 30 days after the day on which the notice is served.

UNDERTAKING

6 Fees

6.1 I undertake to charge fees which do not exceed the Medicare Schedule fee for any service to which this Undertaking and a Medicare item apply, except in the case of**:**

(i) a domiciliary visit where an additional fee per patient may apply, not exceeding the Medicare Schedule fee for Item 10900 less the domiciliary loading, so that the maximum total fee that may be charged is twice the fee for Item 10900 where a comprehensive consultation is provided and 1.5 times the fee for Item 10900 where a subsequent consultation is provided; and

(ii) a patient being billed an Item 10907 attendance where an additional fee not exceeding an amount equal to the difference between the Medicare Schedule fee for Item 10900 and Item 10907 may apply. The appropriate fee for patient billing purposes in such cases should not exceed the Medicare Schedule fee for Item 10900.

6.2 I undertake that when I charge an additional fee as specified in subclause 6.1(ii), I will inform the patient of the Medicare benefit payable for Item 10907, at the time of the consultation, and that the additional fee will not attract benefits.

6.3 I undertake that I will obtain the patient's informed consent to the release of information to me if it is necessary for me to seek patient information from Medicare Australia in order to determine appropriate itemisation of accounts, receipts or bulk-billed claims.

6.4 I undertake that I will not include an amount that relates to a service to which this Undertaking and a Medicare item apply in any charge made for appliances.

6.5 I undertake that I will not include a fee for a visit made or a service provided which is not a service to which this Undertaking applies in any charge made in respect of a Medicare item.

7 Billing procedures

7.1 I undertake to issue a receipt, or an account and a receipt, as the case may require, for all attendances made by myself, or on my behalf, to which a Medicare item applies, except where an assignment of benefit is made in accordance with section 20A of the Act.

7.2 I undertake that any receipt or account issued as provided in subclause 7.1 will contain the details of:

(a) any additional fee for a domiciliary visit where applicable (subclause 6.1(i));

(b) any additional fee in respect of Item 10907 (subclause 6.1(ii)); and

(c) the particulars prescribed in regulations made from time to time pursuant to subsection 19(6) of the Act.

7.3 I undertake that I will ensure that no fee is charged, nor an assignment of benefit made under section 20A of the Act for an attendance to which one of Items 10921-10930 inclusive relates before the date on which the patient takes delivery of the contact lenses.

7.4 I undertake that I will ensure that in respect of each service:

(a) only one original of the receipt or account is issued; and

(b) where a duplicate receipt or account is issued it is clearly marked "duplicate".

7.5 I undertake that I will take all reasonable steps to ensure that all items are billed in accordance with this Undertaking and the appropriate Medicare items.

7.6 I undertake to accept the relevant Medicare benefit as full payment for the consultation where an assignment of benefit is made in accordance with section 20A of the Act. I accept that additional charges for that service (irrespective of the purpose or title of the charge) ***cannot*** be raised against the patient, including the special circumstances relating to domiciliary visits and consultations covered under Item 10907.

8 Referral

8.1 I undertake that I will ensure that a patient is referred to a medical practitioner when it becomes apparent to the Attending Optometrist that the condition of the patient is such that it would be more appropriate for treatment to be undertaken by a medical practitioner.

8.2 I undertake that I will refer patients to other optometrists solely on the basis of the clinical needs of the patient.

9 Prescriptions

9.1 I undertake that I will ensure that patients are informed that they are entitled to a copy of their spectacle prescription, and that they are free to have the prescribed spectacles dispensed by any person of their choice.

9.2 I undertake that I will ensure that where a contact lens prescription is prepared for the patient, the contact lens prescription is available to the patient at the completion of the prescription and fitting process.

10 Recalls

10.1 I undertake that any notice sent to a patient by me or on my behalf suggesting re-examination will be sent solely on the basis of the clinical needs of the patient.

11 Advertising

11.1 I undertake that I will not advertise or allow any person to advertise on my behalf in a manner that would lead to claims for Medicare benefits for services that are not Clinically Relevant Services as defined in the Act.

12 Notification of changes in practice details

12.1 I/we, as an employer of optometrists, undertake that in the event of a change in**,** or addition to**,** the details of the practice, as set out in Schedule 2, I/we will provide Medicare Australia with details of the change or addition within 28 days of the change or addition.

13 Supply of Information

13.1 I undertake to furnish to the Minister such information relating to the rendering of services by, or on behalf of, the Optometrist as is from time to time reasonably requested by the Minister.

[Signature]

[Date]

[Witnesses]

Schedule 1 - Definitions, Interpretation and Other Formalities

1 Definitions

In this Undertaking:

(a) **"Act"** means the *Health Insurance Act 1973*;

(b) **"Attending Optometrist"** means an optometrist as defined in subsection 3(1) of the Act, who renders the service;

(c) **"Clinically Relevant Service"** means a service rendered by an optometrist that is generally accepted in the optometrical profession as being necessary for the appropriate treatment of the patient to whom it is rendered;

(d) **"Commonwealth"** means the Commonwealth of Australia;

(e) **"Department of Health and Ageing"** means the Australian Government Department of Health and Ageing or, where the subject matter of the Undertaking is transferred to another Australian Government Department or Agency, that other Department or Agency;

(f) **"Domiciliary Visit"** means a professional attendance to which an item in the General Medical Services Table relates, given at the request of patients, either at their place of residence or at a nursing home, hospital or other temporary place of residence of the patient;

(g) **General Medical Services Table** means a table of medical services prescribed under section 4 of the Act in the Regulations, as varied from time to time;

(h) **Medicare benefit** means a benefit payable by the Commonwealth in relation to a professional service to which a Medicare item applies;

(i) **Medicare item** means an item specified in the General Medical Services Table;

(j) **Medicare Schedule fee** means a fee specified for a Medicare item;

(k) **"Minister"** means the Minister responsible for administering the Department of Health and Ageing and includes:

(i) any other Minister of the Commonwealth of Australia who is for the time being acting for that Minister;

(ii) a person to whom the relevant powers or functions of the Minister are for the time being delegated;

(l) **"Optometrist"** for the purposes of sections 23A and 23B of the Act, includes a person who employs optometrists to provide services in the course of the practice of their profession;

(m) **"Participating Optometrist"** means an optometrist or other person in respect of whom there is in force an Undertaking given by that person and accepted by the Minister under section 23B of the Act;

(n) **"Person"** includes a body politic or corporation as well as an individual;

(o) **"Service"** means a professional service specified in a Medicare item that relates to an attendance by a Participating Optometrist;

(p) **"Undertaking"** means this Common Form of Undertaking and any Schedules hereto as each may be amended from time to time.

2 Interpretation

In this Undertaking, unless contrary intention appears:

(a) a reference to a clause refers to the relevant clause to this Undertaking;

(b) a reference to a Schedule is to the relevant Schedule of this Undertaking and if a Schedule is at any time varied extends to the Schedule as so varied;

(c) words in the singular include the plural and words in the plural include the singular;

(d) the terms AI≅ and Ame≅ refer to the company or the body corporate where a company or a body corporate is making an undertaking; and

(e) words and expressions used in the Undertaking have the meaning given to them in Schedule 1 of the Undertaking and the Act.

3 Operation of Undertaking

If the Act or the Regulations are amended this Undertaking will be read as amended to comply with the then current form of the Act or Regulations.

Any amendments to the Undertaking will be notified in writing to the Optometrist within 28 days of their coming into force or on such earlier day specified by the Minister not being a day earlier than the day on which the amendment was received by Medicare Australia.

4 Variation of Undertaking

This Undertaking is subject to variation as provided in subsections 23A(3) and 23B(5) of the Act.

5 Notices

Any notice or other communication to the Optometrist under, or for the purpose of, this Undertaking by the Minister shall be deemed to have been duly given or made if it is in writing signed by or on behalf of the Minister or in the case of a delegate signed by that delegate and is sent by prepaid post addressed to the Optometrist at the address shown in Schedule 3 for the forwarding of notices or at such other address as is notified in writing, from time to time, by the Optometrist to the Minister or his delegate for that purpose.

Any notice, or other communication to the Minister under**,** or for the purpose of**,** this Undertaking by the Optometrist shall be deemed to have been duly given or made if it is in writing, signed by or on behalf of the Optometrist, addressed to the Minister and is served personally or by being sent by prepaid post, addressed to the Manager, Medicare Australia in the State in which the premises to which the Undertaking applies are situated. If the premises are situated in the Australian Capital Territory or the Northern Territory, the notice is to be addressed to the General Manager, Medicare Australia, PO Box 1001, Tuggeranong ACT 2901.

A notice, or other communication sent by post shall be deemed to have been received by the Optometrist or the Minister as the case may be, when it would have been delivered in the ordinary course of mail delivery.

Schedule 2

Premises to which this Undertaking relates

The premises specified for the purposes of this Undertaking are located at:

[Address 1]

[Address 2]

[Address 3]

[Etc]

Schedule 3

Address for correspondence

Notices or other communications to the Optometrist relating to this Undertaking should be directed to:

[Name & Address]