

**Australian Government
Department of Health and Ageing**

Medicare Benefits Schedule Book

Category 8

Operating from 01 March 2012

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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>

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G.1.1. THE MEDICARE BENEFITS SCHEDULE - INTRODUCTION

Schedules of Services

Each professional service contained in the Schedule 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 80000-88000 and 82100-82140 and 82200-82215, allied health professionals, dentists, and dental specialists, participating midwives and participating nurse practitioners 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 will vary from case 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

NEW SOUTH WALES Medicare Australia Paramatta Office 130 George Street PARRAMATTA NSW 2150	VICTORIA Medicare Australia Melbourne Office Level 10 595 Collins Street	QUEENSLAND Medicare Australia Brisbane Office 143 Turbot Street BRISBANE QLD 4000
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	MELBOURNE VIC 3000	
SOUTH AUSTRALIA Medicare Australia Adelaide Office 209 Greenhill Road EASTWOOD SA 5063	WESTERN AUSTRALIA Medicare Australia Perth Office Level 4 130 Stirling Street PERTH WA 6003	TASMANIA Medicare Australia Hobart Office 199 Collins Street HOBART TAS 7000
NORTHERN TERRITORY As per South Australia	AUSTRALIAN CAPITAL TERRITORY Medicare Australia National Office 134 Reed Street North GREENWAY 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 numbers have been reserved by Medicare Australia exclusively for inquiries relating to the Schedule:

Provider Enquiries: 132 150

Public Enquiries: 132 011

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, Malta and Belgium.

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 enroll 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 entitled to public hospital care and PBS drugs, and should present their passports before treatment as they are not issued with Medicare cards.
- 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 (ACRRM) 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 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 by Dentists or Optometrists or Participating Midwives or Participating Nurse Practitioners

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

- (c) by a participating midwife where the specialist is an obstetrician or a paediatrician, as clinical needs dictate. A referral given by a participating midwife is valid until 12 months after the first service given in accordance with the referral and for I pregnancy only or
 - (d) by a participating nurse practitioner to specialists and consultant physicians. A referral given by a participating nurse practitioner is valid until 12 months after the first service given in accordance with the referral.
- (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 not 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.

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 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

State and Territory Governments are responsible for the provision of public hospital services to eligible persons in accordance with the National Healthcare Agreement.

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 Medicare Australia CEO, to produce to a medical practitioner who is an employee 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.

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 an 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 words '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:-
 - a. 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;
 - b. 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 a 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). However, where the item has an EMSN benefit cap, there is a maximum limit on the EMSN benefit that will be paid for that item. 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; or
- In the absence of a "responsible person" the patient signature section should be left blank.

Where the signature space is either left blank or another person signs on the patient's behalf, the form **must** include:

- the notation "Patient unable to sign" 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 and 5000 to 5267 (inclusive) 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.

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 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:
decide to take no further action; or
enter into an agreement with the person under review (which must then be ratified by an independent Determining Authority); or
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:
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;

hold hearings and require the person under review to attend and give evidence;
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.

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.

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:

an unusual occurrence;
the absence of other medical services for the practitioner's patients (having regard to the practice location); and
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. COMPREHENSIVE MANAGEMENT FRAMEWORK FOR THE MBS

The Government announced the Comprehensive Management Framework for the MBS in the 2011-12 Budget to improve MBS management and governance into the future. As part of this framework, the Medical Services Advisory Committee (MSAC) Terms of Reference and membership have been expanded to provide the Government with independent expert advice on all new proposed services to be funded through the MBS, as well as on all proposed amendments to existing MBS items. Processes developed under the previously funded MBS Quality Framework are now being integrated with MSAC processes under the Comprehensive Management Framework for the MBS.

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_.

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 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 \$73.70 (indexed annually), whichever is the greater, for all other professional services.

Public hospital services are to be provided free of charge to eligible persons who choose to be treated as public patients in accordance with the National Healthcare Agreement.

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

The Medicare Safety Nets provide families and singles with an additional rebate for out-of-hospital Medicare services, once annual thresholds are reached. There are two safety nets: the original Medicare safety net and the extended Medicare safety net.

Original Medicare Safety Net:

Under the original Medicare safety net, the Medicare benefit for out-of-hospital services is increased to 100% of the Schedule Fee (up from 85%) once an annual threshold in gap costs is reached. Gap costs refer to the difference between the Medicare benefit (85%) and the Schedule Fee. The threshold from 1 January 2012 is \$413.50. This threshold applies to all Medicare-eligible singles and families.

Extended Medicare Safety Net:

Under the extended Medicare safety net (EMSN), once an annual threshold in out-of-pocket costs for out-of-hospital Medicare services is reached, Medicare will pay for 80% of any future out-of-pocket costs for out-of-hospital Medicare services for the remainder of the calendar year. However, where the item has an EMSN benefit cap, there is a maximum limit on the EMSN benefit that will be paid for that item. Further explanation about EMSN benefit caps is provided below. Out-of-pocket costs refer to the difference between the Medicare benefit and the fee charged by the practitioner.

In 2012, the threshold for singles and families that hold Commonwealth concession card, families that received Family Tax Benefit Part (A) (FTB(A)) and families that qualify for notional FTB(A) is \$598.80. The threshold for all other singles and families is \$1,198.00.

The thresholds for both safety nets are indexed on 1 January each year.

Individuals are automatically registered with Medicare Australia for the safety nets; however couples and families are required to register in order to be recognised as a family for the purposes on the safety nets. In most cases, registered families have their expenses combined to reach the safety net thresholds. This may help to qualify for safety net benefits more quickly. Registration forms can be obtained from Medicare Australia offices, or completed online at www.medicareaustralia.gov.au.

EMSN Benefit Caps:

The EMSN benefit cap is the maximum EMSN benefit payable for that item and is paid in addition to the standard Medicare rebate. Where there is an EMSN benefit cap in place for the item, the amount of the EMSN cap is displayed in the item descriptor.

Once the EMSN threshold is reached, each time the item is claimed the patient is eligible to receive up to the EMSN benefit cap. As with the safety nets, the EMSN benefit cap only applies to out-of-hospital services.

Where the item has an EMSN benefit cap, the EMSN benefit is calculated as 80% of the out-of-pocket cost for the service. If the calculated EMSN benefit is less than the EMSN benefit cap; then calculated EMSN rebate is paid. If the calculated EMSN benefit is greater than the EMSN benefit cap; the EMSN benefit cap is paid.

For example:

Item A has a Schedule fee of \$100, the out-of-hospital benefit is \$85 (85% of the Schedule fee). The EMSN benefit cap is \$30. Assuming that the patient has reached the EMSN threshold:

- o If the fee charged by the doctor for Item A is \$125, the standard Medicare rebate is \$85, with an out-of-pocket cost of \$40. The EMSN benefit is calculated as $\$40 \times 80\% = \32 . However, as the EMSN benefit cap is \$30, only \$30 will be paid.
- o If the fee charged by the doctor for Item A is \$110, the standard Medicare rebate is \$85, with an out-of-pocket cost of \$25. The EMSN benefit is calculated as $\$25 \times 80\% = \20 . As this is less than the EMSN benefit cap, the full \$20 is paid.

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 seborrheic 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 *Health 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, 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 service is a health screening service.
- the service is a pre-employment screening service

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

- 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;
- the injection of human chorionic gonadotrophin in the management of obesity;
- the use of hyperbaric oxygen therapy in the treatment of multiple sclerosis;
- the removal of tattoos;
- 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;
- the removal from a cadaver of kidneys for transplantation;
- 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

- Endoluminal gastroplasty, for the treatment of gastro-oesophageal reflux disease;
- Gamma knife surgery;
- Intradiscal electro thermal arthroplasty;
- Intravascular ultrasound (except where used in conjunction with intravascular brachytherapy);
- Intro-articular viscosupplementation, for the treatment of osteoarthritis of the knee;
- Low intensity ultrasound treatment, for the acceleration of bone fracture healing, using a bone growth stimulator;
- Lung volume reduction surgery, for advanced emphysema;
- Photodynamic therapy, for skin and mucosal cancer;
- Placement of artificial bowel sphincters, in the management of faecal incontinence;
- Selective internal radiation therapy for any condition other than hepatic metastases that are secondary to colorectal cancer;
- Specific mass measurement of bone alkaline phosphatase;
- Transmyocardial laser revascularisation;
- Vertebral axial decompression therapy, for chronic back pain.
- Autologous Chondrocyte Implantation and Matrix-induced Autologous Chondrocyte Implantation.
- Vertebroplasty

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 for a person as a prerequisite of that person becoming eligible to foster a child or children;
- 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 or 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.

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.

MISCELLANEOUS SERVICES
CATEGORY 8

SUMMARY OF CHANGES

Changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number

- | | |
|-------------------------|-------|
| (a) new item | New |
| (b) amended description | Amend |
| (c) fee amended | Fee |
| (d) item number changed | Renum |
| (e) EMSN changed | EMSN |

Amended Descriptions

80000 80010 80100 80110 80125 80135 80150 80160

M.1.1. ADDITIONAL BULK BILLING PAYMENT FOR GENERAL MEDICAL SERVICES - (ITEMS 10990 AND 10991)

Item 10990 can only be claimed where all of the conditions set out in paragraphs (a) to (d) of item 10990 have been met.

Item 10991 can only be claimed where all of the conditions set out in paragraphs (a) to (e) of item 10991 have been met.

- Item 10991 can only be used where the service is provided at, or from, a practice location that is listed in item 10991. This includes all regional, rural and remote areas (RRMA 3 to 7 under the Rural Remote Metropolitan Areas classification system), all of Tasmania and those areas covered by a Statistical Subdivision (SSD) or Statistical Local Areas (SLA) listed in item 10991 (SSDs and SLAs are specified in the Australian Standard Geographical Classification (ASGC) 2002). If you are not sure whether your practice location is in an eligible area, you can call Medicare Australia on 132 150.
- Practice location is the place associated with the medical practitioner's provider number from which the service has been provided. This includes services performed either at the medical practitioner's surgery, or those services performed away from the surgery using the provider number for that surgery (eg home visits or visits to aged care facilities).
- Where a medical practitioner has a practice location in both an eligible and ineligible area, item 10991 can only be claimed in respect of those services provided at, or from, the eligible practice location.

Item 10990 and item 10991 can only be used in conjunction with items in the General Medical Services Table of the MBS. There are similar items to be used in conjunction with diagnostic imaging services (item 64990 or 64991) or pathology services (item 74990 or 74991).

Item 10990 or item 10991 can be claimed for each item of service claimable under the MBS (other than diagnostic imaging services and pathology services), provided the conditions of the relevant item, 10990 or 10991, are satisfied. For example, item 10990 or 10991 can be claimed in conjunction with attendance items, procedural items (other than diagnostic imaging or pathology items) or services provided by a practice nurse on behalf of a medical practitioner (items 10983, 10984, 10986, 10987 and 10997). In some cases, this will mean that item 10990 or 10991 can be claimed more than once in respect of a patient visit.

Item 10990 or 10991 can not be claimed in conjunction with each other.

Where a Medicare benefit is not payable for a particular service (eg because the patient has exceeded the number of allowable services in a period of time), the additional bulk billing payment will not be paid for that service.

All GPs whether vocationally registered or not are eligible to claim the additional bulk billing payment.

Commonwealth concession card holder means a person listed on a Pensioner Concession Card, Health Care Card or Commonwealth Seniors Health Card issued by either Centrelink or the Department of Veterans' Affairs. Gold or White Cards issued by the Department of Veterans' Affairs do not attract the additional bulk billing payment. However, if a Gold or White Card holder also holds a recognised Commonwealth concession card and chooses to be treated under the Medicare arrangements, then that patient is an eligible concession card holder.

Unreferred service means a medical service provided to a patient by, or on behalf of, a medical practitioner, being a service that has not been referred to that practitioner by another medical practitioner or person with referring rights.

Medicare Australia will undertake regular post payment auditing to ensure that the additional bulk billing payment is being claimed correctly. Centrelink data will be used to verify concessional status and Medicare records will be used to confirm patient age.

M.1.2. AFTER-HOURS SERVICES PROVIDED IN AREAS ELIGIBLE FOR THE HIGHER BULK BILLING PAYMENT - (ITEM 10992)

Item 10992 can only be claimed where all of the conditions set out in paragraphs (a) to (g) of item 10992 have been met:

- Item 10992 must be claimed in conjunction with one of the items 597, 598, 599, 600, 5003, 5010, 5023, 5028, 5043, 5049, 5063, 5067, 5220, 5223, 5227, 5228, 5260, 5263 5265, or 5267. These items are for services provided after-hours outside of consulting rooms or hospital.
- Item 10992 can only be used where the service is provided in one of the eligible areas listed in item 10992 by a medical practitioner whose practice location (i.e. the location associated with the medical practitioner's provider number) is not in one of these areas.

Medical practitioners whose practice location is inside one of these listed locations should claim item 10991 for eligible services.

Item 10992 cannot be claimed in conjunction with item 10990 or 10991.

From 1 May to 30 June 2010, item 10985 was the higher bulk billing payment that could be claimed in conjunction items 597, 598, 599 or 600. On 1 July 2010, item 10985 ceased and item 10992 became the higher bulk billing payment item to be claimed in conjunction with items 597, 598, 599 and 600.

Where a Medicare benefit is not payable for a particular service the payment for item 10992 will not be paid for that service.

All GPs, whether vocationally registered or not, are eligible to claim the additional bulk billing payment.

Commonwealth concession card holder means a person listed on a Pensioner Concession Card, Health Care Card or Commonwealth Seniors Health Card issued by either Centrelink or the Department of Veterans' Affairs. Gold or White Cards issued by the Department of Veterans' Affairs do not attract the additional bulk billing payment. However, if a Gold or White Card holder also holds a recognised Commonwealth concession card and chooses to be treated under the Medicare arrangements, then that patient is an eligible concession card holder.

Unreferred service means a medical service provided to a patient by, or on behalf of, a medical practitioner, being a service that has not been referred to that practitioner by another medical practitioner or person with referring rights.

Medicare Australia will undertake regular post payment auditing to ensure that the additional bulk billing payment is being claimed correctly. Centrelink data will be used to verify concessional status and Medicare records will be used to confirm patient age.

M.3.1. INDIVIDUAL ALLIED HEALTH SERVICES (ITEMS 10950 TO 10970) FOR CHRONIC DISEASE MANAGEMENT - ELIGIBLE PATIENTS

ELIGIBLE PATIENTS

Medicare benefits are available for certain services provided by eligible allied health professionals to people with chronic conditions and complex care needs who are being managed by a GP using certain Chronic Disease Management (CDM) Medicare items. The allied health services must be recommended in the patient's plan as part of the management of their chronic condition.

Chronic medical conditions and complex care needs

A chronic medical condition is one that has been or is likely to be present for at least six months, e.g. asthma, cancer, cardiovascular illness, diabetes mellitus, musculoskeletal conditions and stroke. A patient is considered to have complex care needs if they require ongoing care from a multidisciplinary team consisting of their GP and at least two other health or care providers.

Prerequisite CDM services

Patients must have received the following MBS CDM services:

- GP Management Plan - MBS item 721 (or review item 732 for a review of a GPMP); and
- Team Care Arrangements - MBS item 723 (or review item 732 for a review of TCAs)

Alternatively, for patients who are permanent residents of an aged care facility, their GP must have contributed to, or contributed to a review of, a multidisciplinary care plan prepared for them by the aged care facility (MBS item 731).

For more information on the CDM planning items, refer to the explanatory notes for these items.

Allied health membership of a TCAs team

The allied health professional providing the service may be a member of the TCAs team convened by the GP to manage a patient's chronic condition and complex care needs. However, the service may also be provided by an allied health professional who is not a member of the TCAs team, provided that the service has been identified as necessary by the patient's GP and recommended in the patient's care plan/s.

Group services

In addition to individual services, patients who have type 2 diabetes may also access MBS items 81100 to 81125 which provide group allied health services.

M.3.2. INDIVIDUAL ALLIED HEALTH SERVICES (ITEMS 10950 TO 10970) FOR CHRONIC DISEASE MANAGEMENT - REFERRAL REQUIREMENTS

Referral form

For Medicare benefits to be payable, the patient must be referred to an eligible allied health professional by their GP using a referral form that has been issued by the Australian Government Department of Health and Ageing or a form that contains all the components of this form.

The form issued by the department is available at <http://www.health.gov.au/mbsprimarycareitems> (click on the link for allied health individual services).

GPs are encouraged to attach a copy of the relevant part of the patient's care plan to the referral form.

GPs may use one referral form to refer patients for single or multiple services of the same service type (e.g. five chiropractic services). If referring a patient for single or multiple services of different service types (e.g. two dietetic services and three podiatry services), a separate referral form will be needed for each service type.

The patient will need to present the referral form to the allied health professional at the first consultation, unless the GP has previously provided it directly to the allied health professional.

It is recommended that Allied health professionals retain the referral form for 24 months from the date the service was rendered (for Medicare Australia auditing purposes).

A copy of the referral form is not required to accompany Medicare claims, and allied health professionals do not need to attach a signed copy of the form to patients' itemised accounts/receipts or assignment of benefit forms.

Completed forms do not have to be sent to the Department of Health and Ageing.

Referral validity

Medicare benefits are available for up to five allied health services per patient per calendar year. If a patient has not used all of their allied health services under a referral in a calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total of five services for which the patient is eligible in that calendar year.

When patients have used all of their referred services, or require a referral for a different type of allied health service recommended in their CDM plan/s, they will need to obtain a new referral from their GP. GPs may choose to use this visit to undertake a review of the patient's CDM plan/s or, where appropriate, to manage the process using a GP consultation item.

It is not necessary to have a new CDM plan/s prepared each calendar year in order to access a new referral/s for eligible allied health services. Patients continue to be eligible for rebates for allied health services while they are being managed under the prerequisite CDM items as long as the need for eligible services continues to be recommended in their plan. However, regular reviews using MBS item 732 are encouraged.

M.3.3. INDIVIDUAL ALLIED HEALTH SERVICES - (ITEMS 10950 TO 10970) FOR CHRONIC DISEASE MANAGEMENT - ELIGIBLE PROVIDERS AND SERVICES

Eligible allied health providers

The following groups of allied health professionals are eligible to provide services under Medicare for patients with a chronic or terminal medical condition and complex care needs when they meet the provider eligibility requirements set out the next section and are registered with Medicare Australia.

- Aboriginal health workers
- Audiologists
- Chiropractors
- Diabetes educators
- Dietitians
- Exercise physiologists
- Mental health workers
- Occupational therapists
- Osteopaths
- Physiotherapists
- Podiatrists
- Psychologists
- Speech pathologists

Number of services per year

Medicare benefits are available for up to five allied health services per eligible patient, per calendar year. The five allied health services can be made up of one type of service (e.g. five physiotherapy services) or a combination of different types of services (e.g. one dietetic and four podiatry services). Five services per calendar year are the legal maximum per patient and exemptions to this are not possible.

Checking patient eligibility for allied health services

Patients seeking Medicare rebates for allied health services will need to have a valid referral form. If there is any doubt about a patient's eligibility, Medicare Australia will be able to confirm the number of allied health services already claimed by the patient during the calendar year. The allied health professional or the patient can call Medicare Australia to check this information (132 150 for provider enquiries; 132 011 for public enquiries).

Service length and type

Individual allied health services under Medicare for patients with a chronic medical condition and complex care needs (items 10950 to 10970) must be of at least 20 minutes duration and provided to an individual patient, not to a group. The allied health professional must personally attend the patient.

Reporting back to the GP

Where an allied health professional provides *a single service* to the patient under a referral, they must provide a written report back to the referring GP after each service.

Where an allied health professional provides *multiple services* to the same patient under the one referral, they must provide a written report back to the referring GP after the first and last service only, or more often if clinically necessary. Written reports should include:

- any investigations, tests, and/or assessments carried out on the patient;
- any treatment provided; and
- future management of the patient's condition or problem.

Out-of-pocket expenses and Medicare Safety Net

Allied health professionals can determine their own fees for the professional service. Charges in excess of the Medicare benefit are the responsibility of the patient. However, out-of-pocket costs will count toward the Medicare Safety Net for that patient. Allied health services in excess of five in a calendar year will not attract a Medicare benefit and the Safety Net arrangements will not apply to costs incurred by the patient for such services.

Publicly funded services

Items 10950 to 10970 do not apply for services that are provided by any Commonwealth or state funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or state/territory government health clinic, items 10950 to 10970 can be claimed for services provided by eligible allied health professionals salaried by, or contracted to, the service or health clinic. All requirements of the relevant item must be met, including registration of the allied health professional with Medicare Australia. Medicare services provided under a subsection 19(2) exemption must be bulk billed (i.e. the Medicare rebate is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

M.3.4. INDIVIDUAL ALLIED HEALTH SERVICES - (ITEMS 10950 TO 10970) FOR CHRONIC DISEASE MANAGEMENT - PROFESSIONAL ELIGIBILITY

The individual allied health items (10950 to 10970) can only be claimed for services provided by eligible allied health professionals who are registered with Medicare Australia. To be eligible to register with Medicare Australia to provide these services, allied health professionals must meet the specific eligibility requirements detailed below.

Aboriginal health workers practising in the Northern Territory must be registered with the Aboriginal Health Workers Board of the NT. In other states and the Australian Capital Territory they must have been awarded a Certificate Level III in Aboriginal and Torres Strait Islander Health (or an equivalent or higher qualification) by a Registered Training Organisation that meets the training standards set by the Australian National Training Authority's Australian Quality Training Framework.

Audiologists must be either a 'Full Member' of the Audiological Society of Australia Inc (ASA), who holds a 'Certificate of Clinical Practice' issued by the ASA; or an 'Ordinary Member – Audiologist' or 'Fellow Audiologist' of the Australian College of Audiology (ACAud).

Diabetes educators must be a Credentialed Diabetes Educator (CDE) as credentialed by the Australian Diabetes Educators Association (ADEA).

Chiropractors must be registered with the Chiropractic Board of Australia.

Dietitians must be an 'Accredited Practising Dietitian' as recognised by the Dietitians Association of Australia (DAA).

Exercise physiologists must be an 'Accredited Exercise Physiologist' as accredited by Exercise and Sports Science Australia (ESSA).

Mental health workers

'Mental health' can include services provided by members of five different allied health professional groups. 'Mental health workers' are drawn from the following:

- psychologists;
- mental health nurses;
- occupational therapists;
- social workers; and
- Aboriginal health workers.

Psychologists, occupational therapists and Aboriginal health workers are eligible in separate categories for these items.

Mental health nurses must be a credentialed mental health nurse, as certified by the Australian College of Mental Health Nurses.

Mental health nurses who were registered in the ACT or Tasmania prior to the introduction of the National Registration and Accreditation Scheme (NRAS) on 1 July 2010, will have until 31 December 2010 to be certified by the Australian College of Mental Health Nurses.

Social workers must be a 'Member' of the Australian Association of Social Workers (AASW) and be certified by AASW as meeting the standards for mental health set out in the document published by AASW titled 'Practice Standards for Mental Health Social Workers' as in force on 8 November 2008.

Occupational therapists in Queensland, Western Australia, South Australia and the Northern Territory must be registered with the Occupational Therapists Board in the State or Territory in which they are practising; in other States and the Australian Capital Territory, they must be a 'Full-time Member' or 'Part-time Member' of Occupational Therapy Australia, the national body of the Australian Association of Occupational Therapists.

Osteopaths must be registered with the Osteopathy Board of Australia.

Physiotherapists must be registered with the Physiotherapy Board of Australia.

Podiatrists must be registered with the Podiatry Board of Australia.

Psychologists must hold General Registration with the Psychology Board of Australia.

Speech pathologists in Queensland must be registered with the Speech Pathologist Board of Queensland. In all other States, the Australian Capital Territory and the Northern Territory, they must be a 'Practising Member' of Speech Pathology Australia.

A copy of these eligibility requirements may be obtained from Medicare Australia by calling 132 150 or at www.medicareaustralia.gov.au or www.health.gov.au/mbsprimarycareitems.

Registering with Medicare Australia

Provider registration forms may be obtained from Medicare Australia on 132 150 or at www.medicareaustralia.gov.au.

Chiropractors, osteopaths, physiotherapists and podiatrists who were already registered with Medicare Australia on 1 July 2004 to order diagnostic imaging under Medicare, do not need to re-register to provide services under this initiative. Allied health professionals registering with Medicare Australia for the first time only need to fill in one application form which will give them rights to provide services under this initiative and order diagnostic imaging tests etc., where appropriate, under Medicare.

Changes to provider details

Allied health providers must notify Medicare Australia in writing of all changes to mailing details to ensure that they continue to receive information about Medicare rebateable allied health services.

M.3.5. INDIVIDUAL ALLIED HEALTH SERVICES (10950 TO 10970) FOR CHRONIC DISEASE MANAGEMENT - FURTHER INFORMATION

Further information about Medicare Benefits Schedule items is available on the Department of Health and Ageing's website at www.health.gov.au/mbsprimarycareitems

M.6.1. PROVISION OF PSYCHOLOGICAL THERAPY SERVICES BY CLINICAL PSYCHOLOGISTS - (ITEMS 80000 TO 80020)

OVERVIEW

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative commenced on 1 November 2006. Under the Better Access initiative MBS items provide Medicare benefits for the following allied mental health services:

- psychological therapy (items 80000 to 80020) – provided by eligible clinical psychologists; and
- focussed psychological strategies – allied mental health (items 80100 to 80170) – provided by eligible psychologists, occupational therapists and social workers.

M.6.2. PSYCHOLOGICAL THERAPY SERVICES ATTRACTING MEDICARE REBATES

Eligible psychological therapy services

There are five MBS items for the provision of psychological therapy services to eligible patients by a clinical psychologist. Clinical psychologists must meet the provider eligibility requirements set out below and be registered with Medicare Australia.

In these notes, 'GP' means a medical practitioner, including a general practitioner, but not including a specialist or consultant physician.

Referrals and Referral Validity

Services provided under the Psychological Therapy items will not attract a Medicare rebate unless:

- a referral has been made by a GP who is managing the patient under a GP Mental Health Treatment Plan (items 2700, 2701, 2715 or 2717);
- a referral has been made by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or
- a referral has been made by a psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see Referral Requirements for further details regarding psychiatrist and paediatrician referrals).

Number of services per year

Medicare rebates are available for up to ten allied mental health services in a calendar year. The ten services may consist of: GP focussed psychological strategies services (items 2721 to 2727); and/or psychological therapy services (items 80000 to 80015); and/or focussed psychological strategies – allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165).

In addition, the referring practitioner may consider that in exceptional circumstances the patient may require an additional six services above those already provided (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012).

Note: Patients will be able to receive an additional six individual allied mental health services under exceptional circumstances from 1 March 2012 to 31 December 2012. From 1 January 2013 the number of individual allied mental health services for which a person can receive a Medicare rebate will be ten services per calendar year.

Exceptional circumstances are defined as a significant change in the patient's clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services.

It is up to the referring practitioner (e.g GP) to determine that the patient meets these requirements.

In these cases a new referral should be provided, and exceptional circumstances noted in that referral. Invoices for services provided under exceptional circumstances must state that exceptional circumstances apply.

Referrals should be provided, as required, for an initial course of treatment (a maximum of six services but may be less depending on the referral and patient need) to a maximum of ten services per calendar year (up to 16 services from 1

March 2012 to 31 December 2012 where exceptional circumstances apply). For the purposes of these services, a course of treatment will consist of the number of services stated in the patient's referral (up to a maximum of six in any one referral).

Patients will also be eligible to claim up to ten separate services within a calendar year for group therapy services involving 6-10 patients to which items 80020 (psychological therapy – clinical psychologist), 80120 (focussed psychological strategies – psychologist), 80145 (focussed psychological strategies – occupational therapist) and 80170 (focussed psychological strategies - social worker) apply. These group services are separate from the individual services and do not count towards the ten individual services per calendar year maximum associated with those items.

Services provided under the Access to Allied Psychological Services (ATAPS) should not be used in addition to the ten (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply) psychological therapy services (items 80000 to 80020), focussed psychological services-allied mental health services (items 80100 to 80170 or GP focussed psychological strategies services (items 2721 to 2727) available under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative per calendar year. Psychologists delivering services under the ATAPS program should refer to the ATAPS Operational Guidelines.

Service length and type

Services provided by eligible clinical psychologists under these items must be within the specified time period within the item descriptor. The clinical psychologist must personally attend the patient.

It is expected that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

In addition to psycho-education, it is recommended that cognitive-behaviour therapy be provided. However, other evidence-based therapies – such as interpersonal therapy – may be used if considered clinically relevant.

Course of treatment and reporting back to the referring medical practitioner

Patients are eligible to receive up to ten individual services (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply) and up to ten group sessions in a calendar year.

Within this maximum service allocation, the clinical psychologist can provide one or more courses of treatment. For the purposes of these services, a course of treatment consists of the number of services stated in the patient's referral (up to a maximum of six in any one referral). This enables the referring medical practitioner to consider a report from the clinical psychologist on the services provided to the patient, and the need for further treatment.

On completion of the initial course of treatment, the clinical psychologist must provide a written report to the referring medical practitioner, which includes information on:

- assessments carried out on the patient;
- treatment provided; and
- recommendations on future management of the patient's disorder.

A written report must also be provided to the referring medical practitioner at the completion of any subsequent course(s) of treatment provided to the patient.

Out of pocket expenses and Medicare safety net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Psychological therapy services and/or focussed psychological strategies – allied mental health services in excess of ten individual services (apart from 1 March 2012 to 31 December 2012 where exceptional circumstances apply) and ten group sessions in a calendar year will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Eligible patients

Items 80000 to 80020 (inclusive) apply to people with an assessed mental disorder and where the patient is referred by a GP who is managing the patient under a GP Mental Health Treatment Plan (item 2700, 2701, 2715 or 2717), or under a referred psychiatrist assessment and management plan (item 291); or on referral from an eligible psychiatrist or paediatrician.

The conditions classified as mental disorders for the purposes of these services are informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version. For the purposes of these items, dementia, delirium, tobacco use disorder and mental retardation are not regarded as a mental disorder.

Checking patient eligibility for psychological therapy services

Patients seeking Medicare rebates for psychological therapy services will need to have a referral from a GP, psychiatrist or paediatrician. If there is any doubt about a patient's eligibility, Medicare Australia will be able to confirm whether a GP Mental Health Treatment Plan; and/or a psychiatrist assessment and management plan is in place and claimed; or an eligible psychiatric or paediatric service has been claimed, as well as the number of allied mental health services already claimed by the patient during the calendar year.

Clinical psychologists can call Medicare Australia on 132 150 to check this information, while unsure patients can seek clarification by calling 132 011.

The patient will not be eligible if they have not been appropriately referred and a relevant Medicare service provided to them. If the referring service has not yet been claimed, Medicare Australia will not be aware of the patient's eligibility. In this case the clinical psychologist should, with the patient's permission, contact the referring practitioner to ensure the relevant service has been provided to the patient.

Publicly funded services

Psychological therapy items 80000 to 80020 do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory clinic, the items apply for services that are provided by eligible clinical psychologists salaried by, or contracted to, the service as long as all requirements of the items are met, including registration with Medicare Australia. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

M.6.3. REFERRAL REQUIREMENTS (GPs, PSYCHIATRISTS OR PAEDIATRICIANS TO CLINICAL PSYCHOLOGISTS FOR PSYCHOLOGICAL THERAPY)

Referrals

Patients must be referred for psychological therapy services by a GP managing the patient under a GP Mental Health Treatment Plan (item 2700, 2701, 2715 or 2717), or a referred psychiatrist assessment and management plan (item 291); or on referral from a psychiatrist or a paediatrician.

Referrals from psychiatrists and paediatricians must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 through 370; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 133.

Referring practitioners are **not** required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible clinical psychologist signed and dated by the referring practitioner.

The clinical psychologist must be in receipt of the referral at the first allied mental health consultation. It is recommended that the clinical psychologist retain the referral for 24 months from the date the service was rendered (for Medicare Australia auditing purposes).

Referral validity

Medicare benefits are available for up to ten individual (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply) and/or ten group psychological therapy services and/or focussed psychological strategies services per patient per calendar year.

Referrals should be provided, as required, for an initial course of treatment (a maximum of six services but may be less depending on the referral and the patient's clinical need) to a maximum of ten services per calendar year (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply). For the purposes of these services, a course of treatment will consist of the number of services stated in the patient's referral (up to a maximum of six in any one referral).

If a patient has not used all of their psychological therapy services and/or focussed psychological strategies services under a referral in a calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total of ten services for which the patient is eligible in that calendar year.

When patients have used all of their referred services they will need to obtain a new referral from the referring practitioner if they are eligible for further services. Where the patient's care is being managed by a GP, the GP may choose to use this

visit to undertake a review of the patient's GP Mental Health Treatment Plan and/or psychiatrist assessment and management plan.

It is not necessary to have a new GP Mental Health Treatment Plan and/or psychiatrist assessment and management plan prepared each calendar year in order to access a new referral(s) for eligible psychological therapy services and/or focussed psychological strategies services. Patients continue to be eligible for rebates for psychological therapy services and/or focussed psychological strategies services while they are being managed under a GP Mental Health Treatment Plan and/or a psychiatrist assessment and management plan as long as the need for eligible services continues to be recommended in their plan.

M.6.4. CLINICAL PSYCHOLOGIST PROFESSIONAL ELIGIBILITY

Eligible clinical psychologists

All consultations providing psychological therapy services must be rendered by a clinical psychologist who is a member of the Australian Psychological Society's College of Clinical Psychologists or meets the requirements for such membership, based on assessment by the Australian Psychological Society or who is endorsed by the Psychology Board of Australia to practice in clinical psychology; and who is registered with Medicare Australia.

Registering with Medicare Australia

Advice about registering with Medicare Australia to provide psychological therapy services using items 80000-80020 inclusive is available from the Medicare Australia provider inquiry line on 132 150.

Further information

For further information about Medicare Benefits Schedule items, please go to the Department of Health and Ageing's website at www.health.gov.au/mbsonline.

For providers, further information is also available for providers from the Medicare Australia provider inquiry line on 132 150

M.7.1. PROVISION OF FOCUSED PSYCHOLOGICAL STRATEGIES SERVICES BY ALLIED HEALTH PROVIDERS - (ITEMS 80100 TO 80170)

OVERVIEW

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative commenced on 1 November 2006. Under the Better Access initiative MBS items provide Medicare benefits for the following allied mental health services:

- psychological therapy (items 80000 to 80020) – provided by eligible clinical psychologists; and
- focussed psychological strategies – allied mental health (items 80100 to 80170) – provided by eligible psychologists, occupational therapists and social workers.

FOCUSED PSYCHOLOGICAL STRATEGIES – ALLIED MENTAL HEALTH SERVICES ATTRACTING MEDICARE REBATES

Eligible focussed psychological strategies services

There are fifteen MBS items for the provision of focussed psychological strategies (FPS) – allied mental health services to eligible patients by allied health professionals:

- 80100, 80105, 80110, 80115 and 80120 for provision of FPS services by a psychologist;
- 80125, 80130, 80135, 80140 and 80145 for provision of FPS services by an occupational therapist; and
- 80150, 80155, 80160, 80165 and 80170 for provision of FPS services by a social worker.

The allied health professional must meet the provider eligibility requirements set out below and be registered with Medicare Australia.

In these notes, 'GP' means a medical practitioner, including a general practitioner, but not including a specialist or consultant physician.

Services provided under the focussed psychological strategies – allied mental health items will not attract a Medicare rebate unless:

- A referral has been made by a GP who is managing the patient under a GP Mental Health Treatment Plan (item 2700, 2701, 2715 or 2717);
- A referral has been made by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or
- A referral has been made by a psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see Referral Requirements for further details regarding psychiatrist and paediatrician referrals).

Number of services per year

Medicare rebates for up to ten individual allied mental health services in a calendar year. These ten services may consist of: GP focussed psychological strategies services (items 2721 to 2727); and/or psychological therapy services (items 80000 to 80015); and/or focussed psychological strategies – allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165).

In addition, the referring practitioner may consider that in exceptional circumstances the patient may require an additional six services above those already provided (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012).

Note: Patients will be able to receive an additional six individual allied mental health services under exceptional circumstances from 1 March 2012 to 31 December 2012. From 1 January 2013 the number of individual allied mental health services for which a person can receive a Medicare rebate will be ten services per calendar year.

Exceptional circumstances are defined as a significant change in the patient's clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services.

It is up to the referring practitioner to determine that the patient meets these requirements. In these cases a new referral should be provided, and exceptional circumstances noted in that referral. Invoices for services provided under exceptional circumstances must state that exceptional circumstances apply.

Referrals should be provided, as required, for an initial course of treatment (a maximum of six services but may be less depending on the referral and patient need) to a maximum of ten services per calendar year (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply). For the purposes of these services, a course of treatment will consist of the number of services stated in the patient's referral (up to a maximum of six in any one referral).

Patients will also be eligible to claim up to ten separate services within a calendar year for group therapy services involving 6-10 patients to which items 80020 (psychological therapy – clinical psychologist), 80120 (focussed psychological strategies – psychologist), 80145 (focussed psychological strategies – occupational therapist) and 80170 (focussed psychological strategies - social worker) apply. These group services are separate from the individual services and do not count towards the ten individual service calendar year maximum associated with those items.

After an initial group of up to six services, the allied mental health professional must provide a report to the referring practitioner. Following receipt of this report, the referring practitioner will consider the need for further treatment, before further allied mental health services may be provided.

Services provided under the Access to Allied Psychological Services (ATAPS) should not be used in addition to the ten (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply) psychological therapy services (items 80000 to 80020), focussed psychological services-allied mental health services (items 80100 to 80170) or GP focussed psychological strategies services (items 2721 to 2727) available under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative per calendar year. Allied mental health professionals delivering services under the ATAPS program should refer to the ATAPS Operational Guidelines.

Service length and type

Services provided by eligible allied health professionals under these items must be within the specified time period within the item descriptor. The allied mental health professional must personally attend the patient.

It is expected that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

A range of acceptable strategies has been approved for use by allied mental health professionals utilising the FPS items.

These are:

- 1. Psycho-education**
(including motivational interviewing)

2. Cognitive-behavioural Therapy including:

- **Behavioural interventions**
 - Behaviour modification
 - Exposure techniques
 - Activity scheduling
- **Cognitive interventions**
 - Cognitive therapy

3. Relaxation strategies

- Progressive muscle relaxation
- Controlled breathing

4. Skills training

- Problem solving skills and training
- Anger management
- Social skills training
- Communication training
- Stress management
- Parent management training

5. Interpersonal Therapy (especially for depression)

6. Narrative therapy (for Aboriginal and Torres Strait Islander people).

Course of treatment and reporting back to the referring medical practitioner

Patients are eligible to receive up to ten individual services (up to 16 services from 1 March 2012 to 31 December 2012 when exceptional circumstances apply) and up to ten group sessions in a calendar year.

Within this maximum service allocation the allied mental health professional can provide one or more courses of treatment. For the purposes of these services, a course of treatment consist of the number of services stated in the patient's referral (up to a maximum of six services in any one referral). This enables the referring medical practitioner to consider a report from the allied mental health professional on the services provided to the patient, and the need for further treatment.

On completion of the initial course of treatment, the allied mental health professional must provide a written report to the referring medical practitioner, which includes information on:

- assessments carried out on the patient;
- treatment provided; and
- recommendations on future management of the patient's disorder.

A written report must also be provided to the referring medical practitioner at the completion of any subsequent course(s) of treatment provided to the patient.

Out of pocket expenses and Medicare safety net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Psychological therapy services and/or focussed psychological strategies services in excess of the maximum annual allowance of ten individual (apart from 1 March 2012 to 31 December 2012 where exceptional circumstances apply) and ten group sessions in a calendar year will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Eligible patients

Items 80100 to 80170 (inclusive) apply to people with an assessed mental disorder and where the patient is referred by a GP who is managing the patient under a GP Mental Health Treatment Plan (item 2700, 2701, 2715 or 2717), referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or from an eligible psychiatrist or paediatrician.

The conditions classified as mental disorders for the purposes of these services are informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version. For the purposes of these items, dementia, delirium, tobacco use disorder and mental retardation are not regarded as a mental disorder.

Checking patient eligibility for focussed psychological strategies – allied mental health services

Patients seeking Medicare rebates for focussed psychological strategies – allied mental health services will need to have a referral from a GP, psychiatrist or paediatrician. If there is any doubt about a patient's eligibility, Medicare Australia will be able to confirm whether a GP Mental Health Treatment Plan; and/or a psychiatrist assessment and management plan is in place and claimed; or an eligible psychiatric or paediatric service has been claimed, as well as the number of allied health services already claimed by the patient during the calendar year.

Allied Mental Health Professionals can call Medicare Australia on 132 150 to check this information, while unsure patients can seek clarification by calling 132 011.

The patient will not be eligible if they have not been appropriately referred and a relevant Medicare service provided to them. If the referring service has not yet been claimed, Medicare Australia will not be aware of the patient's eligibility. In this case the clinical psychologist should, with the patient's permission, contact the referring practitioner to ensure the relevant service has been provided to the patient.

Publicly funded services

Focussed psychological strategies (FPS) services items 80100 to 80170 do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory clinic, the FPS services items apply for services that are provided by eligible allied mental health professionals salaried by, or contracted to, the service as long as all requirements of the items are met, including registration with Medicare Australia. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

REFERRAL REQUIREMENTS (GPs, PSYCHIATRISTS OR PAEDIATRICIANS TO ALLIED MENTAL HEALTH PROFESSIONALS)

Referrals

Patients must be referred for focussed psychological strategies – allied mental health services by either a GP managing the patient under a GP Mental Health Treatment Plan (item 2700, 2701, 2715 or 2717), or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or on referral from a psychiatrist or a paediatrician.

Referrals from psychiatrists and paediatricians must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 through 370; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 133.

Referring practitioners are **not** required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible allied mental health professional signed and dated by the referring practitioner.

The allied mental health professional must be in receipt of the referral at the first allied mental health consultation. It is recommended that the allied health professional retain the referral for 24 months from the date the service was rendered (for Medicare Australia auditing purposes).

Referral validity

Medicare benefits are available for up to ten individual (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply) and ten group psychological therapy services and/or focussed psychological strategies services per patient per calendar year.

Referrals should be provided, as required, for an initial course of treatment (a maximum of six services but may be less depending on the referral and patient's clinical need) to a maximum of ten services per calendar year (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply). For the purposes of these services, a course of treatment will consist of the number of services stated in the patient's referral (up to a maximum of six in any one referral).

If a patient has not used all of their psychological therapy services and/or focussed psychological strategies services under a referral in a calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total of ten services for which the patient is eligible in that calendar year.

When patients have used all of their referred services they will need to obtain a new referral from the referring practitioner if they are eligible for further services. Where the patient's care is being managed by a GP, the GP may choose to use this visit to undertake a review of the patient's GP Mental Health Treatment Plan and/or psychiatrist assessment and management plan.

It is not necessary to have a new GP Mental Health Treatment Plan and/or psychiatrist assessment and management plan prepared each calendar year in order to access a new referral(s) for eligible psychological therapy services and/or focussed psychological strategies services. Patients continue to be eligible for rebates for psychological therapy services and/or focussed psychological strategies services while they are being managed under a GP Mental Health Treatment Plan and/or a psychiatrist assessment and management plan as long as the need for eligible services continues to be recommended in their plan.

ALLIED MENTAL HEALTH PROFESSIONAL ELIGIBILITY

Eligible allied health professionals

A person is an allied health professional in relation to the provision of a FPS service if the person meets one of the following requirements:

- (a) the person is a psychologist who is registered without limitation as a person who may provide that kind of service under the applicable law in force in the State or Territory in which the service is provided;
- (b) the person is a member of the Australian Association of Social Workers (AASW) and certified by AASW as the meeting the standards for mental health set out in the document published by AASW titled 'Practice Standards for Mental Health Social Workers', as in force on 8 November 2008;
- (c) the person:
 - (i) is a full-time member, or a part-time member, of Occupational Therapy Australia; and
 - (ii) is, for a person who provides a focussed psychological strategies health service in Queensland, Western Australia, South Australia or the Northern Territory, registered as a person who may provide that kind of service under the applicable law in force in the State or Territory in which the service is provided; and
 - (iii) has a minimum of 2 years experience in mental health; and
 - (iv) has given an undertaking to Occupational Therapy Australia to observe the standards set out in the document published by Occupational Therapy Australia titled 'Australian Competency Standards for Occupational Therapists in Mental Health', as in force on 1 November 2006.

Continuing professional development (CPD) for allied mental health professionals providing focussed psychological strategies (FPS) services

From 1 July 2011, allied mental health professionals providing FPS services are required to have completed 10 hours FPS CPD since 1 July 2009 and then annually. From 1 July 2011, allied mental health professionals who have not completed the 10 hours of FPS CPD will no longer be eligible to provide FPS Medicare Services.

Part-time allied mental health professionals are required to have 10 hours of FPS related CPD, the same as full-time allied mental health professionals.

For allied mental health professionals who are registered during the course of the CPD year, their obligation to undertake CPD will be on a pro-rata basis. The amount of units will be calculated from the 1st of the month immediately succeeding the month they obtained initial registration. The obligation will be one-twelfth of the yearly requirement for each month.

CPD activities must be relevant to delivering FPS services. Acceptable CPD activities where the content is related to FPS can include formal postgraduate education, workshops, seminars, lectures, journal reading, writing papers, receipt of supervision and peer consultation, and online training.

There is flexibility in the CPD activities that can be undertaken to meet individual professional needs and their practice/client base and client needs. For example, activities could also include assessment and treatment of specific disorders and client types such as youth, or different modalities and delivery such as working with groups.

Registering with Medicare Australia

Advice about registering with Medicare Australia to provide focussed psychological strategies – allied mental health services using items 80100-80170 inclusive is available from the Medicare Australia provider inquiry line on 132 150.

Further information

For further information about Medicare Benefits Schedule items, please go to the Department of Health and Ageing's website at www.health.gov.au/mbsonline

For providers, further information is also available for providers from the Medicare Australia provider inquiry line on 132 150.

M.8.1. PREGNANCY SUPPORT COUNSELLING - ELIGIBLE PATIENTS - (ITEMS 81000 TO 81010)

Medicare benefits are available for non-directive pregnancy support counselling services provided to women who are concerned about a current pregnancy, or a pregnancy that occurred in the preceding 12 months. Services can be provided either by an eligible GP or by an eligible psychologist, social worker or mental health nurse on referral from a GP.

The term 'GP' is used hereafter as a generic reference to medical practitioners (including a general practitioner, but not including a specialist or consultant physician).

The items may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

M.8.2. PREGNANCY SUPPORT COUNSELLING - ELIGIBLE SERVICES - (ITEMS 81000 TO 81010)

There are four MBS items for the provision of non-directive pregnancy support counselling services:

- Item 4001 – services provided by an eligible GP;
- Item 81000 – services provided by an eligible psychologist;
- Item 81005 – services provided by an eligible social worker; and
- Item 81010 – services provided by an eligible mental health nurse.

These notes relate to items 81000-81010. Each individual allied health professional must meet the provider eligibility requirements set out below and be registered with Medicare Australia.

Service length and type

Non-directive pregnancy support counselling services provided by eligible psychologists, social workers and mental health nurses using items 81000-81010 inclusive must be of at least 30 minutes duration and provided to an individual patient. The allied health professional must personally attend the patient.

The service involves the psychologist, social worker or mental health nurse undertaking a safe, confidential process that helps the patient explore concerns they have about a current pregnancy or a pregnancy that occurred in the preceding 12 months. This includes providing, on request, unbiased, evidence-based information about all options and services available to the patient.

Non-directive counselling is a form of counselling that is based on the understanding that, in many situations, people can resolve their own problems without being provided with a solution by the counsellor. The counsellor's role is to encourage the person to express their feelings but not suggest what decision the person should make. By listening and reflecting back what the person reveals to them, the counsellor helps them to explore and understand their feelings. With this understanding, the person is able to make the decision that is best for them.

Number of services per year

Medicare benefits are available for up to three (3) eligible non-directive pregnancy support counselling services per patient, per pregnancy, provided using items 81000, 81005, 81010 and 4001.

Partners of eligible patients may attend each or any counselling session, however, only one fee applies to each service.

Out-of-pocket expenses and Medicare Safety Net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Non-directive pregnancy support counselling services in excess of three (3) per pregnancy will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Publicly funded services

Items 81000, 81005 and 81010 do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital.

However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory clinic, items 81000, 81005 and 81010 can be claimed for services provided by an eligible psychologist, social worker or mental health nurse salaried by or contracted to the service, where all requirements of the relevant item are met, including registration with Medicare Australia. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

M.8.3. PREGNANCY SUPPORT COUNSELLING - REFERRAL REQUIREMENTS - (ITEMS 81000 TO 81010)

Patients must be referred for non-directive pregnancy support counselling services by a GP. GPs are **not** required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible allied health professional signed and dated by the referring GP.

Patients may be referred by a GP to more than one eligible allied health professional for eligible non-directive pregnancy support counselling services (for example, where a patient does not wish to continue receiving services from the provider they were referred to in the first instance). However, Medicare benefits are only available for a maximum of three (3) non-directive pregnancy support counselling services to which items 4001, 81000, 81005 and 81010 apply, per patient, per pregnancy.

Where the patient is unsure of the number of Medicare rebated non-directive pregnancy support counselling services they have already accessed, the patient may check with Medicare Australia on 132 011. Alternatively, the psychologist, social worker or mental health nurse may check with Medicare Australia.

The relevant allied health professional must be in receipt of the referral at the first non-directive pregnancy support counselling service and must retain the referral for 2 years from the date the service was rendered, for Medicare Australia auditing purposes.

A copy of the referral is **not** required to accompany Medicare claims. However, referral details are required to be included on patients' itemised accounts/receipts or Medicare assignment of benefit forms.

Referral validity

The referral is valid for up to three (3) non-directive pregnancy support counselling services, per patient, per pregnancy.

Subsequent Referrals

A new referral is required where the patient seeks to access non-directive pregnancy support counselling in relation to a different pregnancy or where the patient wishes to be referred to a different allied health professional than the one they were referred to in the first instance.

M.8.4. PREGNANCY SUPPORT COUNSELLING - ALLIED HEALTH PROFESSIONAL ELIGIBILITY -(ITEMS 81000 TO 81010)

Eligible allied health professionals

Items 81000, 81005 and 81010 can only be claimed for services provided by psychologists, social workers and mental health nurses who meet the following specific eligibility requirements, and are registered with Medicare Australia.

To be eligible to provide services using MBS Item 81000, a psychologist must be registered with the Psychologists Registration Board in the State or Territory in which they are practising (psychologists whose State/Territory registration includes any limitation, for example, where marked 'provisional registration', are not eligible to register with Medicare Australia to use item 81000), and have completed appropriate non-directive pregnancy counselling training;

To be eligible to provide services using MBS Item 81005, a social worker must be a 'Member' of the Australian Association of Social Workers (AASW), be certified by AASW either as meeting the standards for mental health set out in the document published by AASW titled 'Practice Standards for Mental Health Social Workers' as in force on 8 November 2008 or as an Accredited Social Worker, and have completed appropriate non-directive pregnancy counselling training;

To be eligible to provide services using MBS Item 81010, a mental health nurse must be a 'Credentialled Mental Health Nurse' as certified by the Australian College of Mental Health Nurses, and have completed appropriate non-directive pregnancy counselling training.

REGISTERING WITH MEDICARE AUSTRALIA

Advice about registering with Medicare Australia to provide non-directive pregnancy support counselling services using items 81000-81010 inclusive is available from the Medicare Australia provider inquiry line on 132 150.

Further information

A copy of the Medicare Allied Health Supplement can be accessed from www.health.gov.au/mbsonline. The Supplement includes more information about Medicare, including how to make a claim from Medicare.

Further information is also available for providers from the Medicare Australia provider inquiry line on 132 150.

M.9.1. GROUP ALLIED HEALTH SERVICES (ITEMS 81100 TO 81125) FOR PEOPLE WITH TYPE 2 DIABETES - ELIGIBLE PATIENTS -

MBS items (81100 to 81125) are available for group allied health services for patients with type 2 diabetes. These items apply to services provided by eligible diabetes educators, exercise physiologists and dietitians, on referral from a GP.

Services available under these items are in addition to the five individual allied health services available to patients each calendar year (refer to items 10950 to 10970).

To be eligible for these services, the patient must have in place one of the following:

- a GP Management Plan (GPMP) (item 721); or
- where a patient has an existing GP Management Plan, the GP has reviewed that plan (item 732); or
- for a resident of a residential aged care facility, the GP must have contributed to, or contributed to a review of, a care plan prepared for them by the facility (item 731). [Note: Generally, residents of an aged care facility rely on the facility for assistance to manage their type 2 diabetes. Therefore, the resident may not need to be referred for group allied health services under these items, as the self management approach offered in group services may not be appropriate.]

Unlike the individual allied health services under items 10950 to 10970, there is no additional requirement for a Team Care Arrangement (item 723) in order for the patient to be referred for group allied health services.

Once the patient has been referred by their GP, a diabetes educator, exercise physiologist or dietitian will conduct an individual assessment (under items 81100, 81110 or 81120). A maximum of one (1) assessment service is available per calendar year. After assessment, the patient may receive up to eight (8) group services per calendar year from an eligible diabetes educator, exercise physiologist and/or dietitian (under items 81105, 81115 and 81125). A collaborative approach, where diabetes educators, exercise physiologists and dietitians work together to develop group service programs in their local area, is encouraged.

M.9.2. GROUP ALLIED HEALTH SERVICES (ITEMS 81100 TO 81125) FOR PEOPLE WITH TYPE 2 DIABETES - GP REFERRAL REQUIREMENTS

Patients must be referred by their GP to an eligible allied health professional (diabetes educator, exercise physiologist or dietitian) who will undertake an individual assessment of their suitability for a group services program (under item 81100, 81110 or 81120).

When referring patients, **GPs** must use a referral form that has been issued by the Australian Government Department of Health and Ageing or a form that contains all the components of this form. The form issued by the department is available at <http://www.health.gov.au/mbsprimarycareitems> (click on the link for group allied health services).

GPs are also encouraged to provide a copy of the relevant part of the patient's care plan to the allied health professional.

M.9.3. GROUP ALLIED HEALTH SERVICES (ITEMS 81100 TO 81125) FOR PEOPLE WITH TYPE 2 DIABETES - ELIGIBLE ALLIED HEALTH PROFESSIONALS

Items 81100 to 81125 only apply to services provided by eligible diabetes educators, exercise physiologists and dietitians who are registered with Medicare Australia. If providers are already registered with Medicare Australia to use item 10951, 10953 or 10954, they do not need to register separately for items 81100 to 81125. Eligibility criteria are as follows:

Diabetes educator: must be a 'credentialed diabetes educator' (CDE) as credentialed by the Australian Diabetes Educators Association (ADEA).

Exercise physiologist: must be an 'accredited exercise physiologist' as accredited by Exercise and Sports Science Australia (ESSA).

Dietitian: must be an 'accredited practising dietitian' as recognised by the Dietitians Association of Australia (DAA).

Medicare Australia registration forms may be obtained from Medicare Australia on 132 150 or at www.medicareaustralia.gov.au.

M.9.4. ASSESSMENT FOR GROUP ALLIED HEALTH SERVICES (ITEMS 81100, 81110 AND 81120) FOR PEOPLE WITH TYPE 2 DIABETES

An assessment service is provided by a diabetes educator (item 81100), an exercise physiologist (item 81110) or a dietitian (item 81120), on referral from a GP.

The purpose of this service is to undertake an individual assessment and determine the patient's suitability for a group services program. It involves taking a comprehensive patient history and identification of individual goals. This may also provide an opportunity to identify any patient who is likely to be unsuitable for group services.

Number of services per year

Patients are eligible for a maximum of one assessment for group services (item 81100 **or** 81110 **or** 81120) per calendar year. If more than one assessment service is provided in a calendar year, the subsequent service/s will not attract a Medicare rebate and the MBS Safety Net arrangements will not apply to costs incurred by the patient for the service/s.

If there is any doubt about a patient's eligibility for items 81100, 81110 or 81120, the allied health professional should contact Medicare Australia to confirm the number of assessment services already claimed by the patient in the calendar year. Allied health professionals can call Medicare Australia on 132 150 to check this information.

Referral form

The GP must refer the patient using the *Referral form for group allied health services under Medicare for patients with type 2 diabetes* or a form that contains all the components of this form. The form issued by the department is available at <http://www.health.gov.au/mbsprimarycareitems> (click on the link for group allied health services).

The allied health professional undertaking the assessment service will need to complete Part B of this form, and the patient will then need to present this form to the provider/s of group services.

Length of service

This service must be of at least 45 minutes duration and provided to an individual patient. The allied health professional must personally attend the patient.

Reporting requirements

On completion of the assessment service, the allied health professional must provide a written report back to the referring GP outlining the assessment undertaken, whether the patient is suitable for group services and, if so, the nature of the group services to be delivered.

M.9.5. GROUP ALLIED HEALTH SERVICES (ITEMS 81105, 81115 AND 81125) FOR PEOPLE WITH TYPE 2 DIABETES - SERVICE REQUIREMENTS AND REFERRAL FORMS

These services are provided in a group setting to assist with the management of type 2 diabetes.

Number of services per year

Patients are eligible for up to eight group allied health services in total (items 81105, 81115 and 81125 inclusive) per calendar year. Each separate group service must be provided to the patient by only one type of allied health professional (i.e. by a diabetes educator, or by an exercise physiologist or by a dietitian). However, the overall group services program provided for the patient could be comprised of one type of service only (e.g. eight diabetes education services) or a combination of services (e.g. three diabetes education services, three dietitian services and two exercise physiology services). An eligible allied health professional with more than one Medicare provider number (e.g. for the provision of diabetes education and dietetics) may provide separate services under each of these provider numbers.

Group allied health service providers are strongly encouraged to deliver multidisciplinary group services programs that allow patients to benefit from a range of interventions designed to assist in the management of their type 2 diabetes.

Where a patient receives more than the limit of eight group services in a calendar year, the additional service/s will not attract a Medicare benefit and the MBS Safety Net arrangements will not apply to costs incurred by the patient for the service/s.

If there is any doubt about a patient's eligibility for group services, the allied health professional should contact Medicare Australia to confirm the number of group services already claimed by the patient in the calendar year. Allied health professionals can call Medicare Australia on 132 150 to check this information.

Multiple services on the same day

Where clinically relevant, up to two group services may be provided consecutively on the same day by the same allied health professional.

Referral form

The allied health professional/s undertaking the group services will need to receive the *Referral form for group allied health services under Medicare for patients with type 2 diabetes* issued by the Department of Health and Ageing or a form that contains all the components of this form, with Part B completed by the provider who has undertaken the assessment service. The form issued by the department is available at <http://www.health.gov.au/mbsprimarycareitems> (click on the link for group allied health services).

Group size

The service must be provided to a person who is part of a group of between two and 12 persons.

Length of service

Each group service must be of at least 60 minutes duration.

Reporting requirements

On completion of the group services program, each allied health professional must provide, or contribute to, a written report back to the referring GP in respect of each patient. The report should describe the group services provided for the patient and indicate the outcomes achieved. While each allied health professional is required to provide feedback to the GP in relation to the group services that they provide to the patient, allied health professionals involved in the provision of a multidisciplinary program are encouraged to combine feedback into a single report to the referring GP.

M.9.6. GROUP ALLIED HEALTH SERVICES (ITEMS 81100 TO 81125) FOR PEOPLE WITH TYPE 2 DIABETES - ADDITIONAL REQUIREMENTS**RETENTION OF REFERRAL FORM FOR MEDICARE AUSTRALIA AUDIT PURPOSES**

It is recommended that Allied health professionals retain a copy of the referral form for 24 months from the date the service was rendered (for Medicare Australia auditing purposes).

Publicly funded services

Items 81100 – 81125 do not apply for services that are provided by any other Commonwealth or state-funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or a state/territory government health clinic, items 81100-81125 can be claimed for services provided by eligible allied health professionals salaried by, or contracted to, service or health clinic. All requirements of the relevant item must be met, including registration of the allied health professional with Medicare Australia. These services must also be bulk billed.

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to ‘top up’ the Medicare rebate paid.

Out-of-pocket expenses and Medicare Safety Net

Allied health professionals are free to determine their own fees for the professional service. Charges in excess of the Medicare benefit for the allied health items are the responsibility of the patient. However, such out of pocket costs will count toward the Medicare Safety Net for that patient.

M.9.7. GROUP ALLIED HEALTH SERVICES (ITEMS 81100 TO 81125) FOR PEOPLE WITH TYPE 2 DIABETES - FURTHER INFORMATION

Further information about these items is available on the Department of Health and Ageing’s website at www.health.gov.au/mbsprimarycareitems

M.10.1. PROVISION OF AUTISM, PERSISTENT DEVELOPMENTAL DISORDER OR DISABILITY SERVICES BY ALLIED HEALTH PROFESSIONALS - (ITEMS 82000 TO 82035)**OVERVIEW**

MBS items (82000 to 82035) are available for allied health professional services for children (aged under 13 years for diagnosis and under 15 years for treatment) with autism, pervasive developmental disorder (PDD) or an eligible disability. These items apply to services provided by eligible audiologists, occupational therapists, optometrists, orthoptists, physiotherapists, psychologists and speech therapists, on referral from a consultant psychiatrist or paediatrician for autism or PDD and on referral from a specialist, consultant physician or general practitioner for an eligible disability. These items cover two specific types of service that allow the relevant allied health professionals to:

- assist the referring practitioner in the diagnosis of the child — aged under 13 years — and/or development of the child’s PDD or disability treatment plan (items 82000, 82005, 82010 and 82030); and

- provide treatment to the child — aged under 15 years (and who was aged under 13 years at the time of receiving their PDD or disability treatment plan) for their particular condition, consistent with the treatment plan prepared by the referring practitioner (items 82015, 82020, 82025 and 82035).

ASSESSMENT SERVICES ATTRACTING MEDICARE REBATES

Eligible allied health assessment services

There are four MBS items for eligible audiologists, occupational therapists, optometrists, orthoptists, physiotherapists, psychologists and speech therapists to assist a referring practitioner in the diagnosis of a child (aged under 13 years) and/or preparation of a PDD or disability treatment plan for that child. Allied health professionals wanting to provide these items must meet the provider eligibility requirements set out below (see ‘Eligible allied health professionals’ section) and be registered with Medicare Australia.

Services provided for assisting in the diagnosis of a child and/or preparation of a PDD or disability treatment plan for the child will not attract a Medicare rebate unless:

- for a child with PDD - a referral has been made by a consultant psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see ‘REFERRAL REQUIREMENTS’ section) who, as part of the referral, requests the allied health professional’s assistance in assessing the patient and/or preparing a treatment plan for the patient.
- for a child with disability - a referral has been made by a specialist, consultant physician or general practitioner using items 137 or 139 who, as part of the referral, requests the allied health professional’s assistance in assessing the patient and/or preparing a treatment plan for the patient.

Number of services

Medicare rebates are available for up to four (4) allied health assessment services in total per eligible child. The four services may consist of any combination of items 82000, 82005, 82010 and 82030. It is the responsibility of the referring practitioner to allocate these services in keeping with the child’s individual needs and to refer the child to appropriate allied health professional(s) accordingly.

TREATMENT SERVICES ATTRACTING MEDICARE REBATES

Eligible allied health treatment services

There are four MBS items for eligible audiologists, occupational therapists, optometrists, orthoptists, physiotherapists, psychologists and speech therapists to provide treatment services to eligible children — aged under 15 years (and who were aged under 13 years at the time of receiving a PDD or disability treatment plan) - with a PDD or disability. Allied health professionals wanting to provide these items must meet the provider eligibility requirements set out below (see ‘Eligible allied health professionals’ section) and be registered with Medicare Australia.

Services provided for the treatment of children with a PDD or disability will not attract a Medicare rebate unless:

- for a child with PDD - a referral has been made by a consultant psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see ‘REFERRAL REQUIREMENTS’ section) who is managing the child under a PDD treatment plan (item 135 or 289);
- for a child with disability - a referral has been made by a specialist, consultant physician or general practitioner who is managing the child under a disability treatment plan (item 137 or 139).

Number of services

Medicare rebates are available for up to twenty (20) allied health treatment services in total per eligible child. The twenty services may consist of any combination of items 82015, 82020, 82025 and 82035. It is the responsibility of the referring practitioner to allocate these services in keeping with the child’s individual treatment needs and to refer the child to appropriate allied health professional(s) accordingly.

CONDITIONS GOVERNING THE PROVISION AND CLAIMING OF ITEMS

Please note that these conditions apply to both the assessment (items 82000-82010 and 82030) and treatment (items 82015-82025 and 82035) services.

Service length and type

Services under these items must be for the time period specified within the item descriptor. The allied health professional must personally attend the child.

It is anticipated that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

It is also expected that participating allied health providers will deliver treatment under these items that is consistent with the PDD or disability treatment plan prepared by the medical practitioner, and in keeping with commonly established PDD

or disability interventions as practised by their profession and appropriate for the age and particular needs of the child being treated.

Course of treatment and reporting back to the referring practitioner

Children are eligible to receive up to a total of four (4) PDD or disability assessment services and twenty (20) PDD or disability treatment services with an eligible allied health professional(s).

A written report must be provided to the referring medical practitioner by the allied health professional(s) after having provided the PDD or disability assessment service(s) to the child.

Within the maximum service allocation of twenty services for the PDD or disability treatment items, the allied health professional(s) can provide one or more courses of treatment. For the purposes of these services, a course of treatment will consist of the number of services stated on the child's referral (up to a maximum of 10). This enables the referring practitioner to consider a report from the allied health professional(s) about the services provided to the child, and the need for further treatment.

On completion of the course of treatment, the eligible audiologists, occupational therapists, optometrists, orthoptists, physiotherapists, psychologists and speech therapists must provide a written report to the referring medical practitioner which includes information on:

- treatment provided;
- recommendations on future management of the child's disorder;
- any advice provided to third parties (eg. parents, schools).

A written report must also be provided to the referring medical practitioner at the completion of any subsequent course(s) of treatment provided to the child.

Out-of-pocket expenses and Medicare safety net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. Such out-of-pocket costs will count toward the Medicare safety net for that patient. Any allied health PDD or disability assessment services that are in excess of the maximum of four (4) and any allied health PDD or disability treatment services that are in excess of the maximum of twenty (20) allowable per child will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the child for such services.

Eligible patients

These MBS services apply to children — aged under 13 years — where the child is referred by an eligible medical practitioner, for assessment items 82000-82010 and 82030 inclusive. The MBS treatment services apply to children — aged under 15 years (where the child was aged under 13 years at the time of receiving a PDD or disability treatment plan) — for treatment items 82015-82025 and 82035 inclusive.

The conditions classified as PDD for the purposes of these services are informed by the American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR)*, Washington, DC, American Psychiatric Association, 2000.

The eligible disabilities for these services are sight and hearing impairment, cerebral palsy, Down syndrome and Fragile X syndrome. THESE DISABILITIES ARE LEGISLATED AND EXCEPTIONS ARE NOT POSSIBLE.

Checking patient eligibility for allied health pervasive developmental disorder services

Patients seeking Medicare rebates for the allied health PDD or disability services will need to have a referral from the relevant medical practitioner. If there is any doubt about a child's eligibility, Medicare Australia will be able to confirm whether a relevant medical practitioner MBS service has been claimed (to facilitate access to the assessment items); or that a PDD or disability treatment plan has been claimed (to facilitate access to the treatment items), as well as the number of allied health PDD or disability services already claimed by the child.

Allied health professionals can call Medicare Australia on 132 150 to check this information. Parents and carers can seek clarification by calling 132 011.

The child will not be eligible if they have not been appropriately referred and a relevant Medicare service provided to them. If the referring service has not yet been claimed, Medicare Australia will not be aware of the child's eligibility. In this case the allied health professional should, with the permission of the child's parent or carer, contact the referring medical practitioner to ensure the relevant service has been provided to the child.

Publicly funded services

Allied health PDD or disability assessment and treatment items 82000 to 82035 do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital. However, where a direction under subsection 19(2) of the *Health Insurance Act 1973* has been made in regard to an Aboriginal Community Controlled Health Service or State/Territory clinic, the items apply for services that are provided by eligible allied health professionals salaried by, or contracted to, the service as long as all requirements of the items are met, including registration with Medicare Australia. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services.)

Private health insurance

Patients need to decide if they will use Medicare or, if available, their private health insurance to pay for these services. Patients cannot use their private health insurance to 'top up' the Medicare rebate paid for the services.

REFERRAL REQUIREMENTS (PSYCHIATRISTS OR PAEDIATRICIANS TO ALLIED HEALTH PROFESSIONALS)

Referrals

Referrals from consultant psychiatrists and paediatricians to allied health professionals for the PDD assessment items must be made from eligible Medicare services.

An eligible allied health professional can provide PDD assessment items (82000 or 82030) to a child where:

- the child has previously been provided with any MBS service covering items 110 through 131 inclusive, as provided by an eligible consultant paediatrician; or
- the child has previously been provided with any MBS service covering items 296 through 370 (excepting item 359) inclusive, as provided by an eligible consultant psychiatrist.

An eligible allied health professional can provide PDD treatment items (82015 or 82035) to a child where:

- the child has previously been provided with a PDD treatment plan (MBS item 135) by an eligible consultant paediatrician; or
- the child has previously been provided with a PDD treatment plan (MBS item 289) by an eligible consultant psychiatrist.

An allied health professional wanting to provide any of the items 82000-82035 must be in receipt of a current referral provided by a consultant physician paediatrician or a consultant physician psychiatrist. With specific regard to the treatment items, a patient must have a previous claim for item 135 or 289.

Referring consultant paediatricians and consultant psychiatrists are **not** required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible allied health professional signed and dated by the referring practitioner.

The allied health professional must be in receipt of the referral at the initial consultation. Allied health professionals are required to retain the referral for 24 months from the date the service was rendered for Medicare Australia auditing purposes.

Referral validity

Medicare benefits are available for up to four (4) allied health PDD or disability assessment and up to twenty (20) allied health PDD or disability assessment services treatment services per patient.

Patients will require a separate referral for each allied health professional they receive services from and will also need fresh referrals for each new course of treatment provided to them.

AUDIOLOGIST, OCCUPATIONAL THERAPIST, OPTOMETRIST, ORTHOPTIST, PHYSIOTHERAPIST, PSYCHOLOGIST AND SPEECH PATHOLOGIST PROFESSIONAL ELIGIBILITY

Eligible allied health professionals

Allied health professionals providing services under these items must be registered with Medicare Australia. To be able to register with Medicare Australia, allied health providers must meet the following criteria:

- **An Audiologist** must be either a 'Full Member' of the Audiological Society of Australia Inc (ASA), who holds a 'Certificate of Clinical Practice' issued by the ASA; or an 'Ordinary Member – Audiologist' or 'Fellow Audiologist' of the Australian College of Audiology (ACAud);
- **An Occupational Therapist** in Queensland, Western Australia, South Australia and the Northern Territory must be registered with the Occupational Therapists Board in the State or Territory in which they are practising; in other States and the Australian Capital Territory, they must be a 'Full-time Member' or 'Part-time Member' of Occupational Therapy Australia, the national body of the Australian Association of Occupational Therapists;
- **An Optometrist** must be [registered](#) as an [optometrist](#) or optician under a law of a State or an internal Territory that provides for the registration of [optometrists](#) or opticians, and be a participating optometrist;

- **An Orthoptist** must be registered with the Australian Orthoptic Board in the State or Territory in which they are practising, and be a member of the Orthoptists Association of Australia (OAA) and have a current Certificate of Currency issued by OAA;
- **A Physiotherapist** must be registered with the Physiotherapy Board of Australia;
- **A Psychologist** must hold General Registration with the Psychology Board of Australia; or
- **A Speech Pathologist** in Queensland must be registered with the Speech Pathologist Board of Queensland. In all other States, the Australian Capital Territory and the Northern Territory, they must be a 'Practising Member' of Speech Pathology Australia.

In addition to meeting the above mentioned credentialing requirements, it is expected that eligible providers will “self-select” for the pervasive developmental disorder or disability items (that is, possess the skills and experience appropriate for provision of these services and be oriented to work with children with PDD or disability).

Registering with Medicare Australia

Advice about registering with Medicare Australia to provide allied health professional services using items 82000- 82035 inclusive is available from the Medicare Australia provider inquiry line on 132 150.

Further information

For further information about Medicare Benefits Schedule items, please go to the Department of Health and Ageing's website at www.health.gov.au/mbsonline.

For providers, further information is also available for providers from the Medicare Australia provider inquiry line on 132 150.

M.11.1. FOLLOW-UP ALLIED HEALTH SERVICES FOR PEOPLE OF ABORIGINAL OR TORRES STRAIGHT ISLANDER DESCENT (ITEMS 81300 TO 81360)

ELIGIBLE PATIENTS

A person who is of Aboriginal or Torres Strait Islander descent may be referred by their GP for follow-up allied health services under items 81300 to 81360 when the GP has undertaken a health assessment and identified a need for follow-up allied health services.

These items are similar to the individual allied health items (items 10950 to 10970) available to patients who have a chronic or terminal medical condition and complex care needs and have a GP Management Plan and Team Care Arrangements prepared by their GP. However items 81300 to 81360 provide an alternative referral pathway for Aboriginal or Torres Strait Islander people to access allied health services.

A practice nurse/Aboriginal health worker item (10987) has also been introduced for Indigenous Australians who have received a health check. This item enables Aboriginal or Torres Strait Islander people to receive follow-up services from a practice nurse or registered Aboriginal health worker on behalf of a GP. More detail on this item is provided at explanatory note M.12.4 of the Medicare Benefits Schedule.

ELIGIBLE ALLIED HEALTH SERVICES

The following allied health professionals are eligible to provide services under these items:

- Aboriginal Health Workers
- Audiologists
- Chiropractors
- Diabetes Educators
- Dietitians
- Exercise Physiologists
- Mental Health Workers
- Occupational Therapists
- Osteopaths
- Physiotherapists
- Podiatrists
- Psychologists
- Speech Pathologists

Publicly funded services

Items 81300 to 81360 do not apply for services that are provided by any Commonwealth or state or territory government funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or state/territory government health clinic, items 81300 to 81360 can be claimed for services provided by eligible allied health professionals

salaried by, or contracted to, the service or health clinic. All requirements of the relevant item must be met, including registration of the allied health professional with Medicare Australia. Medicare services provided under a subsection 19(2) exemption must be bulk billed (i.e. the Medicare rebate is accepted as full payment for services).

Number of services per year

Medicare benefits are available for up to five follow-up allied health services per eligible patient, per calendar year. The five allied health services can be made up of one type of service (e.g. five physiotherapy services) or a combination of different types of services (e.g. one dietetic, two podiatry and two physiotherapy services).

The annual limit of five allied health services per patient under items 81300 to 81360 is in addition to the individual allied health services for patients with a chronic or terminal medical condition and complex care needs (items 10950 to 10970).

Checking patient eligibility for items 81300 to 81360

If there is any doubt about a patient's eligibility, Medicare Australia will be able to confirm the number of allied health services already claimed by the patient during the calendar year. Allied health professionals can call Medicare Australia on 132 150 and patients can call Medicare Australia on 132 011 or alternatively the Indigenous Access Line for Medicare Australia on 1800 556 955.

Service length and type

Services provided by eligible allied health professionals under these items must meet the specific requirements set out in the item descriptors. These requirements include that:

- the service is of at least 20 minutes duration;
- the service is provided to the person individually (i.e. not as part of a group service) and in person (i.e. the allied health professional must personally attend the patient);
- the person is not an admitted patient of a hospital;
- the allied health professional must provide a written report to the GP; and
- if the patient has private health insurance, he/she cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for these services.

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

Reporting back to the GP

Where an allied health professional provides a *single* service to the patient under a referral, the allied health professional must provide a written report back to the referring GP after that service.

Where an allied health professional provides *multiple* services to the same patient under a referral, the allied health professional must provide a written report back to the referring GP after the first and last service, or more often if clinically necessary. Written reports should include:

- any investigations, tests, and/or assessments carried out on the patient;
- any treatment provided; and
- future management of the patient's condition or problem.

Out-of-pocket expenses and Medicare safety net

Allied health professionals can determine their own fees for the professional service, except where the service is provided under a subsection 19(2) exemption. Charges in excess of the Medicare benefit for the allied health items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Allied health services in excess of five in a calendar year will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

REFERRAL REQUIREMENTS

Referral form

For Medicare benefits to be payable, the patient must be referred to an eligible allied health professional by their GP using a referral form that has been issued by the Australian Government Department of Health and Ageing or a form that contains all the components of this form.

The form issued by the department is available at <http://www.health.gov.au/mbsprimarycareitems> (click on the link for follow-up allied health services).

GPs are encouraged to attach a copy of the relevant part of the patient's care plan to the referral form.

GPs may use one referral form to refer patients for single or multiple services of the same service type (e.g. five dietetic services). If referring a patient for single or multiple services of different service types (e.g. two dietetic services and three podiatry services), a separate referral form will be needed for each service type.

The patient will need to present the referral form to the allied health professional at the first consultation, unless the GP has previously provided it directly to the allied health professional.

It is recommended that allied health professionals retain the referral form for 24 months from the date the service was rendered (for Medicare Australia auditing purposes). A copy of the referral form is not required to accompany Medicare claims, and allied health professionals do not need to attach a signed copy of the form to patients' itemised accounts/receipts or assignment of benefit forms.

Completed forms do not have to be sent to the Department of Health and Ageing.

Referral validity

A referral is valid for the stated number of services. If all services are not used during the calendar year in which the patient was referred, the unused services can be used in the next calendar year. However, those services will be counted as part of the five rebates for allied health services available to the patient during that calendar year.

When patients have used all of their referred services they will need to obtain a new referral from their GP.

ALLIED HEALTH PROFESSIONAL ELIGIBILITY

Items 81300 to 81360 can only be claimed for services provided by eligible allied health professionals who are registered with Medicare Australia. Allied health professionals already registered with Medicare (e.g. for items 10950 to 10970) do not need to register again to claim these items.

Specific eligibility requirements for allied health professionals providing services under these items are:

Aboriginal health workers practising in the Northern Territory (NT) must be registered with the Aboriginal health workers Registration Board of the NT. In other States and the Australian Capital Territory, they must have been awarded a Certificate Level III in Aboriginal and Torres Strait Islander Health (or an equivalent or higher qualification) from a Registered Training Organisation that meets training standards set by the Australian National Training Authority's Australian Quality Training Framework.

Audiologists must be either a 'Full Member' of the Audiological Society of Australia Inc (ASA), who holds a 'Certificate of Clinical Practice' issued by the ASA; or an 'Ordinary Member – Audiologist' or 'Fellow Audiologist' of the Australian College of Audiology (ACAud).

Chiropractors must be registered with the Chiropractic Board of Australia.

Diabetes educators must be a Credentialed Diabetes Educator (CDE) as credentialed by the Australian Diabetes Educators Association (ADEA).

Dietitians must be an 'Accredited Practising Dietitian' as recognised by the Dietitians Association of Australia (DAA).

Exercise physiologists must be an 'Accredited Exercise Physiologist' as accredited by Exercise and Sports Science Australia (ESSA).

Mental health workers can include services provided by members of five different allied health professional groups. 'Mental health workers' are drawn from the following:

- psychologists;
- mental health nurses;
- occupational therapists;
- social workers; and
- Aboriginal health workers.

Psychologists, occupational therapists and **Aboriginal health workers** are eligible in separate categories for these items.

Mental health nurses must be a credentialed mental health nurse, as certified by the Australian College of Mental Health Nurses.

Mental health nurses who were registered in the ACT or Tasmania prior to the introduction of the National Registration and Accreditation Scheme (NRAS) on 1 July 2010, will have until 31 December 2010 to be certified by the Australian College of Mental Health Nurses.

Social workers must be a 'Member' of the Australian Association of Social Workers (AASW); and be certified by AASW as meeting the standards for mental health set out in the document published by AASW titled 'Practice Standards for Mental Health Social Workers' as in force on 8 November 2008.

Occupational therapists in Queensland, Western Australia, South Australia and the Northern Territory must be registered with the Occupational Therapists Board in the State or Territory in which they are practising. In other States and the Australian Capital Territory, they must be a 'Full-time Member' or 'Part-time Member' of Occupational Therapy Australia, the national body of the Australian Association of Occupational Therapists.

Osteopaths must be registered with the Osteopathy Board of Australia.

Physiotherapists must be registered with the Physiotherapy Board of Australia.

Podiatrists must be registered with the Podiatry Board of Australia.

Psychologists must hold General Registration with the Psychology Board of Australia.

Speech pathologists practising in Queensland must be registered with the Speech Pathologist Board of Queensland. In all other States, the Australian Capital Territory and the Northern Territory, they must be a 'Practising Member' of Speech Pathology Australia.

A copy of these eligibility requirements may be obtained from Medicare Australia by calling 132 150 or at www.medicareaustralia.gov.au or www.health.gov.au/mbsprimarycareitems.

Registering with Medicare Australia

Provider registration forms may be obtained from Medicare Australia on 132 150 or at www.medicareaustralia.gov.au and then search for "allied health application".

FURTHER INFORMATION

Further information about these items, including a fact sheet and the referral form, is available on the Department of Health and Ageing's website at www.health.gov.au/mbsprimarycareitems. For providers, information is also available from the Medicare Australia provider inquiry line on 132 150. The Indigenous Access Line for Medicare Australia on 1800 556 955 is also a useful source of information.

M.12.1. IMMUNISATION SERVICES PROVIDED BY A REGISTERED ABORIGINAL HEALTH WORKER - (ITEM 10988)

Item 10988 can only be claimed by a medical practitioner where an immunisation is provided to a patient by a registered Aboriginal Health Worker on behalf of the medical practitioner.

Item 10988 can be claimed only once per patient visit, even if more than one vaccine is administered during the same patient visit.

A registered Aboriginal Health Worker means an Aboriginal Health Worker in the Northern Territory registered under the Health Practitioners Act 2004 (NT), who is employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under sub-section 19(2) of the Health Insurance Act 1973.

The registered Aboriginal Health Worker must be appropriately qualified and trained to provide immunisations. This includes compliance with any territory requirements.

The medical practitioner under whose supervision the immunisation is provided retains responsibility for the health, safety and clinical outcomes of the patient.

Supervision may include distance supervision where the medical practitioner does not have to be physically present at the time that the service is provided by the registered Aboriginal Health Worker, but should be able to be contacted for advice if required.

The immunisation must be performed by the registered Aboriginal Health Worker in accordance with the current edition of the Australian Immunisation Handbook and the Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual.

Immunisation means the administration of a registered vaccine to a patient for any purpose other than as part of a mass immunisation of persons.

A registered vaccine means a vaccine that is included on the Australian Register of Therapeutic Goods. This includes all vaccines on the Australian Standard Vaccination Schedule and vaccines covered in the current edition of the Australian Immunisation Handbook. The following substances cannot be claimed under this item: vaccines used experimentally; homeopathic substances; immunotherapy for allergies (eg de-sensitisation preparations); and other substances that are not vaccines. There may also be territory limitations on the administration of some vaccines, such as those for tuberculosis, yellow fever and Q-fever.

All GPs whether vocationally registered or not are eligible to claim this item. District Medical Officers (DMOs) employed by the Northern Territory Department of Health and Community Services are also eligible to claim this item.

Where the medical practitioner provides a professional attendance to the patient (in addition to the immunisation service provided by the registered Aboriginal Health Worker), the medical practitioner may also claim for the professional attendance they provide to the patient.

Item 10991 can also be claimed in conjunction with item 10988 provided the conditions of both items are satisfied.

Related Items: 10988

M.12.2. WOUND MANAGEMENT SERVICES PROVIDED BY A REGISTERED ABORIGINAL HEALTH WORKER (ITEM 10989)

Item 10989 can only be claimed by a medical practitioner where wound management (other than normal aftercare) is provided to a patient by a registered Aboriginal Health Worker on behalf of the medical practitioner.

Item 10989 can be claimed only once per patient visit, even if more than one wound is treated during the same patient visit.

A registered Aboriginal Health Worker means an Aboriginal Health Worker in the Northern Territory registered under the Health Practitioners Act 2004 (NT), who is employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under sub-section 19(2) of the Health Insurance Act 1973.

The registered Aboriginal Health Worker must be appropriately qualified and trained to treat wounds. This includes compliance with any territory requirements.

The medical practitioner under whose supervision the treatment is provided retains responsibility for the health, safety and clinical outcomes of the patient.

Supervision may include distance supervision where the medical practitioner does not have to be physically present at the time that the service is provided by the registered Aboriginal Health Worker, but should be able to be contacted for advice if required.

The medical practitioner must conduct an initial assessment of the patient (including under a distance supervision arrangement if the medical practitioner is not physically present) in order to give instruction in relation to the treatment of the wound.

Where a registered Aboriginal Health Worker provides ongoing wound management, the medical practitioner is not required to give instruction or see the patient during each subsequent visit.

M.12.3. HEALTHY KIDS CHECK PROVIDED BY A PRACTICE NURSE OR REGISTERED ABORIGINAL HEALTH WORKER (ITEM 10986)

A health assessment means the assessment of a patient's health and physical, psychological and social function and consideration of whether preventive health care and education should be offered to the patient, to improve that patient's health and physical, psychological and social function.

A health assessment must include the following elements:

- (a) information collection, including taking a patient history and undertaking examinations and investigations as required;
- (b) making an overall assessment of the patient;
- (c) recommending appropriate interventions;
- (d) providing advice and information to the patient;
- (e) keeping a record of the health assessment, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment; and

- (f) offering the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

MBS item 10986 may be provided by a practice nurse or registered Aboriginal health worker, but may only be claimed by a medical practitioner (including a general practitioner but not including a specialist or consultant physician).

A health assessment should not take the form of a health screening service (see General Explanatory Notes G.13.1).

The practice nurse or registered Aboriginal health worker is required to note if a copy of the Department's publication 'Get Set 4 Life – habits for healthy kids' has been provided to the patient's parents/guardian.

The practice nurse or registered Aboriginal health worker is also required to note that the four year-old immunisation has been given (including evidence provided).

The practice nurse is a registered or enrolled nurse who is employed by, or whose services are otherwise retained by a general practice. A registered Aboriginal health worker means a person in the Northern Territory who is registered as an Aboriginal health worker under the Health Practitioners Act 2004 (NT), who is employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under sub-section 19(2) of the *Health Insurance Act 1973*.

Should the practice nurse or registered Aboriginal health worker identify any health concerns that require medical intervention, the patient must be reviewed by the patient's 'usual doctor' who will arrange referrals and follow-up as clinically required.

In all cases, the medical practitioner under whose supervision the health Check is being provided retains responsibility for the health, safety and clinical outcomes of the patient. The medical practitioner must be satisfied that the practice nurse or registered Aboriginal health worker is appropriately qualified and trained to provide the service.

General practices and Aboriginal Community Controlled Health Services and State/Territory health clinics that are exempt under subsection 19(2) of the *Health Insurance Act 1973* that utilise nurses and registered Aboriginal health workers to provide the Healthy Kids Check must also have a written clinical risk management strategy.

Where the medical practitioner and practice nurse or registered Aboriginal health worker are at the same location, the medical practitioner is not required to be present while the Healthy Kids Check is undertaken. The medical practitioner must decide whether he or she needs to see the patient.

Items 10988 (immunisation by registered Aboriginal Health Worker) can be claimed in conjunction with the Healthy Kids Check health assessment, provided the conditions of item 10988 are satisfied.

The Healthy Kids Check must include the following basic physical examinations and assessments:

- (a) Height and weight (plot and interpret growth curve/calculate BMI)
- (b) Eyesight
- (c) Hearing
- (d) Oral health (teeth and gums)
- (e) Toileting
- (f) Allergies

Item 10986 does not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, item 10986 can be claimed for services provided by nurses or registered Aboriginal health workers salaried by or contracted to, the Service or health clinic. All other requirements of the item must be met.

The Healthy Kids Check provided by a practice nurse or registered Aboriginal Health Worker (item 10986) may only be claimed once by an eligible patient and only if the patient has not already claimed a Healthy Kids Check service under items 701, 703, 705 or 707.

M.12.4. FOLLOW UP SERVICE PROVIDED BY A PRACTICE NURSE OR REGISTERED ABORIGINAL HEALTH WORKER, ON BEHALF OF A MEDICAL PRACTITIONER, FOR AN INDIGENOUS PERSON WHO HAS RECEIVED A HEALTH ASSESSMENT (ITEM 10987)

Item 10987 may be claimed by a medical practitioner, where a follow up service is provided by a practice nurse or registered Aboriginal Health Worker on behalf of that medical practitioner for an Indigenous person who has received a Health Check.

All GPs whether vocationally registered or not are eligible to claim this item. District Medical Officers (DMOs) employed by state/territory health Departments are also eligible to claim this item. The term 'GP' is used in these notes as a generic reference to medical practitioners able to claim this item.

Item 10987 does not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government Health clinic, item 10987 can be claimed for services provided by practice nurses or registered Aboriginal Health Workers salaried or contracted to, the Service or Health clinic. All requirements of the item must be met.

Item 10987 will assist Indigenous patients who have received a Health Check which has identified a need for follow up services which can be provided by a practice nurse or registered Aboriginal Health Worker between further consultations with the patient's GP.

Item 10987 may be used to provide:

- Examinations/interventions as indicated by the Health Check;
- Education regarding medication compliance and associated monitoring;
- Checks on clinical progress and service access;
- Education, monitoring and counselling activities and lifestyle advice;
- Taking a medical history; and
- Prevention advice for chronic conditions, and associated follow up.

Item 10987 may be claimed up to a maximum of 10 times per patient per calendar year.

Item 10987 may be accessed by an Indigenous patient who has received the Aboriginal and Torres Strait Islander Peoples Health Assessment (item 715), which is available to:

- a) children between the ages of 0 and 14 years;
- b) adults between the ages of 15 and 54 years; and
- c) older people over the age of 55 years.

The item can also be accessed by a child who has received a health check as part of the Northern Territory Emergency Response (NTER).

Patients whose condition is unstable/deteriorating should be referred to their GP for further treatment.

A practice nurse means a registered or enrolled nurse who is employed by, or whose services are otherwise retained by a general practice or by a health service that has an exemption to claim Medicare benefits under sub-section 19(2) of the *Health Insurance Act 1973*.

An Aboriginal Health Worker means a person in the Northern Territory who is registered as an Aboriginal Health Worker under the *Health Practitioners Act 2004 (NT)*, who is employed or retained by a general practice or by a health service that has an exemption to claim Medicare benefits under sub-section 19(2) of the *Health Insurance Act 1973*.

In all cases, the GP under whose supervision the health check follow-up is being provided retains responsibility for the health, safety and clinical outcomes of the patient. The GP must be satisfied that the practice nurse or Aboriginal health worker is appropriately qualified and trained to provide the relevant follow up for the patient. GPs are advised to consult their insurer concerning indemnity coverage for services provided on their behalf.

General practices where nurses or Aboriginal Health Workers provide follow up for Indigenous people who have received a health check, should also have a written clinical risk management strategy covering issues like clinical roles, patient follow up and patient consent.

Continuing professional development is recommended for all nurses and Aboriginal health workers providing follow up services for Indigenous people who have received a health check.

Supervision of the practice nurse/Aboriginal health worker by the GP at a distance is recognised as an acceptable form of supervision. This means that the claiming GP does not have to be physically present at the time the service is provided. However the GP should be able to be contacted if required.

Where the GP and practice nurse/Aboriginal health worker are at the same location, the GP is not required to be present while the health check follow up is undertaken. It is up to the GP to decide whether they need to see the patient. Where the GP has a consultation with the patient, then the GP is entitled to claim a Medicare item for the time and complexity of their personal attendance on the patient. The time the patient spends receiving a service from the practice nurse or Aboriginal Health Worker is itemised separately under item 10987 and should not be counted as part of the Medicare items claimed for time spent with the GP. Where the practice nurse or Aboriginal Health Worker provides another service (eg immunisation, Pap smear) on the same day, the GP is able to claim for all practice nurse/Aboriginal Health Worker services provided.

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with item 10987 provided the conditions of item 10990 or 10991 are satisfied.

M.12.5. PROVISION OF MONITORING AND SUPPORT FOR A PERSON WITH A CHRONIC DISEASE BY A PRACTICE NURSE OR REGISTERED ABORIGINAL HEALTH WORKER (ITEM 10997)

Item 10997 may be claimed by a medical practitioner, where a monitoring and support service for a person with a chronic disease care plan is provided by a practice nurse or registered Aboriginal Health Worker on behalf of that medical practitioner.

All GPs whether vocationally registered or not are eligible to claim this item. The term 'GP' is used in these notes as a generic reference to medical practitioners able to claim this item.

Item 10997 does not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, item 10997 can be claimed for services provided by practice nurses or registered Aboriginal Health Workers salaried by or contracted to, the Service or health clinic. All requirements of the item must be met.

Item 10997 will assist patients who require access to ongoing care, routine treatment and ongoing monitoring and support between the more structured reviews of the care plan by the patient's usual GP.

Item 10997 may be used to provide:

- checks on clinical progress;
- monitoring medication compliance;
- self management advice, and;
- collection of information to support GP reviews of Care Plans.

The services provided by the practice nurse or Aboriginal Health Worker should be consistent with the scope of the GP Management Plan, Team Care Arrangements, or Multidisciplinary Care Plan.

Item 10997 may be claimed up to a maximum of 5 times per patient per calendar year.

Item 10997 may only be accessed by a patient with a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan (items 721, 723, 729, 731 and 732).

Patients whose condition is unstable/deteriorating should be referred to their GP for further treatment.

A practice nurse means a registered or enrolled nurse or Nurse Practitioner who is employed by, or whose services are otherwise retained by a general practice.

An Aboriginal Health Worker means a person in the Northern Territory who is registered as an Aboriginal Health Worker under the Health Practitioners Act 2004 (NT), who is employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under sub-section 19(2) of the Health Insurance Act 1973.

In all cases, the GP under whose supervision the chronic disease monitoring and support is being provided retains responsibility for the health, safety and clinical outcomes of the patient. The GP must be satisfied that the practice nurse is appropriately qualified and trained to provide chronic disease support and monitoring. GPs are advised to consult their insurer concerning indemnity coverage for services performed on their behalf.

General practices where nurses or Aboriginal Health Workers provide chronic disease support and monitoring, should also have a written clinical risk management strategy covering issues like clinical roles, patient follow up and patient consent.

Continuing professional development is recommended for all nurses and Aboriginal Health Workers providing chronic disease monitoring and support.

Supervision by the GP at a distance is recognised as an acceptable form of supervision. This means that the claiming GP does not have to be physically present at the time the service is provided. However, the GP should be able to be contacted if required.

Where the GP and practice nurse/Aboriginal Health Worker are at the same location, the GP is not required to be present while the chronic disease monitoring and support is undertaken. It is up to the GP to decide whether they need to see the patient. Where the GP has a consultation with the patient, then the GP is entitled to claim a Medicare item for the time and complexity of their personal attendance on the patient. The time the patient spends receiving a service from the practice nurse or Aboriginal Health Worker is itemised separately under item 10997 and should not be counted as part of the Medicare item claimed for time spent with the GP. Where the practice nurse or Aboriginal Health Worker provides another service (eg immunisation) on the same day, the GP is able to claim for both practice nurse/Aboriginal Health Worker items.

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with item 10997 provided the conditions of item 10990 or 10991 are satisfied (see explanatory note M.1).

M.12.6. TELEHEALTH SUPPORT SERVICES BY HEALTH PROFESSIONALS

These notes provide information on the introduction of new telehealth MBS attendance items for health professionals to provide clinical support to their patients during video consultations with a specialist, consultant physicians and psychiatrists.

A video consultation will involve a single specialist, consultant physician or psychiatrist attending to the patient, with the possible support of a participating nurse practitioner, a participating midwife, practice nurse or Aboriginal health worker at the patient end.

New item numbers 82150, 82151 and 82152 in Group M13 have been introduced for participating midwives, items 82220 to 82225 in Group M14 for participating nurse practitioners and items 10983 and 10984 in Group M12 for practice nurses and Aboriginal health workers for services provided for and on behalf of a medical practitioner. These items can only be provided when participating in a video conference where there is a MBS item that relates to the specialist or consultant physician service and that service is rendered in Australia.

The new items provide for attendances in various settings including a residential aged care service, an Aboriginal Medical Service or Aboriginal Community Controlled Health Service to which a 19(2) direction under the Health Insurance Act 1973 applies.

In most cases it is expected that video consultations will be provided from a medical facility or a facility with the capacity for professional medical support. However it is acknowledged that, especially in more remote areas, video consultations may be supported in a range of other locations and may even be provided from the home, if considered clinically appropriate by the specialist, consultant physician or psychiatrist and by the referring medical practitioner or health professional.

Clinical indications

The specialist, consultant physician or psychiatrist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. Advice from the referring medical practitioner or health professional may assist in this decision. The remote specialist, consultant physician or psychiatrist may form the view that it is clinically necessary for the patient to be accompanied during the consultation by the referring medical practitioner, a nurse practitioner, a midwife, or a practice nurse or Aboriginal health worker providing the service on behalf of a medical practitioner. The decision to provide clinical support to the patient must be made in consultation with the specialist, consultant physician or psychiatrist.

Collaborative Consultation

The health professional who provides assistance to the patient during a video consultation with a specialist may seek assistance from another health professional (e.g. a practice nurse or Aboriginal health worker) or medical practitioner but only one item is billable for the patient-end support service. The health professional must be present during part or all of the consultation in order to bill an appropriate time-tiered MBS item. Any time spent by another health professional or practitioner called to assist with the consultation may not be counted against the overall time taken to complete the video consultation.

Restrictions

The new MBS telehealth attendance items are not payable for services to an admitted hospital patient. Benefits are not payable for telephone or email consultations. In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote specialist is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth support attendance is not payable.

Eligible Geographical Areas

A specialist, consultant physician or psychiatrist can be located anywhere throughout Australia but the location of the patient at the time of the consultation must be in a remote, regional or an outer metropolitan area. This means that all areas outside inner metropolitan are eligible locations for patient services.

The exception to this rule is for approved residents of a residential aged care service or patients receiving a service from an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service to which a direction made under subsection 19(2) of the Health Insurance Act 1973 applies. For these patients, the inner metropolitan exclusion does not apply.

Static maps of Telehealth Eligible Service Areas are available at www.mbsonline.gov.au/telehealth Dynamic maps are also available to search exact street locations at www.doctorconnect.gov.au

Record Keeping

Participating telehealth practitioners and health professionals are required to keep contemporaneous notes of the consultation and this includes documenting that the service was performed by video conference, including the time and the people who participated. Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Multiple attendances on the same day

A patient may receive a telehealth consultation and a face to face consultation by the same or different health professional/medical practitioner on the same day.

Medicare benefits are not payable for a group telehealth consultation. The legislation applying to video consultations requires an attendance by a health professional or a medical practitioner on a single patient on a single occasion. It is possible to provide consultations to multiple patients consecutively during a single video link, but these would need to be separate consultations.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same health professional/medical practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Health professionals and medical practitioners/will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Referrals

The referral procedure for a video consultation is the same as that for conventional face-to-face consultations. No special documentation is required.

Technical requirements

In order to bill for a MBS telehealth consultation item a visual and audio link between the patient and the remote practitioner must be established. The Government is not mandating or endorsing any particular technical solution for telehealth. In providing MBS billed telehealth services, health professionals should be confident that the technical solution they choose is:

- capable of providing sufficient video quality for the clinical service being provided; and
- sufficiently secure to ensure normal privacy requirements for health information are met. Individual clinicians will need to be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

You should discuss with your professional association any requirements/recommendations they have regarding appropriate equipment for video consultations.

Incentive payments

A range of financial incentives are available from 1 July 2011 to encourage and support the provision of telehealth services. A telehealth bulk billing incentive is also applicable to these items. See Program Guidelines: MBS Items and Financial Incentives for Telehealth at www.mbsonline.gov.au/telehealth

Duration of attendance

The co-located health professional does not need to be present for the entire consultation, only as long as is clinically relevant - this can be established in consultation with the specialist/consultant physician or psychiatrist. The MBS fee payable for the supporting health professional will be determined by the total time spent assisting the patient. This time does not need to be continuous.

Aboriginal health workers

For the purpose of items 10983 and 10984 an Aboriginal health worker means a person who:

- a) holds a Certificate III in Aboriginal or Torres Strait Islander Health Worker Primary Health Care (Clinical) or other appropriate qualifications; or
- b) is registered, and holds a current registration issued by a State or Territory regulatory authority, as an Aboriginal health worker; and
- c) is employed by, or whose services are otherwise retained by a medical practitioner or their practice. This includes health service in relation to which a direction made under subsection 19(2) of the Act applies.

Practice Nurse

For the purpose of items 10983 and 10984 a practice nurse means a registered or enrolled nurse who is employed by, or whose services are otherwise retained by a medical practitioner or their practice. This includes a health service in relation to which a direction made under subsection 19(2) of the Act applies.

M.13.1. MATERNITY SERVICES BY PARTICIPATING MIDWIVES - OVERVIEW

As at 1 November 2010, Medicare benefits are payable for antenatal, intrapartum and postnatal care for the first 6 weeks after the delivery, provided by eligible privately practising midwives. Eligible midwives can also request certain pathology and diagnostic imaging services for their patients and refer patients to obstetricians and paediatricians, as the clinical need arises. Each service that attracts a Medicare benefit is identified in the Medicare Benefits Schedule (MBS) by an item number. Each item describes the service that the item covers.

M.13.2. PARTICIPATING MIDWIVES

To provide services under Medicare, the legislation requires that a midwife be a participating midwife. A participating midwife is an eligible midwife who provides services in a collaborative arrangement or collaborative arrangements with one or more medical practitioners, of a kind or kinds specified in the regulations.

For more details on collaborative arrangements required under the regulations see Point M.13.5.

M.13.3. ELIGIBLE MIDWIVES

Under the legislation, to be an eligible midwife the midwife must be registered or authorised (however described) under State and Territory law to practice midwifery. The midwife must also demonstrate that he or she has the appropriate qualifications and experience to meet the registration standard developed by the Nursing and Midwifery Board of Australia

Information regarding eligibility can be found on the Nursing and Midwifery Board of Australia (NMBA) site of the Australian Health Practitioner Regulatory Agency (AHPRA) website at:

<http://www.nursingmidwiferyboard.gov.au/>.

M.13.4. MIDWIFE PROFESSIONAL INDEMNITY INSURANCE

Under National Law, which governs the National Registration and Accreditation Scheme (NRAS), it is a requirement for midwives to have appropriate professional indemnity insurance. All privately practising midwives who wish to provide private midwifery services in must have appropriate professional indemnity insurance from the date the State or Territory in which they were registered enacted National Law.

Further information about professional indemnity insurance for midwives can be found at:

<http://www.health.gov.au/internet/main/publishing.nsf/Content/Maternity+Services+Review-Q&A-PIMI>

M.13.5. COLLABORATIVE ARRANGEMENTS

To provide Medicare rebate-able services an eligible midwife must have a collaborative arrangement in place that must provide for consultation, referral or transfer of care as clinical needs dictate, to ensure safe, high quality maternity care.

Under the legislation a collaborative arrangement can be with the following “specified” medical practitioners:

- 1) an obstetrician;
- 2) a medical practitioner who provides obstetric services; or
- 3) a medical practitioner employed or engaged by a hospital authority and authorised by the hospital authority to participate in a collaborative arrangement.

The types of practitioners listed 1) and 2) are defined in the Regulations as “obstetric specified medical practitioners”.

Collaborative arrangement can be established in the following ways:

- a) being employed or engaged by 1 or more obstetric specified medical practitioners or by an entity that employs or engages 1 or more obstetric specified medical practitioners; **OR**
- b) receiving patients by referral in writing to the midwife for midwifery treatment from a specified medical practitioner, **OR**
- c) having a signed written agreement with one or more specified medical practitioners, **OR**
- d) having an arrangement with *and acknowledged* by at least one specified medical practitioner
 - a. an arrangement requires that the eligible midwife must record the following in the midwife's written records:-
 - i. The name of at least one specified medical practitioner who is, or will be, collaborating with the midwife in the patient's care (a **named medical practitioner**);
 - ii. That the midwife has told the patient that the midwife will be providing midwifery services to the patient in collaboration with one or more specified medical practitioners;
 - iii. Acknowledgement by a named medical practitioner that the practitioner will be collaborating in the patient's care;
 - iv. Plans for the circumstances in which the midwife will do any of the following:
 - 1. consult with an obstetric specified medical practitioner;
 - 2. refer the patient to a specified medical practitioner;
 - 3. transfer the patient's care to an obstetric specified medical practitioner.
 - b. The midwife must also record the following in the midwife's written records:
 - i. Any consultation or other communication between the midwife and an obstetric specified medical practitioner about the patient's care;
 - ii. Any referral of the patient by the midwife to a specified medical practitioner;
 - iii. Any transfer by the midwife of the patient's care to an obstetric specified medical practitioner;
 - iv. When the midwife gives a copy of the hospital booking letter for the patient to a named medical practitioner – acknowledgement that the named medical practitioner has received the copy;
 - v. When the midwife give a copy of the patient's maternity care plan prepared by the midwife to a named medical practitioner – acknowledgement that the named medical practitioner has received the copy;
 - vi. If the midwife requests diagnostic imaging or pathology services for the patient – when the midwife gives the results of the services to a named medical practitioner
 - vii. That the midwife has given a discharge summary at the end of the midwife's care for the patient to:
 - 1. a named medical practitioner; and
 - 2. the patient's usual general practitioner.

The legislation requires that collaborative arrangements must be in place at the time the participating midwife provides the service. It is also a requirement that for each kind of collaborative arrangement, at least one medical practitioner is needed; it is not possible for the midwife to have a collaborative arrangement with an entity such as a health service.

a) Being employed or engaged by a medical practice or an entity

An entity may refer to a community health centre. For a midwife to have a collaborative arrangement in these circumstances, that midwife must be employed or engaged by an entity that also employs or engages 1 or more obstetric specified medical practitioners.

The terms *employs* or *engage* covers both employees and contractors. This will cover an eligible midwife who is employed or engaged by a medical practice so long as that medical practice employs or engages at least one obstetrician or medical practitioner that provides obstetric services.

There must be at least one obstetric specified medical practitioner employed or engaged by the entity each time the midwife renders a service/performs treatment. However, there is no requirement that the consultation, referral or transfer of care must always be to the medical practitioner(s) employed/engaged by the entity.

b) Referral from a medical practitioner

A participating midwife's patient will be able to access the MBS and PBS if a patient has been referred in writing to the midwife by a specified medical practitioner. The arrangement must provide for consultation, referral and transfer of care should the clinical need arise.

c) Written agreement with a medical practitioner

A participating midwife's patient will be able to access the MBS and PBS if the nurse practitioner has a written agreement in place with one or more specified medical practitioners. The agreement must be signed by the nurse practitioner and doctor. The arrangement must provide for with consultation, referral and transfer of care.

d) Arrangement with, acknowledged by a medical practitioner.

Evidence of 'acknowledgement' by an obstetrician/GP obstetrician for each woman for whom the midwife provides care is a requirement to ensure that the medical practitioner being named understands and accepts the collaborative arrangement.

The acknowledgement does not have to be obtained on an individual patient basis. This means that, for example, a midwife could obtain an acknowledgement from a specified medical practitioner that he or she will be the collaborating medical practitioner for some or all of the midwife's patients. Arrangements to collaborate could be obtained in a number of ways including signing of documents, email or fax confirmation, or verbal acknowledgement which the midwife documents in their written records.

The midwife is required to record in written records communications in regard to consultations, referral and transfer of the woman's care with the medical practitioner, including information that has been forwarded to the medical practitioner. The midwife is also required to send a copy of all pathology and diagnostic imaging results to a named medical practitioner and to record in the midwife's written records when this occurs (however, there is no requirement that the midwife consult with a medical practitioner in relation to every test result). The purpose of sharing records with the collaborating medical practitioner is to prevent duplication of services and to ensure continuity of care.

M.13.6. PROVIDER NUMBERS

To access the Medicare arrangements, eligible midwives will need to apply to Medicare Australia for a provider number. A separate provider number is required for each location at which a midwife practices.

Advice about registering with Medicare Australia to provide midwifery services using items 82100 to 82140 inclusive, is available from the Medicare Australia provider inquiry line on 132 150.

Medicare provider application forms for midwives can be downloaded from the following site:

www.medicareaustralia.gov.au

M.13.7. SCHEDULE FEES AND MEDICARE BENEFITS

Each midwifery service is identified in the MBS by an item number. The fee set for any item in the MBS is known as the "Schedule fee". The Schedule fee and Medicare benefit for each service is listed in the item description.

There are two levels of benefit payable for midwifery services:

75% of the Schedule fee for midwifery services rendered to privately insured patients as part of an episode of hospital treatment (other than for public patients); or

85% of the Schedule fee for antenatal and postnatal services rendered to non-admitted patients.

M.13.8. SAFETY NETS

Where practitioners charge more than the Medicare benefit, the resultant out-of-pocket costs are the responsibility of the patient.

Assistance is provided to families and singles for out-of-pocket costs for out-of-hospital services through the "original" and "extended" Medicare safety nets:

- the original safety net provides that once the threshold is met, the Medicare benefit increases to 100 per cent of the Schedule fee. The threshold in 2012 is \$413.50; and
- under the extended Medicare safety net (EMSN), once certain thresholds are met, Medicare reimburses 80 per cent of the out-of-pocket costs. However, where the item has an EMSN benefit cap, there is a maximum limit on the EMSN benefit that will be paid for that item.

In 2012, the annual EMSN threshold for concession cardholders and people who receive Family Tax Benefits (Part A) is \$598.80. For all other singles and families the annual threshold is \$1,198.00. These amounts are indexed by Consumer Price Index on 1 January each year.

M.13.9. SAFETY NET CAPPING FOR MIDWIFERY ITEMS

Midwifery services will be subject to a benefit limit or cap under the EMSN. This is in line with obstetric services which are also subject to a safety net cap. The caps that apply to midwifery services are outlined below:

Item	Maximum increase (\$)
82100	21.40
82105	16.10
82110	21.40
82115	53.45
82130	16.10
82135	21.40
82140	16.10

M.13.10. WHERE MEDICARE BENEFITS ARE NOT PAYABLE

Medicare benefits are not available:

- a. for services listed in the MBS, where the service rendered does *not* meet the item description and associated requirements;
- b. where the midwifery service is *not* personally performed by the participating midwife;
- c. for MBS services that are time based, the inclusion of any time period in the consultation periods when the patient is *not* receiving active attention e.g. the time the provider may take to travel to the patient's home or where the patient is resting between blood pressure readings; and
- d. services provided where the patient is not in attendance, such as the issuing of repeat prescriptions;
- e. for telephone attendances;
- f. group sessions; and
- g. The issuing of repeat prescriptions, updating patient notes or telephone consultations.

The fee charged under Medicare must not include the cost of services that are not part of the MBS service being claimed. Medicare benefits are not payable for good or appliances associated with the service, such as bandages or other skin dressings

Unless the Minister otherwise directs, Medicare benefits are not payable where funding has already been provided under an arrangement with the Commonwealth, state or a local governing body.

M.13.11. BILLING OF PATIENT

Where the practitioner bills the patient for medical services rendered, the patient needs a properly itemised account/receipt to enable a claim to be made for Medicare benefits.

Under the provisions of the Health Insurance Act and Regulations, Medicare benefits are not payable in respect of a professional 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 the service, the following particulars:-

- (a) Patient's name;
- (b) The date on which the professional service was rendered;
- (c) An item number or a description of the professional service sufficient to identify the item that relates to that service, including an indication where the service is rendered to a person while hospital treatment is provided in a hospital "admitted patient" immediately preceding the description of the service or an asterisk "*" directly after an item number where used;
- (d) The name and practice address and provider number of the participating midwife who actually rendered the service; (where the participating midwife 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).

Only one original itemised account should be issued in respect of any one service and any 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".

M.13.12. ASSIGNMENT OF BENEFITS (DIRECT-BILLING) ARRANGEMENTS

Under the Health Insurance Act the 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 participating midwife direct-bills, the participating midwife 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 card number must be quoted on all direct-bill forms for that patient.
- The basic 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 Subsection 19(6) of the Health Insurance Act.
- The practitioner must include the particulars relating to the professional service out on the assignment form before the patient signs the form and ensure that 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 practitioner, practitioner'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.

The administration of the direct-billing arrangements under Medicare as well as the payment of Medicare benefits on patient claims is the responsibility of **Medicare Australia**. Any enquiries in regard to these matters should therefore be directed to Medicare offices or enquiry points.

M.13.13. ASSIGNMENT OF BENEFIT FORMS

Participating midwives wishing to direct-bill are required to use a specific form available from Medicare Australia. This stationary is available from Medicare Australia. Note that these forms are approved forms under the Health Insurance Act, and no other forms can be used to assign benefits without the approval of Medicare Australia. Further information about direct-billing stationary can be obtained by telephoning **132150**.

M.13.14. 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 benefit) 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 (e.g. hardship 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.

M.13.15. OVERVIEW OF THE MATERNITY ITEMS

Antenatal, intrapartum and postnatal care provided by participating midwives are covered by MBS items 82100, 82105, 82110, 82115, 82120, 82125, 82130, 82135, 82140. These items cover nine specific types of service that allow the participating midwife to:

- undertake an initial antenatal attendance of more than 40 minutes duration (item 82100)
- provide a short antenatal attendance of up to 40 minutes duration (item 82105)
- provide a long antenatal attendance of more than 40 minutes duration (item 82110);
- make an assessment of and prepare a maternity care plan for a woman across a pregnancy that has progressed beyond 20 weeks (item 82115);
- undertake management of a confinement for up to 12 hours, including delivery (item 82120);
- undertake management of a confinement in excess of 12 hours including delivery (item 82125);
- provide a short postnatal attendance of up to 40 minutes duration (item 82130);
- provide long postnatal attendance of at least 40 minutes duration (item 82135); and
- provide a comprehensive postnatal check to a woman six weeks after the birth of her baby (item 82140).

M.13.16. MATERNITY SERVICES ATTRACTING MEDICARE REBATES

Medicare Benefits are only payable for clinically relevant services. *Clinically relevant* in relation to midwifery care means a service generally accepted by the midwifery profession as necessary to the appropriate treatment of the patient's clinical condition.

Medicare benefits are only payable where the participating midwife provides care to not more than one patient on the one occasion.

Antenatal Care

Eligible maternity care plan service

There is one MBS item available for eligible midwife practitioners to undertake a comprehensive assessment of and prepare a written maternity care plan for a woman, who is not an admitted patient of a hospital, across a pregnancy that has progressed beyond 20 weeks. It is expected that the care plan would be agreed with the women and detail such things as agreed expectation, health problems and care needs and appropriate referrals, medication and diagnostic tests.

Number of services

Only one (1) midwifery care plan is payable in any pregnancy.

Antenatal Attendances

Medicare benefits are payable for an antenatal service where a midwife provides a clinically relevant service in respect of a miscarriage. Medicare benefits are not payable for an antenatal attendance associated with the confinement. The confinement items 82120 and 82125 include all associated attendances

Any clinically relevant indication that requires an antenatal attendance by a midwife on an admitted patient in hospital, but that is not associated with the confinement, will attract a Medicare benefit.

Number of services

Only one (1) initial antenatal attendance under item 82100 is payable in any pregnancy.

There is no limit attached to long and short antenatal attendances by a participating midwife. However, only clinically relevant attendances should be itemised under Medicare and services provided by participating midwives will be subject to Medicare Audit and Professional Review Processes.

Management of Confinement

The MBS includes two items for management of confinement by a participating midwife; 82120 for a confinement of up to 12 hours, and 82125 for a confinement where labour is in excess of 12 hours, and the woman's care has been transferred to another participating midwife.

Medicare benefits are payable under items 82120 and 82125 whether or not the participating midwife undertakes the delivery i.e. including where the woman's care is escalated to an obstetrician during labour or for the delivery.

Medicare benefits are only payable where the service is provided to a woman who is an admitted patient of a hospital, including a hospital birthing centre. For Medicare benefit purposes a confinement is taken to commence when the participating midwife attends a patient that is in labour and who has been admitted to the hospital for confinement and delivery. The time period for these items is the period for which the midwife is in exclusive and continuous attendance on the woman for labour, and delivery where performed.

Medicare benefits are only payable for management of confinement where the participating midwife undertaking the service has provided the patient's antenatal care or who is a member of a practice that provided the patient's antenatal care.

It is not intended that these items be claimed routinely by midwives who do not intend to undertake the delivery i.e. where the midwife has arranged beforehand for a medical practitioner to undertake the delivery. Where the midwife does not undertake the delivery it is because:

- care was transferred to a second midwife for management of labour which had exceeded 12 hours; or
- there was a clinical need to escalate care to an obstetrician or medical practitioner who provides obstetric services.

Number of services

Medicare rebates are only payable (1) confinement item 82120, and 82125 where provided, regardless of the number of participating midwives involved in the service.

Postnatal Care

In addition to the long and short antenatal attendance items for postnatal care in the first 6 weeks post delivery the MBS provides for a 6 week postnatal check, after which the woman would be referred back to her usual GP.

Number of services

Only one (1) postnatal check by a participating midwife is payable in any pregnancy.

There is no limit attached to long and short postnatal attendances by a participating midwife. However, only clinically relevant attendances should be itemised under Medicare and services provided by participating midwives will be subject to Medicare Audit and Professional Review Processes.

M.13.17. CONDITIONS GOVERNING THE PROVISION AND CLAIMING OF ITEMS**Service length and type**

Services under these items must be for the time period specified within the item descriptor.

Professional attendance for MBS items 82100, 82105, 82110, 82115, 82130, 82135, 82140 may be provided in an appropriate setting that includes but is not limited to: the woman's home, a midwifery group practice, a midwife practitioner's rooms or a medical practice.

M.13.18. REFERRAL REQUIREMENTS

A participating midwife will be able to refer women to specialist obstetricians and paediatricians as clinical services dictate.

This measure does not include referral by a midwife for allied health care. If a participating midwife refers a patient to an allied health practitioner, no benefits would be payable for that service.

Medicare benefits are not payable specifically for services provided by a lactation consultant at this time. Medicare benefits would be payable for breast feeding support provide as part of the postnatal care by the participating midwife.

A referral is valid for 12 months to cover the confinement (antenatal, birthing and postnatal care for 6 weeks post delivery). Should there be a new pregnancy in that period, a new referral will be required.

A new pregnancy represents a new episode of care.

A referral to a specialist must be in writing in the form of a letter or a note to the specialist and must be signed and dated by the referring midwife. The referral must contain any information relevant to the patient and the specialist must have received the referral on or prior to providing a specialist consultation.

If a specialist provides a consultation without a referral, the specialist's consultation would not attract Medicare benefits at the specialist rate.

There are exemptions from this requirement in an emergency if the specialist considers the patient's condition requires immediate attention without a referral. In that situation, the specialist is taken to be the referring practitioner.

If a referral is lost, stolen or destroyed, the midwife would need to provide a replacement referral as soon as is practicable after the service is provided.

If the woman is a privately admitted patient of a hospital a letter or note is not required. The referring midwife would make a notation in the woman's hospital, which he or she would sign, approving the referral.

A referral is not required to transfer a woman's care during the intra-partum period under items 16527 and 16528. The midwife would make a signed notation in the woman's clinical record approving the transfer of care

A referral is not required to refer the woman back to her GP after the 6 week postnatal period. The midwife would provide a discharge summary to the GP outlining her maternity history and any relevant clinical issues, which would also be recorded on the patient's notes.

M.13.19. REQUESTING REQUIREMENTS**Pathology Services*****Determination of Necessity of Service***

The participating midwife requesting a pathology service for a woman must determine that the pathology service is necessary.

Request for Service

The service may only be provided in response to a request from the treating practitioner and the request must be in writing (or, if oral, confirmed in writing within fourteen days).

Pathology Services approved for participating midwives

<ul style="list-style-type: none"> FBC (item 65070) 	<ul style="list-style-type: none"> vaginal /anal swab/GBS (69312)* varicella 69384 - 69401 (antibody test) parvo virus 69384 - 69401
<ul style="list-style-type: none"> Hb (item 65060) 	<ul style="list-style-type: none"> rubella titre } syphilis } Hep B/C } items 69405, 69408, 69411, 69413 or 69415 HIV }
<ul style="list-style-type: none"> Group and antibodies (items 65090, 65093, 65096) glucose load (items 66545, 66548) 	<ul style="list-style-type: none"> Serum Bilirubin (SBR); 66500
<ul style="list-style-type: none"> Downs Syndrome/ Spina Bifida (items 66743, 66750, 66751) 	<ul style="list-style-type: none"> Direct Coombs; 65114
<ul style="list-style-type: none"> eye swab (69303) 	<ul style="list-style-type: none"> Blood glucose level (item 66500);
<ul style="list-style-type: none"> skin swab (69306) 	<ul style="list-style-type: none"> Cord PH and gases cord (O2 and CO2) (Item 66566)
<ul style="list-style-type: none"> skin scrapings (69309) 	<ul style="list-style-type: none"> Group and Hold (item 65099)
<ul style="list-style-type: none"> Chlamydia (item 69316) 	<ul style="list-style-type: none"> Coagulation Studies (items 65129, 65070)
<ul style="list-style-type: none"> Gonorrhea (item 69317) 	<ul style="list-style-type: none"> Mid stream urine (item 69324)
<ul style="list-style-type: none"> Cervical Pap tests (item 73053) 	<ul style="list-style-type: none"> HCG (item 73529)

Diagnostic Imaging Services

Determination of Necessity of Service

The participating midwife requesting a diagnostic imaging service for a woman must determine that the diagnostic imaging service is necessary for the appropriate professional care of the patient.

Request for Service

The service may only be provided in response to a request from the treating practitioner, and the request must be in writing, signed and dated.

The request does not have to be in a particular form. However, legislation provides that a request must be in writing and contain sufficient information, in terms that are generally understood by the profession, to clearly identify the item/s of service requested. This includes, where relevant, noting on the request the clinical indication(s) for the requested service. The provision of additional relevant clinical information can often assist the service provider, and enhance the overall service provided to the patient.

It is not necessary that a written request for a diagnostic imaging service be addressed to a particular provider or that, if the request is addressed to a particular provider, the service must be rendered by that provider.

A single request may be used to order a number of diagnostic imaging services. However, all services provided under this request must be rendered within seven days after rendering the first service.

Ultrasound:

➤ Routine morphology scan (item 55706)	➤ Nuchal Translucency (item 55707)
➤ Early dating scan (item 55700)	➤ Post 22 weeks scan (item 55718)
➤ Scan at 12-16 weeks (item 55704)	

M.14.1. PARTICIPATING NURSE PRACTITIONERS SERVICES - OVERVIEW

As at 1 November 2010, Medicare benefits are payable for services provided by privately practising participating nurse practitioners in collaboration with other health care providers. Participating nurse practitioners can also request certain pathology and diagnostic imaging services for their patients and refer patients to specialist, as the clinical need arises. The nurse practitioner services that attract a Medicare benefit are identified in the Medicare Benefits Schedule (MBS) by an item number and the each item describes the service requirements and schedule fee.

M.14.2. ELIGIBLE NURSE PRACTITIONERS

Under the legislation, to be an eligible nurse practitioner the nurse practitioner must be registered or authorised (however described) under State and Territory law. The nurse practitioner must also demonstrate that he or she has the appropriate qualifications and experience to meet the registration standard developed by the Nursing and Midwifery Board of Australia (NMBA).

This standard was developed for the purposes of the National Registration and Accreditation Scheme (NRAS), a single regulation and accreditation scheme for health professionals, including nurse practitioners. Additional information is available at the Australian Health Practitioners Regulation Agency (AHPRA) website at: <http://www.ahpra.gov.au/index.php>

M.14.3. PROVIDER NUMBERS

To access the Medicare arrangements, eligible nurse practitioners will need to apply to Medicare Australia for a provider number. A separate provider number is required for each location at which a nurse practitioner practices.

Advice about registering with Medicare Australia to provide nurse practitioner services using items 82200 to 82215 inclusive, is available from the Medicare Australia provider inquiry line on 132 150.

Medicare provider application forms for nurse practitioners can be downloaded from the following site: www.medicareaustralia.gov.au

M.14.4. PARTICIPATING NURSE PRACTITIONERS

To provide services under Medicare, the legislation requires that a nurse practitioner be a participating nurse practitioner. A participating nurse practitioner is an eligible nurse practitioner who has a Medicare provider number and who provides Medicare services in a collaborative arrangement or collaborative arrangements with one or more medical practitioners, of a kind or kinds specified in the regulations.

M.14.5. COLLABORATIVE ARRANGEMENTS

Under the Medicare program collaboration is having arrangements in place with a medical practitioner/s to consult, refer or transfer care as clinical needs dictate, to ensure safe, high quality maternity care. Under Medicare a collaborative arrangement can be with any medical practitioner.

Collaborative arrangement can be established in the following ways:

- a) being employed or engaged by 1 or more specified medical practitioners or by an entity that employs or engages 1 or more specified medical practitioners; OR

- b) receiving patients by referral in writing to the nurse practitioner for treatment from a specified medical practitioner, OR
- c) having a signed written agreement with one or more specified medical practitioners, OR
- d) having an arrangement with and acknowledged by at least one specified medical practitioners. This includes keeping comprehensive notes on all instances of consultation, referral and transfer of care, diagnostic tests requested and the test results and providing the collaborating practitioner/s with those results.

The legislation requires that collaborative arrangements must be in place at the time the participating nurse practitioner provides the service. The legislation requires that for each kind of collaborative arrangement, at least one medical practitioner is needed; it is not possible for the nurse practitioner to have a collaborative arrangement with an entity such as a health service.

- a) Being employed or engaged by a medical practice or an entity
An entity may refer to a hospital or community health centre. For a nurse practitioner to have a collaborative arrangement in these circumstances, that nurse practitioner must be employed or engaged by an entity that also employs or engages 1 or more specified medical practitioners.

The terms employ or engage covers both employees and contractors. This will cover an eligible nurse practitioner who is employed or engaged by a medical practice so long as that medical practice employs or engages at least one medical practitioner.

There must be at least one specified medical practitioner employed or engaged by the entity each time the nurse practitioner renders a service/performs treatment. However, there is no requirement that the consultation, referral or transfer of care must always be to the medical practitioner(s) employed/engaged by the entity.

- b) Referral from a medical practitioner
A participating nurse practitioner's patient will be able to access the MBS and PBS if a patient has been referred in writing to the nurse practitioner by a specified medical practitioner. The arrangement must provide for consultation, referral and transfer of care should the clinical need arise.
- c) Written agreement with a medical practitioner
A nurse practitioner's patient will be able to access the MBS and PBS if the nurse practitioner has a written agreement in place with one or more doctors. The agreement must be signed by the nurse practitioner and a doctor. The arrangement must deal with consultation, referral and transfer to a doctor.
- d) Arrangement with, acknowledged by a medical practitioner.
Evidence of 'acknowledgement' by a medical practitioner for each patient for whom the nurse practitioner provides care is a requirement to ensure that the medical practitioner being named understands and accepts the collaborative arrangement.

The acknowledgement does not have to be obtained on an individual patient basis. This means that, for example, a nurse practitioner could obtain an acknowledgement from a specified medical practitioner that he or she will be the collaborating medical practitioner for some or all of the nurse practitioner's patients. Arrangements to collaborate could be obtained in a number of ways including signing of documents, email or fax confirmation, or verbal acknowledgement which the nurse practitioner documents in their written records.

The nurse practitioner is required to record in written records any communications in regard to consultations, referral and transfer of the patient's care with the medical practitioner, including information that has been forwarded to the medical practitioner. The nurse practitioner is also required to send a copy of all pathology and diagnostic imaging results to a named medical practitioner and to record in the nurse practitioner's written records when this occurs (however, there is no requirement that the nurse practitioner consult with a medical practitioner in relation to every test result). The purpose of sharing records with the collaborating medical practitioner is to prevent duplication of services and to ensure continuity of care.

Arrangements to collaborate could be obtained in a number of ways including signing of documents, email or fax confirmation, or verbal acknowledgement which the nurse practitioner documents in their written records.

M.14.6. SCHEDULE FEES AND MEDICARE BENEFITS

Each nurse practitioner service is identified in the MBS by an item number. The fee set for any item in the MBS is known as the "Schedule fee". The Schedule fee and Medicare benefit for each service is listed in the item description. The Medicare benefit for nurse practitioner services rendered to non-admitted patients is 85% of the Schedule fee.

M.14.7. WHERE MEDICARE BENEFITS ARE NOT PAYABLE

Medicare benefits are not available:

- a. where the service rendered does not meet the item description and associated requirements;
- b. where the nurse practitioner service is not personally performed by the participating nurse practitioner;
- c. for any time period in the consultation periods when the patient is not receiving active attention e.g. the time the provider may take to travel to the patient's home or where the patient is resting between blood pressure readings;
- d. services provided where the patient is not in attendance, such as the issuing of repeat prescriptions;
- e. for telephone attendances; and
- f. group sessions.

The fee charged under Medicare must not include the cost of services that are not part of the MBS service being claimed. Medicare benefits are not payable for good or appliances associated with the service, such as bandages or other skin dressings.

Unless the Minister otherwise directs, Medicare benefits are not payable where funding has already been provided under an arrangement with the Commonwealth, state or a local governing body.

M.14.8. BILLING OF THE PATIENT

Where the nurse practitioner bills the patient for medical services rendered, the patient needs a properly itemised account/receipt to enable a claim to be made for Medicare benefits.

Under the provisions of the Health Insurance Act and Regulations, Medicare benefits are not payable in respect of a professional 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 the service, the following particulars:

- (a) Patient's name;
- (b) The date on which the professional service was rendered;
- (c) An item number or a description of the professional service sufficient to identify the item that relates to that service, including an indication where the service is rendered to a person while hospital treatment is provided in a hospital "admitted patient" immediately preceding the description of the service or an asterisk "*" directly after an item number where used;
- (d) The name and practice address and provider number of the participating nurse practitioner who actually rendered the service; (where the participating nurse 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).

Only one original itemised account should be issued in respect of any one service and any 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".

M.14.9. ASSIGNMENT OF BENEFITS (DIRECT-BILLING ARRANGEMENTS)

Under the Health Insurance Act the 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 participating nurse practitioner direct-bills, the participating nurse practitioner 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 card number must be quoted on all direct bill forms for that patient.

The basic 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 Subsection 19(6) of the Health Insurance Act.

The nurse practitioner must include the particulars relating to the professional service out on the assignment form before the patient signs the form and ensure that 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 nurse practitioner, nurse practitioner'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.

The administration of the direct billing arrangements under Medicare as well as the payment of Medicare benefits on patient claims is the responsibility of Medicare Australia. Any enquiries in regard to these matters should therefore be directed to Medicare offices or enquiry points.

M.14.10. ASSIGNMENT OF BENEFIT FORMS

Participating nurse practitioners wishing to direct-bill are required to use a specific form available from Medicare Australia. This stationary is available from Medicare Australia. Note that these forms are approved forms under the Health Insurance Act, and no other forms can be used to assign benefits without the approval of Medicare Australia. Further information about direct-billing stationary can be obtained by telephoning 132150.

M.14.11. 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 benefit) 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 (e.g. hardship 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.

M.14.12. OVERVIEW OF THE NURSE PRACTITIONER ITEMS

Services provided by participating nurse practitioners are covered by MBS items 82200, 82205, 82210, 82215. These items cover four time-tiered specific types of service that allow the participating nurse practitioner to perform a:

professional attendance for an obvious problem, straight forward in nature, with limited examination and management required (82200)

professional attendance for a patient presenting with clinical signs and symptoms with an easily identifiable underlying cause following a short consultation lasting less than 20 minutes duration (item 82205)

professional attendance for a patient presenting with clinical signs and symptoms with no obvious underlying cause requiring a more detailed consultation lasting at least 20 minutes duration (item 82210);

professional attendance for a patient presenting with multiple clinical signs and symptoms with the possibility of multiple causes and outcomes requiring an extensive consultation of at least 40 minutes (item 82215);

M.14.13. NURSE PRACTITIONER SERVICES ATTRACTING MEDICARE REBATES

Medicare Benefits are only payable for clinically relevant services. Clinically relevant in relation to nurse practitioner care means a service generally accepted by the nursing profession as necessary to the appropriate treatment of the patient's clinical condition.

Medicare benefits are only payable where the participating nurse practitioner provides care to not more than one patient on one occasion.

M.14.14. CONDITIONS GOVERNING THE PROVISION AND CLAIMING OF ITEMS

Service length and type

Services under these items must be for the time period specified within the item descriptor.

Professional attendance for MBS items 82200, 82205, 82210, 82215, may be provided in an appropriate setting that includes but is not limited to: the patient's home, a nurse practitioner group practice, a nurse practitioner's rooms or a medical practice.

M.14.15. REFERRAL REQUIREMENTS

A participating nurse practitioner will be able to refer private patients to a specialist and consultant physician as clinical services dictate.

This measure does not include referral by a nurse practitioner for allied health care. If a participating nurse practitioner refers a patient to an allied health practitioner, no benefits would be payable for that service provided by the allied health professional.

A referral given by a participating nurse practitioner is valid until 12 months after the first service given in accordance with the referral.

If the referral is lost, stolen or destroyed, the nurse practitioner would need to provide a replacement referral as soon as is practicable after the service is provided.

A referral to a specialist must be in writing in the form of a letter or a note to the specialist and must be signed and dated by the referring nurse practitioner. The referral must contain any information relevant to the patient and the specialist must have received the referral on or prior to providing a specialist consultation.

There are exemptions from this requirement in an emergency if the specialist considers the patient's condition requires immediate attention without a referral. In that situation, the specialist is taken to be the referring practitioner.

M.14.16. REQUESTING REQUIREMENTS

Pathology Services

Determination of Necessity of Service

The participating nurse practitioner requesting a pathology service for a patient must determine that the pathology service is necessary.

Request for Service

The service may only be provided in response to a request from the treating practitioner and the request must be in writing (or, if oral, confirmed in writing within fourteen days).

Pathology Services approved for participating nurse practitioners

Nurse practitioners may request MBS pathology items 65060 – 73810 (inclusive). Requesting pathology services must be within the nurse practitioner's scope of practice.

Further information

For further information about Medicare Benefits Schedule items, please go to the Department of Health and Ageing's website at www.health.gov.au/mbsonline.

Diagnostic Imaging Services

Determination of Necessity of Service

The participating nurse practitioner requesting a diagnostic imaging service for a patient must determine that the diagnostic imaging service is necessary for the appropriate professional care of the patient.

Request for Service

The service may only be provided in response to a request from the treating nurse practitioner, and the request must be in writing, signed and dated. The legislation provides that a request must be in writing and contain sufficient information, in terms that are generally understood by the profession, to clearly identify the item/s of service requested. This includes, where relevant, noting on the request the clinical indication(s) for the requested service. The provision of additional relevant clinical information can often assist the service provider, and enhance the overall service provided to the patient.

It is not necessary that a written request for a diagnostic imaging service be addressed to a particular provider or that, if the request is addressed to a particular provider, the service must be rendered by that provider.

A single request may be used to order a number of diagnostic imaging services. However, all services provided under this request must be rendered within seven days after rendering the first service.

Ultrasound:

Subgroup 1: General Ultrasound

MBS item: 55036 (abdomen)

MBS items: 55070, 55076 (breast)

Subgroup 4: Urological

MBS item: 55600 (prostate)

Subgroup 5: Obstetric and Gynaecological

MBS item: 55768

Subgroup 6: Musculoskeletal

MBS items: 55800, 55804, 55808, 55812, 55816, 55820, 55824, 55828, 55832, 55836, 55840, 55844, 55848, 55850, 55852

X-ray:

Subgroup 1: Radiographic examination of the extremities
MBS items: 57509, 57515, 57521

subgroup 6: Radiographic examination of the thoracic region
MBS items: 58503 – 58527 (inclusive)

Schedules of Services

Each professional service contained in the Schedule 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.

10952	<p>AUDIOLOGY Audiology health service provided to a person by an eligible audiologist if:</p> <ul style="list-style-type: none"> (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible audiologist by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible audiologist gives a written report to the referring medical practitioner mentioned in paragraph (c): <ul style="list-style-type: none"> (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year <i>(See para M3.1 and M3.2 and M3.3 and M3.4 and M3.5 of explanatory notes to this Category)</i> <p>Fee: \$61.10 Benefit: 85% = \$51.95</p>
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10953	<p>EXERCISE PHYSIOLOGY Exercise physiology service provided to a person by an eligible exercise physiologist if:</p> <ul style="list-style-type: none"> (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible exercise physiologist by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible exercise physiologist gives a written report to the referring medical practitioner mentioned in paragraph (c): <ul style="list-style-type: none"> (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year <i>(See para M3.1 and M3.2 and M3.3 and M3.4 and M3.5 of explanatory notes to this Category)</i> <p>Fee: \$61.10 Benefit: 85% = \$51.95</p>
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10954	<p>DIETETICS SERVICES</p> <p>Dietetics health service provided to a person by an eligible dietitian if:</p> <p>(a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and</p> <p>(b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and</p> <p>(c) the person is referred to the eligible dietitian by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and</p> <p>(d) the person is not an admitted patient of a hospital; and</p> <p>(e) the service is provided to the person individually and in person; and</p> <p>(f) the service is of at least 20 minutes duration; and</p> <p>(g) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (c):</p> <p>(i) if the service is the only service under the referral - in relation to that service; or</p> <p>(ii) if the service is the first or the last service under the referral - in relation to that service; or</p> <p>(iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and</p> <p>(h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year (See para M3.1 and M3.2 and M3.3 and M3.4 and M3.5 of explanatory notes to this Category)</p> <p>Fee: \$61.10 Benefit: 85% = \$51.95</p>
10956	<p>MENTAL HEALTH SERVICE</p> <p>Mental health service provided to a person by an eligible mental health worker if:</p> <p>(a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and</p> <p>(b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and</p> <p>(c) the person is referred to the eligible mental health worker by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and</p> <p>(d) the person is not an admitted patient of a hospital; and</p> <p>(e) the service is provided to the person individually and in person; and</p> <p>(f) the service is of at least 20 minutes duration; and</p> <p>(g) after the service, the eligible mental health worker gives a written report to the referring medical practitioner mentioned in paragraph (c):</p> <p>(i) if the service is the only service under the referral - in relation to that service; or</p> <p>(ii) if the service is the first or the last service under the referral - in relation to that service; or</p> <p>(iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and</p> <p>(h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year (See para M3.1 and M3.2 and M3.3 and M3.4 and M3.5 of explanatory notes to this Category)</p> <p>Fee: \$61.10 Benefit: 85% = \$51.95</p>

10962	<p>PODIATRY</p> <p>Podiatry health service provided to a person by an eligible podiatrist if:</p> <ul style="list-style-type: none"> (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible podiatrist by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible podiatrist gives a written report to the referring medical practitioner mentioned in paragraph (c): <ul style="list-style-type: none"> (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year (See para M3.1 and M3.2 and M3.3 and M3.4 and M3.5 of explanatory notes to this Category) <p>Fee: \$61.10 Benefit: 85% = \$51.95</p>
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10964	<p>CHIROPRACTIC SERVICE</p> <p>Chiropractic health service provided to a person by an eligible chiropractor if:</p> <ul style="list-style-type: none"> (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible chiropractor by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible chiropractor gives a written report to the referring medical practitioner mentioned in paragraph (c): <ul style="list-style-type: none"> (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year (See para M3.1 and M3.2 and M3.3 and M3.4 and M3.5 of explanatory notes to this Category) <p>Fee: \$61.10 Benefit: 85% = \$51.95</p>
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SPEECH PATHOLOGY

Speech pathology health service provided to a person by an eligible speech pathologist if:

- (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and
- (b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and
- (c) the person is referred to the eligible speech pathologist by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and
- (d) the person is not an admitted patient of a hospital; and
- (e) the service is provided to the person individually and in person; and
- (f) the service is of at least 20 minutes duration; and
- (g) after the service, the eligible speech pathologist gives a written report to the referring medical practitioner mentioned in paragraph (c):
 - (i) if the service is the only service under the referral - in relation to that service; or
 - (ii) if the service is the first or the last service under the referral - in relation to that service; or
 - (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and
- (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year
(See para M3.1 and M3.2 and M3.3 and M3.4 and M3.5 of explanatory notes to this Category)

10970

Fee: \$61.10**Benefit:** 85% = \$51.95

MISCELLANEOUS	TELEHEALTH SUPPORT SERVICE
	GROUP M12 - SERVICES PROVIDED BY A PRACTICE NURSE OR REGISTERED ABORIGINAL HEALTH WORKER ON BEHALF OF A MEDICAL PRACTITIONER
	<i>SUBGROUP 1 - TELEHEALTH SUPPORT SERVICE ON BEHALF OF A MEDICAL PRACTITIONER</i>
10983	<p>Service by a practice nurse or Aboriginal health worker provided on behalf of, and under the supervision of, a medical practitioner that requires the provision of clinical support to a patient who is:</p> <p>a) located at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; or</p> <p>b) located outside an inner metropolitan area, not being an admitted patient;</p> <p>and who is participating in a video consultation with a specialist or consultant physician.</p> <p><i>(See para M12.6 of explanatory notes to this Category)</i></p> <p>Fee: \$31.80 Benefit: 100% = \$31.80</p>
	<i>SUBGROUP 2 - TELEHEALTH SUPPORT SERVICE ON BEHALF OF A MEDICAL PRACTITIONER AT A RESIDENTIAL AGED CARE FACILITY</i>
10984	<p>Service by a practice nurse or Aboriginal health worker provided on behalf of, and under the supervision of, a medical practitioner that requires the provision of clinical support to a patient who is:</p> <p>a) a care recipient receiving care in a residential aged care service (other than a self-contained unit); or</p> <p>b) at consulting rooms situated within such a complex if the patient is a care recipient receiving care in a residential aged care service (excluding accommodation in a self-contained unit);</p> <p>and who is participating in a video consultation with a specialist or consultant physician.</p> <p><i>(See para M12.6 of explanatory notes to this Category)</i></p> <p>Fee: \$31.80 Benefit: 100% = \$31.80</p>
	<i>SUBGROUP 3 - SERVICES PROVIDED BY A PRACTICE NURSE OR REGISTERED ABORIGINAL HEALTH WORKER ON BEHALF OF A MEDICAL PRACTITIONER</i>
10986	<p>Service provided by a practice nurse or registered Aboriginal health worker being the provision of a health assessment for a patient who is receiving or has received their four year old immunisation, if:</p> <p>(a) the service is provided on behalf of, and under the supervision of, a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), and</p> <p>(b) the person is not an admitted patient of a hospital.</p> <p>Not being an attendance on a patient in respect of whom a payment has already been made under this item or item 701, 703, 705, 707. Benefits are payable on one occasion only for each eligible patient</p> <p><i>(See para M12.3 of explanatory notes to this Category)</i></p> <p>Fee: \$57.10 Benefit: 100% = \$57.10</p>
10987	<p>Follow up service provided by a practice nurse or registered Aboriginal health worker, on behalf of a medical practitioner, for an Indigenous person who has received a health assessment if:</p> <p>a) The service is provided on behalf of and under the supervision of a medical practitioner; and</p> <p>b) the person is not an admitted patient of a hospital; and</p> <p>c) the service is consistent with the needs identified through the health assessment;</p> <p>- to a maximum of 10 services per patient in a calendar year</p> <p><i>(See para M12.4 of explanatory notes to this Category)</i></p> <p>Fee: \$23.55 Benefit: 100% = \$23.55</p>
10988	<p>Immunisation provided to a person by a registered Aboriginal Health Worker if:</p> <p>(a) the immunisation is provided on behalf of, and under the supervision of, a medical practitioner; and</p> <p>(b) the person is not an admitted patient of a hospital.</p> <p><i>(See para M12.1 of explanatory notes to this Category)</i></p> <p>Fee: \$11.80 Benefit: 100% = \$11.80</p>
10989	<p>Treatment of a person's wound (other than normal aftercare) provided by a registered Aboriginal Health Worker if:</p> <p>(a) the treatment is provided on behalf of, and under the supervision of, a medical practitioner; and</p> <p>(b) the person is not an admitted patient of a hospital.</p> <p><i>(See para M12.2 of explanatory notes to this Category)</i></p> <p>Fee: \$11.80 Benefit: 100% = \$11.80</p>

GROUP M1 - MANAGEMENT OF BULK-BILLED SERVICES	
10990	<p>A medical service to which an item in this table (other than this item or item 10991) applies if:</p> <ul style="list-style-type: none"> (a) the service is an unreferral service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in respect of the fees for: <ul style="list-style-type: none"> (i) this item; and (ii) the other item in this table applying to the service <p><i>(See para M1.1 of explanatory notes to this Category)</i></p> <p>Fee: \$6.90 Benefit: 85% = \$5.90</p>
10991	<p>A medical service to which an item in this table (other than this item or item 10990) applies if:</p> <ul style="list-style-type: none"> (a) the service is an unreferral service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in respect of the fees for: <ul style="list-style-type: none"> (i) this item; and (ii) the other item in this table applying to the service; and (e) the service is provided at, or from, a practice location in: <ul style="list-style-type: none"> (i) a regional, rural or remote area; or (ii) Tasmania; or (iii) A geographical area included in any of the following SSD spatial units: <ul style="list-style-type: none"> (A) Beaudesert Shire Part A (B) Belconnen (C) Darwin City (D) Eastern Outer Melbourne (E) East Metropolitan, Perth (F) Frankston City (G) Gosford-Wyong (H) Greater Geelong City Part A (I) Gungahlin-Hall (J) Ipswich City (part in BSD) (K) Litchfield Shire (L) Melton-Wyndham (M) Mornington Peninsula Shire (N) Newcastle (O) North Canberra (P) Palmerston-East Arm (Q) Pine Rivers Shire (R) Queanbeyan (S) South Canberra (T) South Eastern Outer Melbourne (U) Southern Adelaide (V) South West Metropolitan, Perth (W) Thuringowa City Part A (X) Townsville City Part A (Y) Tuggeranong (Z) Weston Creek-Stromlo (ZA) Woden Valley (ZB) Yarra Ranges Shire Part A; or (iv) the geographical area included in the SLA spatial unit of Palm Island (AC) <p><i>(See para M1.1 of explanatory notes to this Category)</i></p> <p>Fee: \$10.45 Benefit: 85% = \$8.90</p>

A medical service to which item 597, 598, 599, 600, 5003, 5010, 5023, 5028, 5043, 5049, 5063, 5067, 5220, 5223, 5227, 5228, 5260, 5263, 5265 or 5267 applies if:

- (a) the service is an unreferral service; and
- (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and
- (c) the person is not an admitted patient of a hospital; and
- (d) the service is not provided in consulting rooms; and
- (e) the service is provided in one of the following eligible areas:
 - (i) a regional, rural or remote area; or
 - (ii) Tasmania; or
 - (iii) A geographical area included in any of the following SSD spatial units:
 - (A) Beaudesert Shire Part A
 - (B) Belconnen
 - (C) Darwin City
 - (D) Eastern Outer Melbourne
 - (E) East Metropolitan, Perth
 - (F) Frankston City
 - (G) Gosford-Wyong
 - (H) Greater Geelong City Part A
 - (I) Gungahlin-Hall
 - (J) Ipswich City (part in BSD)
 - (K) Litchfield Shire
 - (L) Melton-Wyndham
 - (M) Mornington Peninsula Shire
 - (N) Newcastle
 - (O) North Canberra
 - (P) Palmerston-East Arm
 - (Q) Pine Rivers Shire
 - (R) Queanbeyan
 - (S) South Canberra
 - (T) South Eastern Outer Melbourne
 - (U) Southern Adelaide
 - (V) South West Metropolitan, Perth
 - (W) Thuringowa City Part A
 - (X) Townsville City Part A
 - (Y) Tuggeranong
 - (Z) Weston Creek-Stromlo
 - (ZA) Woden Valley
 - (ZB) Yarra Ranges Shire Part A; or
 - (iv) the geographical area included in the SLA spatial unit of Palm Island (AC)
- (f) the service is provided by, or on behalf of, a medical practitioner whose practice location is not in an eligible area; and
- (g) the service is bulk billed in respect of the fees for:
 - (i) this item; and
 - (ii) the other item in this table applying to the service.

(See para M1.2 of explanatory notes to this Category)

10992

Fee: \$10.45

Benefit: 85% = \$8.90

MISCELLANEOUS	MISCELLANEOUS
	<p>GROUP M12 - SERVICES PROVIDED BY A PRACTICE NURSE OR REGISTERED ABORIGINAL HEALTH WORKER ON BEHALF OF A MEDICAL PRACTITIONER</p>
	<p><i>SUBGROUP 3 - SERVICES PROVIDED BY A PRACTICE NURSE OR REGISTERED ABORIGINAL HEALTH WORKER ON BEHALF OF A MEDICAL PRACTITIONER</i></p>
10997	<p>Service provided to a person with a chronic disease by a practice nurse or registered Aboriginal Health Worker if:</p> <ul style="list-style-type: none"> (a) the service is provided on behalf of and under the supervision of a medical practitioner; and (b) the person is not an admitted patient of a hospital; and (c) the person has a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan in place; and (d) the service is consistent with the GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan <p>to a maximum of 5 services per patient in a calendar year <i>(See para M12.5 of explanatory notes to this Category)</i></p> <p>Fee: \$11.80 Benefit: 100% = \$11.80</p>

MISCELLANEOUS	MISCELLANEOUS
	GROUP M6 - PSYCHOLOGICAL THERAPY SERVICES
Amend 80000	<p>Professional attendance for the purpose of providing psychological assessment and therapy for a mental disorder by a clinical psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting more than 30 minutes but less than 50 minutes, where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.</p> <p>These therapies are time limited, being deliverabl, in up to ten planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply).</p> <p>Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012).</p> <p>(Professional attendance at consulting rooms) (See para M6.1 of explanatory notes to this Category) Fee: \$97.90 Benefit: 85% = \$83.25</p>
80005	<p>Professional attendance at a place other than consulting rooms.</p> <p>As per the service requirements outlined for item 80000. (See para M6.1 of explanatory notes to this Category) Fee: \$122.35 Benefit: 85% = \$104.00</p>
Amend 80010	<p>Professional attendance for the purpose of providing psychological assessment and therapy for a mental disorder by a clinical psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting at least 50 minutes, where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.</p> <p>These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply).</p> <p>Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012).</p> <p>(Professional attendance at consulting rooms) (See para M6.1 of explanatory notes to this Category) Fee: \$143.70 Benefit: 85% = \$122.15</p>
80015	<p>Professional attendance at a place other than consulting rooms</p> <p>As per the service requirements outlined for item 80010. (See para M6.1 of explanatory notes to this Category) Fee: \$168.15 Benefit: 85% = \$142.95</p>
80020	<p>Professional attendance for the purpose of providing psychological therapy for a mental disorder by a clinical psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.</p> <p>These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80120, 80145 and 80170 apply).</p> <p>- GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT (See para M6.1 of explanatory notes to this Category) Fee: \$36.50 Benefit: 85% = \$31.05</p>

GROUP M7 - FOCUSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	
Amend 80100	<p>Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.</p> <p>These services are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply).</p> <p>Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012).</p> <p>(Professional attendance at consulting rooms) (See para M7.1 of explanatory notes to this Category) Fee: \$69.35 Benefit: 85% = \$58.95</p>
80105	<p>Professional attendance at a place other than consulting rooms.</p> <p>As per the psychologist service requirements outlined for item 80100. (See para M7.1 of explanatory notes to this Category) Fee: \$94.35 Benefit: 85% = \$80.20</p>
Amend 80110	<p>Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.</p> <p>These services are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply).</p> <p>Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012).</p> <p>(Professional attendance at consulting rooms) (See para M7.1 of explanatory notes to this Category) Fee: \$97.90 Benefit: 85% = \$83.25</p>
80115	<p>Professional attendance at a place other than consulting rooms.</p> <p>As per the psychologist service requirements outlined for item 80110. (See para M7.1 of explanatory notes to this Category) Fee: \$122.95 Benefit: 85% = \$104.55</p>
80120	<p>Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.</p> <p>These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80020, 80145 and 80170 apply).</p> <p>GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT (See para M7.1 of explanatory notes to this Category) Fee: \$25.00 Benefit: 85% = \$21.25</p>

EXERCISE PHYSIOLOGY SERVICE – ASSESSMENT FOR GROUP SERVICES

Exercise physiology health service provided to a person by an eligible exercise physiologist for the purposes of ASSESSING a person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs, and preparing the person for the group services, if:

- (a) the service is provided to a person who has type 2 diabetes; and
- (b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP Management Plan [ie item 721 or 732, or if the person is a resident of an aged care facility, their medical practitioner has contributed to a multidisciplinary care plan [ie item 731]; and
- (c) the person is referred to an eligible exercise physiologist by the medical practitioner using a referral form that has been issued by the Department of Health and Ageing, or a referral form that contains all the components of the form issued by the Department; and
- (d) the person is not an admitted patient of a hospital; and
- (e) the service is provided to the person individually and in person; and
- (f) the service is of at least 45 minutes duration; and
- (g) after the service, the eligible exercise physiologist gives a written report to the referring medical practitioner mentioned in paragraph (c); and
- (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit.

Benefits are payable **once** only in a calendar year for this or any other Assessment for Group Services item (including services to which items 81100, 81110 and 81120 apply).

(See para M9.1 and M9.2 and M9.3 and M9.4 and M9.6 and M9.7 of explanatory notes to this Category)

81110

Fee: \$78.35**Benefit:** 85% = \$66.60**EXERCISE PHYSIOLOGY SERVICE – GROUP SERVICE**

Exercise physiology health service provided to a person by an eligible exercise physiologist, as a GROUP SERVICE for the management of type 2 diabetes if:

- (a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120; and
- (b) the service is provided to a person who is part of a group of between 2 and 12 patients inclusive; and
- (c) the person is not an admitted patient of a hospital; and
- (d) the service is provided to a person involving the personal attendance by an eligible exercise physiologist; and
- (e) the service is of at least 60 minutes duration; and
- (f) after the last service in the group services program provided to the person under items 81105, 81115 or 81125, the eligible exercise physiologist prepares, or contribute to, a written report to be provided to the referring medical practitioner; and
- (g) an attendance record for the group is maintained by the eligible exercise physiologist; and
- (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit;

- to a maximum of eight GROUP SERVICES (including services to which items 81105, 81115 and 81125 apply) in a calendar year.

(See para M9.1 and M9.2 and M9.3 and M9.5 and M9.6 and M9.7 of explanatory notes to this Category)

81115

Fee: \$19.55**Benefit:** 85% = \$16.65

DIETETICS SERVICE – ASSESSMENT FOR GROUP SERVICES

Dietetics health service provided to a person by an eligible dietitian for the purposes of ASSESSING a person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs, and preparing the person for the group services, if:

- (a) the service is provided to a person who has type 2 diabetes; and
- (b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP Management Plan [ie item 721 or 732], or if the person is a resident of an aged care facility, their medical practitioner has contributed to a multidisciplinary care plan [ie item 731]; and
- (c) the person is referred to an eligible dietitian by the medical practitioner using a referral form that has been issued by the Department of Health and Ageing, or a referral form that contains all components of the form issued by the Department; and
- (d) the person is not an admitted patient of a hospital; and
- (e) the service is provided to the person individually and in person; and
- (f) the service is of at least 45 minutes duration; and
- (g) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (c); and
- (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit.

Benefits are payable **once** only in a calendar year for this or any other Assessment for Group Services item (including services to which items 81100, 81110 and item 81120 apply).

(See para M9.1 and M9.2 and M9.3 and M9.4 and M9.6 and M9.7 of explanatory notes to this Category)

81120

Fee: \$78.35

Benefit: 85% = \$66.60

DIETETICS SERVICE – GROUP SERVICE

Dietetics health service provided to a person by an eligible dietitian, as a GROUP SERVICE for the management of type 2 diabetes if:

- (a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120; and
- (b) the service is provided to a person who is part of a group of between 2 and 12 patients inclusive; and
- (c) the person is not an admitted patient of a hospital; and
- (d) the service is provided to a person involving the personal attendance by an eligible dietitian; and
- (e) the service is of at least 60 minutes duration; and
- (f) after the last service in the group services program provided to the person under items 81105, 81115 or 81125, the eligible dietitian prepares, or contribute to, a written report to be provided to the referring medical practitioner; and
- (g) an attendance record for the group is maintained by the eligible dietitian; and
- (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit;

- to a maximum of eight GROUP SERVICES (including services to which items 81105, 81115 and 81125 apply) in a calendar year.

(See para M9.1 and M9.2 and M9.3 and M9.5 and M9.6 and M9.7 of explanatory notes to this Category)

81125

Fee: \$19.55

Benefit: 85% = \$16.65

81315	<p>EXERCISE PHYSIOLOGY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible exercise physiologist if:</p> <ul style="list-style-type: none"> (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible exercise physiologist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible exercise physiologist gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters; <p>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para M11.1 of explanatory notes to this Category)</p> <p>Fee: \$61.10 Benefit: 85% = \$51.95</p>
81320	<p>DIETETICS HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible dietitian if:</p> <ul style="list-style-type: none"> (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible dietitian by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters <p>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para M11.1 of explanatory notes to this Category)</p> <p>Fee: \$61.10 Benefit: 85% = \$51.95</p>
81325	<p>MENTAL HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible mental health worker if:</p> <ul style="list-style-type: none"> (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible mental health worker by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible mental health worker gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters <p>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para M11.1 of explanatory notes to this Category)</p> <p>Fee: \$61.10 Benefit: 85% = \$51.95</p>

81330	<p>OCCUPATIONAL THERAPY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible occupational therapist if</p> <ul style="list-style-type: none"> (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible occupational therapist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible occupational therapist gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters <p>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para M11.1 of explanatory notes to this Category)</p> <p>Fee: \$61.10 Benefit: 85% = \$51.95</p>
81335	<p>PHYSIOTHERAPY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible physiotherapist if:</p> <ul style="list-style-type: none"> (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible physiotherapist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible physiotherapist gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters <p>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para M11.1 of explanatory notes to this Category)</p> <p>Fee: \$61.10 Benefit: 85% = \$51.95</p>
81340	<p>PODIATRY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible podiatrist if:</p> <ul style="list-style-type: none"> (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible podiatrist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible podiatrist gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters <p>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para M11.1 of explanatory notes to this Category)</p> <p>Fee: \$61.10 Benefit: 85% = \$51.95</p>

81345	<p>CHIROPRACTIC HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible chiropractor if:</p> <ul style="list-style-type: none"> (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible chiropractor by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible chiropractor gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters <p>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year <i>(See para M11.1 of explanatory notes to this Category)</i></p> <p>Fee: \$61.10 Benefit: 85% = \$51.95</p>
81350	<p>OSTEOPATHY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible osteopath if:</p> <ul style="list-style-type: none"> (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible osteopath by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible osteopath gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters <p>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year <i>(See para M11.1 of explanatory notes to this Category)</i></p> <p>Fee: \$61.10 Benefit: 85% = \$51.95</p>
81355	<p>PSYCHOLOGY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible psychologist if:</p> <ul style="list-style-type: none"> (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible psychologist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible psychologist gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters <p>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year <i>(See para M11.1 of explanatory notes to this Category)</i></p> <p>Fee: \$61.10 Benefit: 85% = \$51.95</p>

SPEECH PATHOLOGY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible speech pathologist if:

- (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and
- (b) the person is referred to the eligible speech pathologist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and
- (c) the person is not an admitted patient of a hospital; and
- (d) the service is provided to the person individually and in person; and
- (e) the service is of at least 20 minutes duration; and
- (f) after the service, the eligible speech pathologist gives a written report to the referring medical practitioner mentioned in paragraph (b):
 - (i) if the service is the only service under the referral – in relation to that service; or
 - (ii) if the service is the first or the last service under the referral – in relation to the service; or
 - (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters

- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year

(See para M11.1 of explanatory notes to this Category)

81360

Fee: \$61.10**Benefit:** 85% = \$51.95

	GROUP M13 - MIDWIFERY SERVICES	
	<i>SUBGROUP 1 - MBS ITEMS FOR PARTICIPATING MIDWIVES</i>	
	Initial antenatal professional attendance by a participating midwife, lasting at least 40 minutes, including all of the following:	
	<ul style="list-style-type: none"> (a) taking a detailed patient history; (b) performing a comprehensive examination; (c) performing a risk assessment; (d) based on the risk assessment - arranging referral or transfer of the patient’s care to an obstetrician; (e) requesting pathology and diagnostic imaging services, when necessary; (f) discussing with the patient the collaborative arrangements for her maternity care and recording the arrangements in the midwife’s written records in accordance with section 2E of the Health Insurance Regulations 1975. 	
EMSN 82100	Payable once only for any pregnancy. (See para M13.16 of explanatory notes to this Category) Fee: \$52.40 Benefit: 85% = \$44.55 Extended Medicare Safety Net Cap: \$21.40	
	Short antenatal professional attendance by a participating midwife, lasting up to 40 minutes.	
EMSN 82105	(See para M13.16 of explanatory notes to this Category) Fee: \$31.70 Benefit: 75% = \$23.80 85% = \$26.95 Extended Medicare Safety Net Cap: \$16.10	
	Long antenatal professional attendance by a participating midwife, lasting at least 40 minutes.	
EMSN 82110	(See para M13.16 of explanatory notes to this Category) Fee: \$52.40 Benefit: 75% = \$39.30 85% = \$44.55 Extended Medicare Safety Net Cap: \$21.40	
	Professional attendance by a participating midwife, lasting at least 90 minutes, for assessment and preparation of a maternity care plan for a patient whose pregnancy has progressed beyond 20 weeks, if:	
	<ul style="list-style-type: none"> (a) the patient is not an admitted patient of a hospital; and (b) the participating midwife undertakes a comprehensive assessment of the patient; and (c) the participating midwife develops a written maternity care plan that contains: <ul style="list-style-type: none"> • outcomes of the assessment; and • details of agreed expectations for care during pregnancy, labour and delivery; and • details of any health problems or care needs; and • details of collaborative arrangements that apply for the patient; and • details of any medication taken by the patient during the pregnancy, and any additional medication that may be required by the patient; and • details of any referrals or requests for pathology services or diagnostic imaging services for the patient during the pregnancy, and any additional referrals or requests that may be required for the patient; and (d) the maternity care plan is explained and agreed with the patient; and (e) the fee does not include any amount for the management of the labour and delivery. 	
	(Includes any antenatal attendance provided on the same occasion).	
EMSN 82115	Payable once only for any pregnancy. (See para M13.16 of explanatory notes to this Category) Fee: \$313.05 Benefit: 85% = \$266.10 Extended Medicare Safety Net Cap: \$53.45	
	Management of confinement for up to 12 hours, including delivery (if undertaken), if:	
	<ul style="list-style-type: none"> (a) the patient is an admitted patient of a hospital; and (b) the attendance is by a participating midwife who: <ul style="list-style-type: none"> (i) provided the patient’s antenatal care; or (ii) is a member of a practice that provided the patient’s antenatal care. 	
	(Includes all attendances related to the confinement by the participating midwife)	
EMSN 82120	Payable once only for any pregnancy (See para M13.16 of explanatory notes to this Category) Fee: \$739.25 Benefit: 75% = \$554.45	

MISCELLANEOUS	MISCELLANEOUS
82125	<p>Management of confinement for in excess of 12 hours, including delivery where performed. Management of confinement, including delivery (if undertaken) when care is transferred from 1 participating midwife to another participating midwife (the second participating midwife), if:</p> <ul style="list-style-type: none"> (a) the patient is an admitted patient of a hospital; and (b) the patient's confinement is for longer than 12 hours; (c) the second participating midwife: <ul style="list-style-type: none"> (i) has provided the patient's antenatal care; or (ii) is a member of a practice that has provided the patient's antenatal care. <p>(Includes all attendances related to the confinement by the second participating midwife)</p> <p>Payable one only for any pregnancy. (See para M13.16 of explanatory notes to this Category)</p> <p>Fee: \$739.25 Benefit: 75% = \$554.45</p>
EMSN 82130	<p>Short Postnatal Attendance Short postnatal professional attendance by a participating midwife, lasting up to 40 minutes, within 6 weeks after delivery. (See para M13.16 of explanatory notes to this Category)</p> <p>Fee: \$52.40 Benefit: 75% = \$39.30 85% = \$44.55</p> <p>Extended Medicare Safety Net Cap: \$16.10</p>
EMSN 82135	<p>Long Postnatal Attendance Long postnatal professional attendance by a participating midwife, lasting at least 40 minutes, within 6 weeks after delivery. (See para M13.16 of explanatory notes to this Category)</p> <p>Fee: \$77.05 Benefit: 75% = \$57.80 85% = \$65.50</p> <p>Extended Medicare Safety Net Cap: \$21.40</p>
EMSN 82140	<p>Six Week Postnatal Attendance Postnatal professional attendance by a participating midwife on a patient not less than 6 weeks but not more than 7 weeks after delivery of a baby, including:</p> <ul style="list-style-type: none"> (a) a comprehensive examination of patient and baby to ensure normal postnatal recovery; and (b) referral of the patient to a general practitioner for the ongoing care of the patient and baby <p>Payable once only for any pregnancy. (See para M13.16 of explanatory notes to this Category)</p> <p>Fee: \$52.40 Benefit: 85% = \$44.55</p> <p>Extended Medicare Safety Net Cap: \$16.10</p>
SUBGROUP 2 - TELEHEALTH ATTENDANCES	
82150	<p>A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating midwife that requires the provision of clinical support to a patient who is:</p> <ul style="list-style-type: none"> a) located outside an inner metropolitan area, not being an admitted patient; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; <p>and who is participating in a video consultation with a specialist practising in their specialty of obstetrics or paediatrics. (See para M12.6 of explanatory notes to this Category)</p> <p>Fee: \$27.75 Benefit: 85% = \$23.60</p>
82151	<p>A professional attendance lasting at least 20 minutes (whether or not continuous) by a participating midwife that requires the provision of clinical support to a patient who is:</p> <ul style="list-style-type: none"> a) located outside an inner metropolitan area, not being an admitted patient; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; <p>and who is participating in a video consultation with a specialist practising in their specialty of obstetrics or paediatrics. (See para M12.6 of explanatory notes to this Category)</p> <p>Fee: \$52.70 Benefit: 85% = \$44.80</p>
82152	<p>A professional attendance lasting at least 40 minutes (whether or not continuous) by a participating midwife that requires the provision of clinical support to a patient who is:</p> <ul style="list-style-type: none"> a) located outside an inner metropolitan area, not being an admitted patient; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; <p>and who is participating in a video consultation with a specialist practising in their specialty of obstetrics or paediatrics. (See para M12.6 of explanatory notes to this Category)</p> <p>Fee: \$77.50 Benefit: 85% = \$65.90</p>

