The Australian Government

Department of Health and Ageing

Medicare Benefits Schedule
Allied Health and Dental Care Services

Medicare benefits for allied health and dental care services provided to people with chronic conditions and complex care needs

1 November 2005

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

CONTENTS

OUTLINE OF THE MEDICARE ALLIED HEALTH AND DENTAL CARE INITIATIVE AND EXPLANATORY NOTES FOR GUIDANCE OF USERS OF THE ITEMS

INTRODUCTION

This book provides information on the arrangements for the payment of Medicare benefits for allied health services. These services are available to people with chronic conditions and complex care needs who are being managed by a medical practitioner (including a general practitioner (GP), but not including a specialist or consultant physician) under an Enhanced Primary Care (EPC) plan. The term 'GP' is used in this book as a generic reference to medical practitioners able to refer patients for eligible allied health and dental care services.

Eligible services are those provided by the following allied health professional groups:

- Aboriginal health workers;
- Audiologists;
- Chiropodists;
- Chiropractors;
- Diabetes Educators;
- Exercise Physiologists;
- Dietitians;
- Mental health workers;
- Osteopaths;
- Physiotherapists;
- Podiatrists;
- Psychologists;
- Occupational Therapists; and
- Speech Pathologists.

The book also provides information on the arrangements for the payment of Medicare benefits for dental care services provided by dental practitioners (dentists) and dental specialists to people with chronic conditions and complex care needs who are being managed by their GP under an EPC plan and whose dental problems are exacerbating their chronic condition.

Section 1 of this book contains an overview of the Medicare allied health and dental care initiative, an outline of Medicare and its billing and claiming arrangements and information on how to contact Medicare Australia.

Section 2 of this book provides explanatory notes on the allied health Medicare Benefits Schedule (MBS) items, including relevant MBS item numbers, service requirements, Schedule fee and Medicare benefits payable.

Section 3 of this book provides explanatory notes on the dental care MBS items, including relevant MBS item numbers, service requirements, Schedule fee and Medicare benefits payable.

Schedule of Services
Each professional service has been allocated a unique item number.

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:

NSW –	132 150	WA –	132 150
VIC –	03 9605 7964	TAS –	03 6215 5740
QLD –	07 3004 5450	ACT –	02 6124 6362
SA -	08 8274 9788	NT –	use South Australia number

Changes to Provider Details
Please call Medicare Australia on 132 150 to notify of changes to mailing details to ensure receipt of the MBS Allied Health and Dental Services book and updates.

Internet
This book is also available on the Department of Health and Ageing's Internet site at **www.health.gov.au/mbsonline.** The site contains a viewing file in pdf and html formats and an ASCII text downloadable file of the current version of the book.

What's New

Summary of changes included in this Edition

An overview of Medicare is now included.

On 1 October 2005, the Health Insurance Commission changed its name to "Medicare Australia". All references to the Health Insurance Commission have been amended.

General Fee increase – 1 November 2005

MBS Items	Schedule Fee From 1 Nov 2005	Medicare Rebate From 1 Nov 2005
Allied Health items 10950 – 10970 inclusive	**$53.90**	**$45.85**
Dental Care items 10975 – 10977 inclusive	**$89.90**	**$76.35**

Change to referral form use

The need for signed copies of referral forms to accompany Medicare claims has been removed. This will cut red tape for allied health professionals, dentists and consumers.

Referral forms must still be used by GPs to refer patients for allied health or dental care services. However, copies of the forms do not need to be attached to the patients' itemised receipts or assignment of benefit forms.

Change to allied health professional reporting requirements

Previously, a written report had to be provided by the servicing allied health professionals to the referring GP after each service.

On 1 November 2005, allied health professional reporting requirements were amended as follows:

- Where an allied health professional provides a single service to the patient under one or more referrals, 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.

This change is in line with current clinical practice and cuts red tape for allied health professionals and GPs.

Change of methodology for counting patient eligibility for rebates

From 1 January 2006, the methodology for counting patient eligibility for Medicare rebates for eligible allied health and dental care services changes to 'in a calendar year' instead of 'in a 12 month period' (which was counted from the date patients have their first allied health and dental care service). That is, eligible patients will be able to access rebates for five (5) allied health and three (3) dental care services between 1 January and 31 December each year where these services are recommended in their EPC plan.

Inclusion of Exercise Physiologists

From 1 January 2006, exercise physiology services are included under the Medicare allied health and dental care initiative. Exercise physiologists must be registered with Medicare Australia to provide these services. To register with Medicare Australia, exercise physiologists must be an 'Accredited Exercise Physiologist' as accredited by the Australian Association for Exercise and Sports Science (AAESS).

SECTION 1

1.1 MEDICARE ALLIED HEALTH AND DENTAL CARE INITIATIVE

Overview and relationship to EPC plan

The Medicare allied health and dental care initiative commenced on 1 July 2004. It provides for Medicare benefits to be paid for certain services provided to people with chronic conditions and complex care needs by eligible allied health professionals, dentists and dental specialists.

Under the initiative, people with chronic conditions and complex care needs who are being managed by their GP under an Enhanced Primary Care (EPC) plan may be eligible to receive a Medicare benefit for up to five (5) eligible allied health services per year. The five services can be made up of five of the one type of service or a combination of different types of service, for example, five physiotherapy services or one dietetic and four podiatry services.

In addition, people with chronic conditions and complex care needs who are being managed by their GP under an EPC plan, and whose dental problems are exacerbating their chronic condition, may be eligible to receive a Medicare benefit for up to three (3) eligible dental care services a year.

The term 'EPC plan' is a generic one. Patients are considered to be managed under an EPC plan, if during the last two years:

- their GP has prepared an EPC plan for them and claimed:
  - Medicare Benefits Schedule (MBS) item 720 – preparation of an EPC multidisciplinary care plan; or
  - MBS item 722 – preparation of an EPC multidisciplinary discharge care plan; or
  - MBS items 721 and 723 together – Chronic Disease Management (CDM) items for the preparation of a GP Management Plan (GPMP) and coordination of Team Care Arrangements (TCA); or
- their GP has contributed to a plan prepared for them as a resident of an aged care facility and claimed item 730 or 731; or
- their GP has reviewed their existing EPC plan and claimed MBS item 724, 725 or 727.

Medicare benefits are payable in respect of services listed in the Schedule (items 10950 – 10977 inclusive), when the services are rendered to eligible patients, by eligible allied health professionals, dentists or dental specialists registered with Medicare Australia.

Publicly funded services

Items 10950 -10977 inclusive 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 or day-hospital facility.

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, allied health and dental items 10950-10977 inclusive can be claimed for services provided by eligible allied health professionals and dentists 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.

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

1.2 MEDICARE

Overview

The Australian Medicare Program provides access to medical and hospital services for all Australian residents and certain categories of visitors to Australia. Legislation covering the major elements of the Program is contained in the *Health Insurance Act 1973* (as amended).

With regard to medical expenses, the basic aim of the Medicare program is to provide:

- automatic entitlement to benefits in respect of professional services (other than professional services to which the following dot points apply) equal to 85% of the Medicare Benefits Schedule fee, with a maximum payment of $61.50 (indexed annually) by the patient for any one service where the Schedule fee is charged;
- for professional services rendered while hospital treatment (ie accommodation and nursing care) is provided to a patient who has been admitted to a hospital or day hospital facility (other than public patients), a flat rate of benefit of 75% of the Schedule fee, that is, there is no limit to the maximum amount of gap between the benefit and the Schedule fee;
- benefits equal to 100% of the Schedule fee for non-referred attendances by a general practitioner to non admitted patients and for services provided by a practice nurse on behalf of a general practitioner; and
- access to public hospital services for eligible persons who choose to be treated free of charge as public patients in accordance with the provisions of the 2003-2008 Australian Health Care Agreements.

Patients may insure with private health insurance organisations for the gap between the 75% Medicare benefit and the Schedule fee, or for amounts in excess of the Schedule fee where the patient has an arrangement with their health fund. For out-of-hospital services the maximum amount of 'gap' (ie the difference between the Medicare rebate and the Schedule fee) payable by a family group or an individual in any one calendar year is $335.50 (indexed annually from 1 January). Thereafter, patients are reimbursed 100% of the Schedule fee. Under the extended safety net, Medicare will meet 80% of the out-of-pocket costs (ie the difference between the fees charged and the Medicare benefits paid) for out-of-hospital medical services, once an annual threshold of $500 for families in receipt of the Family Tax Benefit Part A and concession card holders, or $1000 for all other individuals and families is reached. A family group includes a spouse and dependent children under 16 years of age or dependent students under the age of 25. Individuals do not need to register with Medicare for the safety net threshold. However, families are required to register with Medicare to be eligible. Registration forms can be obtained from Medicare offices or completed online at www.health.gov.au or www.medicareaustralia.gov.au .

Medicare Australia is responsible for the operation of Medicare and the payment of Medicare benefits. Listed below are the locations of Medicare offices:

Postal: Medicare, GPO Box 9822, in the Capital City in each State
Telephone: 132 150 - Australia wide at the cost of a local call.

NEW SOUTH WALES
The Colonial State Bank Tower
150 George Street
PARRAMATTA NSW 2165

VICTORIA
State Headquarters
460 Bourke Street
MELBOURNE VIC 3000

QUEENSLAND
State Headquarters
444 Queen Street
BRISBANE QLD 4000

SOUTH AUSTRALIA
State Headquarters
209 Greenhill Road
EASTWOOD SA 5063

WESTERN AUSTRALIA
State Headquarters
Bank West Tower
108 St. George's Terrace
PERTH WA 6000

TASMANIA
242 Liverpool Street
HOBART TAS 7000

AUSTRALIAN CAPITAL TERRITORY
134 Reed Street
TUGGERANONG ACT 2901

NORTHERN TERRITORY
As per South Australia

Clinically relevant professional service

Where an eligible person incurs medical expenses in respect of a professional service, Medicare will pay benefits for that service as outlined in these notes. The definition of professional service as contained in the Health Insurance Act provides that such a service must be "clinically relevant". A clinically relevant service means a service rendered by a medical or dental practitioner, an optometrist or an eligible allied health professional that is generally accepted in the medical, dental, optometric or allied health profession (as the case may be) as being necessary for the appropriate treatment of the patient to whom it is rendered.

It is recognised that allied health professionals and dentists will sometimes be called upon to provide services which cannot be considered as being medically necessary. Accounts for these services should not be itemised as attracting Medicare benefits. The fee charged for such services is a private matter between the practitioner and the patient.

For any service listed in the Schedule to be eligible for a Medicare rebate, the service must be rendered in accordance with the provisions of the relevant Commonwealth and State and Territory laws. Practitioners have the responsibility to ensure that the supply of medicines or medical devices used in the provision of medical services is strictly in accordance with the provisions of the *Therapeutic Goods Act 1989*.

Where a Medicare benefit has been inappropriately paid, Medicare Australia may request recovery of that benefit from the practitioner concerned.

Payment of Medicare benefits

Specific information must be included in an account or receipt for a professional service for a Medicare benefit to be payable for that service.

This information includes the fee the allied health professional, dentist or dental specialist has charged for providing the service set out in the Medicare Benefits Schedule (MBS).

Allied health professionals, dentists and dental specialists are free to determine their own fees for professional services. However, the amount that is specified in the account must be the amount charged for the service that is specified. The fee cannot include any component for other goods or services that are not part of the specified MBS item.

Billing practices contrary to the Act

The following illustrate billing practices that are not permissible under the *Health Insurance Act 1973.*

1. Including the cost of a non-clinically relevant service in a consultation charge.

- Medicare benefits can only be paid in respect of clinically relevant services. A clinically relevant service is one that is generally regarded by the relevant profession as being necessary for the appropriate treatment of the patient receiving the service.
- If an allied health professional, dentist or dental specialist chooses to use a procedure that is not generally accepted in their profession as necessary for the treatment of the patient, then the cost of this procedure cannot be included in the fee for a Medicare item.
- Any charge for this procedure must be separately listed on the account and not billed to Medicare.

2. Including an amount for goods supplied for the patient to use at home in the consultation charge (eg. Wheelchairs, oxygen tanks, continence pads).

- Medicare benefits are paid in respect of specific services provided by an allied health professional, dentist or dental specialist at the time of the consultation.
- The provision of goods, such as wheelchairs and oxygen tanks, for later use is not part of the consultation and cannot be charged to Medicare.
- Charges can be levied for these items but must be separately listed on the account and not billed to Medicare.

3. Charging part or all of an in-patient procedure to an out-patient consultation.

- If an allied health professional, dentist or dental specialist charges part or all of an in-hospital procedure to an out-patient consultation, then the account issued by the practitioner is not an accurate statement of the services provided and would constitute a false or misleading statement.
- No Medicare benefits would be payable in respect of the services provided.

4. Re-issuing modified accounts to include other charges and out of pocket expenses not previously included in the account.

- The account issued to a patient by an allied health professional, dentist or dental specialist must state the amount charged for the service provided and truly reflect what occurred between the patient and practitioner.
- Re-issuing an account to correct a genuine error is legitimate.
- However, if an account is re-issued to increase the fee or load additional components to the fee, the account is not a true statement of the fee charged for the service and would constitute a false or misleading statement.
- No Medicare benefits would be payable in respect of the services provided.

Multiple consultations on the same day

Generally, consultations that run longer than the minimum time required of 20 minutes should be billed as a single consultation.

Payment of a benefit may be made for more than one (1) consultation on a patient on the same day by the same allied health professional provided the subsequent consultation is not a continuation of the initial consultation. However, there should be a reasonable lapse of time between such consultations before they can be regarded as separate consultations.

For some services (for example, diabetes education, psychology or mental health), it is likely that a subsequent service provided on the same day would be a continuation of the initial consultation. It is also likely that providing, for example, two diabetes education or psychology services on the same day does not provided a 'reasonable time lapse between consultations' as patients need adequate time to absorb and synthesise information before more information is provided. This is especially important for patients with complex conditions.

Where two consultations are made on the one day by the same allied health professional the time of each consultation should be stated on the account (eg 10.30am and 3.15pm) in order to assist in the assessment of benefits.

For information on multiple attendances by a dentist or dental specialist, please see Section 3, dental assessment.

1.3 CLAIMING FROM MEDICARE

Paid Accounts

The patient may pay the account provided by an allied health professional, dentist or dental specialist and subsequently present the itemised receipt at a Medicare office for assessment and payment of the Medicare benefit in cash. The claimant is not required to complete a Medicare Patient Claim Form (PC-1).

A Medicare Patient Claim Form (PC-1) is required to be completed where the claimant is mailing his or 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.

The particulars that are required to be on the account/receipt are:

- patient’s name and date of service;
- MBS item number and/or description of service;
- name and practice address or name and provider No. of servicing allied health professional;
- name and practice address or name and provider No. of referring GP and date of referral; and
- amount charged, total amount paid, and any amount outstanding in relation to the service.

Unpaid accounts

Where the patient has not paid the account, the itemised unpaid account may be presented to Medicare (in person or by mail) with a Medicare patient claim form. In this case, Medicare will forward to the claimant a benefit cheque made payable to the allied health professional, dentist or dental specialist.

It will be the patient's responsibility to forward the cheque to the allied health professional, dentist or dental specialist and make arrangements for payment of the balance of the account, if any.

When issuing a receipt to a patient in respect of an amount that is being paid wholly or in part by a Medicare 'pay allied health professional/dentist/dental specialist' cheque, the allied health professional, dentist or dental specialist should indicate on the receipt that a 'Medicare' cheque for $…. was involved in the payment of the account.

Assignment of benefit arrangements

Where an allied health professional, dentist or dental specialist accepts the Medicare rebate as full payment for the service, s/he 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.

The allied health professional, dentist or dental specialist would submit:

- the assignment of benefit (direct-payment) form (form DB2-AH); and
- a DB1N-AH claim form.

to Medicare (note that direct-payment forms DB1N-AH should be used to claim assigned Medicare benefits for allied health or dental care services rendered through an EPC plan, by one provider from a single practice location. Up to 50 DB2-AH forms can be included under the one DB1N-AH form). Under these arrangements –

- the patient's Medicare number must be quoted on all direct-payment assignment forms for that patient;
- the allied health professional, dentist or dental specialist 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 allied health professional, dentist, dental specialist or their staff) is acceptable. The reason the patient is unable to sign should also be stated. In the absence of a 'responsible person' the patient signature section should be left blank and in the section headed 'Allied Health Professional's/Dentist's/Dental Specialist's Use', an explanation should be given as to why the patient was unable to sign (e.g. injured hand etc.) and this note should be signed or initialled by the allied health professional, dentist or dental specialist. If in the opinion of the allied health professional, dentist or dental specialist 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.

Claims should be posted to Medicare, GPO Box 9822, in the Capital City in each state.

Use of Medicare cards in direct payment

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

Assignment of benefit forms

To meet varying requirements, different 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.

Form DB2-AH is used to assign benefits for professional services rendered by allied health professionals, dentists and dental specialists. The form may not be used for services other than services rendered under the allied health and dental care initiative.

Direct payment stationery

Allied health professionals, dentists or dental specialists wishing to use the direct-payment method may order direct-payment stationery by telephoning 1800 067 307.

Time limits applicable to lodgement of claims for assigned benefits

A time limit of six months applies to the lodgement of claims with Medicare under the direct-payment (assignment of benefits) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than six months 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.

Checking patient eligibility for services

Patients seeking Medicare rebates for allied health and/or dental care services will need to have an *EPC program referral form for allied health or dental services under Medicare* signed by their GP. If there is any doubt about a patient's eligibility, Medicare Australia will be able to confirm with the patient whether previous EPC and allied health/dental care services have been received. Allied health professionals, dentists and dental specialists can call with the patient present, or alternatively the patient can call Medicare Australia on 132 011.

Further information

Information about the allied health and dental care items is also printed in the 1 November 2005 MBS book. The book also contains comprehensive explanatory notes and descriptors of all of Medicare EPC items including the requirements for access to EPC chronic disease management items 721 – 731 inclusive (pages 44 to 50).

Allied health professionals, dentists and dental specialists wishing to obtain further information about Medicare billing and claiming should call the Medicare Australia provider inquiry line on 132 150.

SECTION 2

2.1 ALLIED HEALTH ITEMS (ITEMS 10950 – 10970 INCLUSIVE)

Medicare benefits are available for up to five (5) eligible allied health services per patient, per calendar year.

These items only apply to patients with chronic conditions and complex care needs being managed under an EPC plan and where the patient is referred to an eligible allied health professional by their GP.

A chronic medical condition is one that has been or is likely to be present for at least six (6) months including, but not limited to, asthma, cancer, cardiovascular illness, diabetes mellitus, mental health conditions, arthritis and musculoskeletal conditions. 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 (2) other health or care providers.

The allied health services provided must be services recommended in the patient's EPC plan as part of the management of their chronic and complex condition.

2.2 ALLIED HEALTH PROFESSIONAL ELIGIBILITY

Eligible professions

These items can only be claimed for services provided by Aboriginal health workers; audiologists; diabetes educators; dietitians; exercise physiologists; mental health workers; occupational therapists; physiotherapists; podiatrists; chiropodists; chiropractors; osteopaths; psychologists; and speech pathologists, who are registered with Medicare Australia.

To be eligible to register with Medicare Australia to provide these services, an allied health professional needs to be:

(a) a recognised professional who is registered under relevant State or Territory law; or
(b) where there is no such State or Territory law, a practitioner who is a member of a professional association with uniform national registration requirements.

Specific eligibility requirements

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

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 (or higher) in Aboriginal and Torres Strait Islander Health from a Registered Training Organisation that meets training standards of 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 Credentialled Diabetes Educator (CDE) as credentialled by the Australian Diabetes Association (ADEA).

Chiropractors must be registered with the Chiropractors (or Chiropractors and Osteopaths) Registration Board in the State or Territory in which they are practising.

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 the Australian Association for Exercise and Sports Science (AAESS).

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.

A **mental health nurse** may qualify if they are –

- a registered mental health nurse in Tasmania or the Australian Capital Territory (ACT), if providing mental health services in Tasmania or the ACT; or
- a 'Credentialled Mental Health Nurse' as certified by the Australian and New Zealand College of Mental Health Nurses (ANZCMHN), if providing mental health services in other States or the Northern Territory.

To be eligible to provide mental health services for the purposes of this item, a social worker 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 AASW's 'Standards for Mental Health Social Workers 1999'.

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 OT AUSTRALIA, the national body of the Australian Association of Occupational Therapists.

Osteopaths must be registered with the Osteopaths (or Chiropractors and Osteopaths) Registration Board in the State or Territory in which they are practising.

Physiotherapists must be registered with the Physiotherapists Registration Board in the State or Territory in which they are practising.

Podiatrists/Chiropodists in all States and the Australian Capital Territory must be registered with the Podiatrists Registration Board in the State or Territory in which they are practising. If practising in the Northern Territory, Podiatrists/Chiropodists must be registered with the Podiatrists Registration Board in any other State or the Australian Capital Territory, or be a "Full Member" of the Australian Podiatry Association (ApodA) in any other State or the Australian Capital Territory.

Psychologists must be registered with the Psychologists Registration Board in the State or Territory in which they are practising.

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.

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.

2.3 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 an *EPC program referral form for allied health services under Medicare* (the referral form). GPs are encouraged to attach a copy of the relevant part of the patient's care plan to the referral form.

The referral form may be downloaded from the Department of Health and Ageing website at www.health.gov.au/strengtheningmedicare or ordered by faxing (02) 6289 7120. GPs may modify the relevant referral form to suit their practice needs (for example, relevant software packages) as long as the information contained therein is substantially retained.

As a copy of the referral form is no longer required to accompany Medicare claims, allied health professionals do not need to attach a signed copy of the form to patients' itemised accounts/receipts or assignment of benefit forms.

The allied health professional must be in receipt of the referral at the first allied health consultation. An allied health professional is required to retain the referral form for 24 months from the date the service was rendered for Medicare Australia auditing purposes.

Referral validity

The referral remains valid for the stated number of services. If the services are not used during the calendar year in which the patient is referred, the unused services may be used in the next calendar year. However, they will be counted as part of the five (5) rebates for allied health services available to the patient during that calendar year (that is, the patient may only claim up to five (5) rebates in total each year).

Subsequent referrals

Where patients wish to access Medicare benefits for eligible allied health services during their next period of eligibility for rebates (that is, the next calendar year), they should see their GP to obtain a new referral form(s) when they have used up their current referral form(s) or require a referral for a different type of allied health service recommended in their EPC plan. Depending on the patient's circumstances and needs, GPs may choose to use this visit to undertake a review of the patient's EPC plan or, where appropriate, to manage the process using a GP consultation item.

It is not necessary to have a new EPC plan prepared every 12 months in order to access a new referral(s) for eligible allied health services. Patients continue to be eligible for rebates for allied health and dental services while they are being managed under an EPC plan as long as the need for eligible services continues to be recommended in their plan.

2.4 REQUIREMENTS OF THE SERVICE

Service length and type

Services provided by eligible allied health professionals under these items 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 one or more referrals 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, for example:

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

Allied health professionals providing the service may be part of the EPC planning team convened by the GP to manage a patient's chronic and complex condition. However, the service may also be provided by allied health professionals who are not part of the care planning team, where the service has been identified as necessary by the patient's GP.

2.5 BENEFIT LIMITATIONS

Number of services and Medicare rebate payable

Patients being managed under an EPC plan are entitled to up to five (5) rebates for services covered by items 10950-10970 inclusive, within a calendar year. The maximum Medicare benefit per patient, per calendar year is $229.25, that is, a total of five (5) rebates at $45.85 per 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. Allied health services in excess of five (5) 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.

2.6 GROUP M3 – SCHEDULE OF ALLIED HEALTH ITEMS

Medicare item number, service type and item descriptor for items 10950 – 10970 inclusive

Medicare item number	Service
10950 – 10970 inclusive	The following conditions MUST be met before items 10950 – 10970 can be claimed: a) the service is provided to a person who has a chronic and complex condition that is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic and complex condition; and (c) the person is referred to the eligible [allied health professional] by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital or day-hospital facility; 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 [allied health professional] 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 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; 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 5 services (including services to which items 10950 to 10970 inclusive apply) in a calendar year.

Item Number	Type of allied health provider
10950	Aboriginal or Torres Strait Islander health service provided to a person by an eligible Aboriginal health worker **Fee:** $53.90 **Benefit:** 85% = $45.85
10951	Diabetes education health service provided to a person by an eligible diabetes educator **Fee:** $53.90 **Benefit:** 85% = $45.85
10952	Audiology health service provided to a person by an eligible Audiologist **Fee:** $53.90 **Benefit:** 85% = $45.85
10953 **Effective 1 January 2006**	Exercise Physiology service provided to a person by an eligible exercise physiologist **Fee:** $53.90 **Benefit:** 85% = $45.85
10954	Dietetics health service provided to a person by an eligible dietitian **Fee:** $53.90 **Benefit:** 85% = $45.85
10956	Mental health service provided to a person by an eligible mental health worker **Fee:** $53.90 **Benefit:** 85% = $45.85
10958	Occupational therapy health service provided to a person by an eligible occupational therapist **Fee:** $53.90 **Benefit:** 85% = $45.85
10960	Physiotherapy health service provided to a person by an eligible physiotherapist **Fee:** $53.90 **Benefit:** 85% = $45.85
10962	Chiropody health service provided to a person by an eligible chiropodist, or podiatry health service provided to a person by an eligible podiatrist **Fee:** $53.90 **Benefit:** 85% = $45.85
10964	Chiropractic health service provided to a person by an eligible chiropractor **Fee:** $53.90 **Benefit:** 85% = $45.85
10966	Osteopathy health service provided to a person by an eligible osteopath **Fee:** $53.90 **Benefit:** 85% = $45.85
10968	Psychology health service provided to a person by an eligible psychologist **Fee:** $53.90 **Benefit:** 85% = $45.85
10970	Speech pathology health service provided to a person by an eligible speech pathologist **Fee:** $53.90 **Benefit:** 85% = $45.85

SECTION 3

3.1 DENTAL CARE ITEMS (ITEMS 10975 - 10977 INCLUSIVE)

Medicare benefits are available for up to three (3) dental care services per patient, per calendar year.

These items apply to patients with chronic conditions and complex care needs (see explanation, page 14) being managed under an EPC plan and where the patient is referred to an eligible dental practitioner (dentist) by their GP for a dental condition that is exacerbating the patient's chronic and complex medical condition.

The dental care services provided must be services recommended in the patient's EPC plan as part of the management of their chronic and complex condition.

These services may include combinations of item 10975 and items 10976 or 10977, for example:

- a dental assessment (1 x item 10975) and two dental treatments (2 x item 10976) provided by an eligible dentist; or
- a dental assessment (1 x item 10975) and one dental treatment (1 x item 10976) provided by an eligible dentist and one dental assessment or treatment (1 x item 10977) provided by another dentist or dental specialist; or
- a dental assessment (1 x item 10975) provided by an eligible dentist and two dental assessments or treatments (2 x item 10977) provided by another dentist or dental specialist.

When a patient is first referred to a dentist under an EPC plan they must receive a dental assessment (item 10975) as their first service and then each calendar year where further dental care is being provided.

For example, if a GP identifies a need for dental care as part of a patient's EPC plan and refers the patient to an eligible dentist in June 2006, the patient must receive a dental assessment as their first service, and may claim a Medicare benefit for that service and for two (2) subsequent dental treatment services (see combinations above) during the remainder of the 2006 calendar year.

Where the patient is referred to an eligible dentist during the following calendar year (2007), they may claim a Medicare benefit for, for example, two (2) dental treatment services and a dental assessment. That is, as long as the patient has a dental assessment as their first treatment under an EPC plan, they may choose the order in which they access eligible services each successive calendar year, as long as sometime during that year, they have a dental assessment.

3.2 DENTIST AND DENTAL SPECIALIST ELIGIBILITY

Items 10975 and 10976 may only be claimed for services provided by an eligible dentist.
Item 10977 may be claimed for services provided by an eligible dentist or an eligible dental specialist.

Eligibilty requirements

Eligible dentists and dental specialists are those recognised professionals who are registered under relevant State or Territory law, and who are also registered with Medicare Australia to provide dental care services under the Medicare allied health and dental care initiative.

Registering with Medicare Australia

Dentists and dental specialists who were already registered with Medicare Australia on 1 July 2004 to order diagnostic imaging or pathology tests, for prescribing, or for specialist referral under Medicare, do not need to re-register to provide services under this initiative. Dentists and dental specialists 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 or pathology tests etc., under Medicare.

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

3.3 REFERRAL REQUIREMENTS

Referral forms

For Medicare benefits to be payable, the patient must be referred to an eligible dentist by their GP using an *EPC program referral form for dental care services under Medicare* (the referral form). GPs are encouraged to attach a copy of the relevant part of the patient's EPC plan to the referral form.

The referral form may be downloaded from the Department of Health and Ageing website at www.health.gov.au/strengtheningmedicare or ordered by faxing (02) 6289 7120. GPs may modify the relevant referral form to suit their practice needs (for example, relevant software packages) as long as the information contained therein is substantially retained.

As a copy of the referral form is no longer required to accompany Medicare claims, dentists/dental specialists do not need to attach a signed copy of the form to patients' itemised accounts/receipts and assignment of benefit forms.

The dentist/ dental specialist must be in receipt of the referral at the first dental care consultation. The dentist/dental specialist is required to retain the referral form for 24 months from the date the service was rendered for Medicare Australia auditing purposes.

Referral validity

The referral remains valid for the stated number of services. If the services are not used during the calendar year in which the patient is referred, the unused services may be used in the next calendar year. However, they will be counted as part of the three (3) rebates for dental care services available to the patient during that calendar year (that is, the patient may only claim up to three (3) rebates in total each year).

Subsequent referrals

Where patients wish to access Medicare benefits for eligible dental care services during their next period of eligibility for rebates (that is, the next calendar year), they should see their GP to obtain a new referral. Depending on the patient's circumstances and needs, GPs may choose to use this visit to undertake a review of the patient's EPC plan or, where appropriate, to manage the process using a GP consultation item.

It is not necessary to have a new EPC plan prepared every 12 months in order to access a new referral(s) for eligible dental care services. Patients continue to be eligible for rebates for dental services while they are being managed under an EPC plan.

3.4 REQUIREMENTS OF THE SERVICE

There are three (3) dental care items: 10975 (dental assessment); 10976 (dental treatment); and 10977 (dental assessment or treatment by a registered dentist or dental specialist on referral from another dentist).

Dental assessment (item 10975) and written report

This item can only be provided on referral from a GP for a patient being managed under an EPC plan. It MUST be claimed first for all eligible patients in order for items 10976 and 10977 to be provided under a dental care plan, and then as one of the three items each calendar year where further care is being provided.

The item should not be claimed more than once per calendar year unless the condition of the patient has changed substantially. Where the patient's condition requires an additional assessment to be provided within the calendar year, the patient's invoice or Medicare voucher should be annotated to indicate this.

Example:

Common examples of circumstances where a dental condition can exacerbate a chronic and complex disease might include (but are not restricted to):

(a) where the patient has valvular heart disease and poor oral hygiene and gum disease (putting them at the risk of developing bacterial endocarditis);

(b) where the patient has diabetes and oral hygiene problems (such as tooth abscesses, and where infection can compromise the management of their diabetes);
(c) where the patient has malignancies of the head and neck where surgery [or radiation] has resulted in damage to the oral cavity, or has exacerbated underlying dental disease (and affects eating); or
(d) where the patient has baseline poor oral health and experience significant worsening while undergoing chemotherapy or is immuno-suppressed.

A dental assessment means a comprehensive assessment of a patient's dental health, and whether further dental treatment should be offered to the patient – to improve the patient's chronic and complex condition for which the multidisciplinary care plan has been formed.

The assessment should include:

(a) an evaluation of all teeth, their supporting tissues and the oral tissues; and
(b) a written report provided to the referring GP.

The written report should include:

(a) the findings of the evaluation and prognosis;
(b) the proposed treatment, including the likely number of visits, and an estimated cost of each visit, or the total treatment; and
(c) any specific investigations that would be required (such as radiology or pathology services) that would assist in the management of the dental condition as it relates to the chronic and complex medical condition.

The written report of the assessment should be provided to the referring GP and a copy should also be offered to the patient. Where the patient has an informal or family carer, a copy of the report (or relevant extracts) should be offered to the carer, with the patient's agreement.

The dental assessment item may include referral for other services attracting a Medicare benefit from Medicare Benefits Schedule item category 5 (diagnostic imaging) or category 6 (pathology) services where clinically relevant, but should not take the form of a health screening service. These diagnostic and pathology services do not count towards the three (3) annual dental visits available under the allied health and dental care initiative.

Dentists can provide services under item 10976 on the same day as a dental assessment if clinically indicated. These services will count as two (2) of the three (3) annual visits available under the allied health and dental care initiative.

Dental treatment (item 10976)

Services provided under item 10976 may only be provided where the patient has been the recipient of a dental assessment (item 10975). (Note: Item 10975 MUST be claimed first for all eligible patients in order for item 10976 to be provided under a dental care plan, and then each calendar year where further dental care is being provided).

This item only applies to services provided that will improve or relieve the dental condition that is exacerbating the chronic and complex medical condition for which the EPC plan has been formed.

Some services that would be appropriate under this item may be - but **are not** restricted to:

(a) Tooth extraction and oral surgery;
(b) Treatment of acute periodontal infection;
(c) Restorative services, such as metallic or adhesive restorations, or capping;
(d) Root planning and subgingival curettage;
(e) Endodontics; and
(f) Drainage of abscesses or cysts.

Supply of Prostheses

The cost of making/supplying prostheses such as, an inlay, crown, bridge, implant, denture, obturator, veneer or a combination of these are NOT covered by Medicare. Dentists should separately itemise any costs associated with the supply/making of prostheses when billing patients for a dental treatment using item 10976. Costs associated with fitting prostheses can be included under the item.

Dental assessment or treatment by a registered dentist or dental specialist on referral from another dentist (item 10977)

Services provided under item 10977 may only be provided where the patient has been the recipient of a dental assessment (item 10975), where the dentist providing the service under item 10975 determined that further assessment and treatment from a dental specialist or another dentist was required. (Note: Item 10975 MUST be claimed first for all eligible patients in order for item 10977 to be provided under a dental care plan, and then each calendar year where further dental care is being provided).

A written report of the assessment must also be sent to the referring dentist as well as the original referring GP.

Supply of Prostheses

The cost of making/supplying prostheses such as, an inlay, crown, bridge, implant, denture, obturator, veneer or a combination of these are NOT covered by Medicare. Dentists/dental specialists should separately itemise any costs associated with the supply/making of prostheses when billing patients for a dental treatment using item 10977. Costs associated with fitting prostheses can be included under the item.

A dental specialist is a person who is:

(a) registered or licensed as a periodontist, endodontist, pedeodontist, or orthodontist under a law of a State or Territory; or
(b) registered or licensed as a dental specialist under a law of a State or Territory and recognised by the registering or licensing authority as a person who practices in the speciality of periodontics, endodontics, pedeodontics, or orthodontics.

For the purposes of item 10977, 'dentist or dental specialist' includes all registered dental specialists as well as registered dentists who restrict their practice to 'special needs' dentistry.

3.5 BENEFIT LIMITATIONS

Number of services and Medicare rebate payable

Patients being managed under an EPC plan are entitled to up to three (3) rebates for services covered by items 10975-10977 inclusive, within a calendar year. The maximum Medicare benefit per patient, per year is $229.05, that is, a total of three (3) rebates at $76.35 per 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 safety net limit for that patient. Dental services in excess of three (3) 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.

3.6 GROUP M4 – SCHEDULE OF DENTAL CARE ITEMS

10975	Dental assessment provided to a person by an eligible dental practitioner if: (a) the service is provided to a person whose dental condition is exacerbating a chronic and complex condition that is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic and complex condition; and (c) the person is referred to the eligible dental practitioner by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital or day-hospital facility; and (e) after the assessment, the eligible dental practitioner gives a written report to the referring medical practitioner; and (f) 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 3 services (including services to which this item or 10976 or 10977 applies) in a calendar year. **Fee:** $89.80 **Benefit:** 85% = $76.35
10976	Dental treatment provided to a person by an eligible dental practitioner if: (a) the service is provided to a person whose dental condition is exacerbating a chronic and complex condition that is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic and complex condition; and (c) the service is associated with a service of the kind described in item 10975 previously provided to the person; and (d) the person is referred to the eligible dental practitioner by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially complies with the form issued by the Department; and (e) the person is not an admitted patient of a hospital or day-hospital facility; and (f) 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 3 services (including services to which this item or 10975 or 10977 applies) in a calendar year. **Fee:** $89.80 **Benefit:** 85% = $76.35
10977	Dental service provided to a person by an eligible dental practitioner or an eligible dental specialist (the ***providing dentist***) if: (a) the service is provided to a person whose dental condition is exacerbating a chronic and complex condition that is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic and complex condition; and (c) the service is associated with a service of the kind described in item 10975 previously provided to the person by another eligible dental practitioner; and (d) the person is referred to the providing dentist by the eligible dental practitioner who provided the service described in item 10975 using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially complies with the form issued by the Department; and (e) the person is not an admitted patient of a hospital or day-hospital facility; and (f) after the service, the providing dentist gives a written report to the referring eligible dental practitioner and the medical practitioner mentioned in the paragraph (a); and (g) 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 3 services (including services to which this item or 10975 or 10976 applies) in a calendar year. **Fee:** $89.80 **Benefit:** 85% = $76.35