

The Australian Government

Department of Health and Ageing

**Medicare Benefits Schedule
Allied Health Services**

1 May 2010

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 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.

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INTRODUCTION

This booklet provides information for allied health professionals who are eligible to provide services under Medicare. To provide Medicare rebatable allied health services, professionals must meet the eligibility requirements for the particular Medicare item, as set out in the relevant Part of this document, and be registered with Medicare Australia.

Specific requirements must be met prior to general practitioners (GPs) making referrals to allied health professional services.

Medicare benefits are available for a range of allied health services for certain patients, as summarised below.

WHAT'S NEW

On 1 May 2010, items 725 (Review of a GP Management Plan) (GPMP) and 727 (Coordinate a Review of Team Care Arrangements) (TCAs) were combined into one new item number (732). The old item numbers have been deleted from the Medicare Benefits Schedule (MBS) and each of the services that applied to items 725 and 727 can be delivered using item 732. References to items 725 and 727 have been replaced with references to item 732.

Language around Indigenous patients and items for these patients has been amended slightly to make it more precise, as well as consistent with the other Medicare primary care items. This is also in keeping with cultural sensitivity requirements with respect to references to Indigenous peoples.

References to the Allied Health Determination apply to the most recent version: *Health Insurance (Allied Health Services) Amendment Determination 2010*.

Eligible Patients	No. of Services per Patient	Allied Health Professionals Eligible to Provide Services
Patients who have a chronic medical condition and complex care needs (refer Part 2)	Up to five individual services (in total) per calendar year	Aboriginal Health Worker Audiologist Chiropractor Diabetes Educator Dietitian Exercise Physiologist Mental Health Worker Occupational Therapist Osteopath Physiotherapist Podiatrist Psychologist Speech Pathologist
Aboriginal and Torres Strait Islander peoples who have had a health check (refer Part 3)	Up to five individual services (in total) per calendar year (Note: these services are in addition to the five individual services for patients with a chronic medical condition and complex care needs)	Aboriginal Health Worker Audiologist Chiropractor Diabetes Educator Dietitian Exercise Physiologist Mental Health Worker Occupational Therapist Osteopath Physiotherapist Podiatrist Psychologist Speech Pathologist
Patients who have type 2 diabetes (refer Part 4)	One individual assessment AND up to eight group sessions per calendar year (Note: these services are in addition to the five individual services for patients with a chronic medical condition and complex care needs)	
Patients with an assessed mental disorder (refer Parts 5 and 6)	Up to 12 individual services and an additional six services in exceptional circumstances (to a maximum total of 18 individual services per calendar year) AND up to 12 group therapy services per calendar year	Clinical Psychologist Psychologist Occupational Therapist Social Worker (Note: services can also be provided by a qualified medical practitioner)
Women who are concerned about either a current pregnancy, or one that occurred in the previous 12 months (refer Part 7)	Up to three services per pregnancy	Psychologist Social Worker Mental Health Nurse (Note: services can also be provided by a medical practitioner)
Children with autism or any other pervasive developmental disorder (PDD) - aged under 13 years for diagnosis and under 15 years for treatment (refer Part 8)	Up to four services for assessment (in total per child) and up to 20 early intervention treatment services in total per child-	Psychologist Occupational Therapist Speech Pathologist

PART 1

INFORMATION FOR ALL ALLIED HEALTH PROVIDERS

ELIGIBLE ALLIED HEALTH PROVIDERS

To be eligible to provide services under Medicare, allied health professionals must meet specific eligibility requirements, be in private practice and be registered with Medicare Australia. The specific requirements for each Medicare item are detailed in the relevant Part of this document.

Provider registration forms can be obtained from Medicare Australia on 132 150 or at medicareaustralia.gov.au (search for ‘allied health application’).

Chiropractors, osteopaths, physiotherapists and podiatrists who are already registered with Medicare Australia to order diagnostic imaging under Medicare, do not need to re-register to provide services under these initiatives. Allied health professionals registering with Medicare Australia for the first time only need to fill in one application form to obtain rights to provide services under the allied health initiative and to order diagnostic imaging tests etc., where appropriate, under Medicare.

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

ELIGIBILITY OF PATIENTS

The specific requirements for each Medicare item are detailed in the relevant Part of this document. If there is any doubt about a patient’s eligibility, Medicare Australia will be able to assist. The allied health professional or GP can call Medicare Australia on 132 150 to check. Alternatively the patient can call Medicare Australia on 132 011.

GENERAL PRACTITIONER (GP)

In this document, a reference to a GP is a generic reference to a medical practitioner (including a general practitioner, but not including a specialist or consultant physician).

MULTIPLE CONSULTATIONS ON THE SAME DAY

Consultations that run longer than the minimum time specified in the Item Description should be billed as a single consultation. For payment of a benefit/rebate for more than one consultation with a patient on the same day by the same allied health professional, the subsequent consultation must not be a continuation of the initial consultation (except in the case of items 81105, 81115 and 81125).

SERVICE REQUIREMENTS

The service requirements for each allied health item are contained in the Item Descriptions provided at the end of each Part of this document. These are legislative requirements contained in the *Health Insurance (Allied Health Services) Amendment Determination 2010*, and therefore must be met before the item can be claimed.

For any service listed on the MBS to be eligible for a Medicare rebate, the service must be provided in accordance with the provisions of all relevant Commonwealth and State and Territory laws.

MEDICARE BENEFIT/REBATE

The amount of the Medicare benefit (rebate) for each item is provided in the Item Description for that item. These amounts are indexed on 1 November of each year.

DIRECT (BULK) BILLING

The allied health provider may choose to accept the amount of the Medicare benefit/rebate that is payable to the patient as full payment for the service. In such cases, the patient assigns his/her Medicare benefit to the provider, and the provider is not legally able to charge the patient any amount in addition to the Medicare rebate.

Where the patient is bulk billed, he/she will have no out-of-pocket costs.

OUT-OF-POCKET COSTS

Allied health professionals are free to 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 the patient. Allied health services in excess of the available limit for each item will not attract a Medicare benefit and the Safety Net Arrangements will not apply to costs incurred for such services.

MEDICARE SAFETY NET

For information about the original and the extended Medicare Safety Nets, please refer to G.10.2 of the General Explanatory notes for the MBS.

PUBLICLY FUNDED SERVICES

Allied health items do not apply to services that are provided by any Commonwealth or State or Territory funded services or provided to an admitted patient of a public hospital.

However, where an exemption under section 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, the allied health items can be claimed for services provided by eligible allied health professionals salaried by, or contracted to, the Service or clinic. All requirements of the item must be met, including registration of the allied health professional with Medicare Australia.

PRIVATE HEALTH INSURANCE

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

CLAIMING FROM MEDICARE

Account/Receipt Requirements

For a Medicare payment to be made the account/receipt must include the following information:

- patient's name;
- date of service;
- MBS item number;
- allied health professional's name and provider number, or name and practice address;
- referring medical practitioners name and provider number, or name and practice address;
- date of referral; and
- amount charged, total amount paid, and any amount outstanding in relation to the service.

1. Paid accounts

A patient may choose to pay the account provided by the allied health professional in full and present the itemised account receipt (see above) to a Medicare office, for processing.

Alternatively, the patient may request their allied health provider to submit their claim electronically to Medicare, on their behalf.

If the patient chooses to mail the claim to Medicare, a Medicare Patient Claim Form (PC-1) must be completed. This also applies when the patient is arranging for an agent to collect cash on his/her behalf at a Medicare office.

2. Unpaid accounts

Cheque from Medicare

If the patient has not paid the account, the itemised unpaid account can be presented to Medicare (in person or by mail) with a Medicare Patient Claim Form (PC-1). In this case Medicare will forward to the patient a benefit cheque made payable to the allied health professional. It is the patient's responsibility to forward the cheque to the allied health professional and make arrangements for payment of the balance of the account, if any.

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

Assignment of benefit (bulk billing or direct payment) arrangements

When bulk billing, the allied health professional will need to submit the approved forms (DB2-AH and DBIN-AH) to Medicare. These forms are approved forms under the *Health Insurance Act 1973*, and no other forms can be used to assign benefits without the approval of Medicare Australia. They can be ordered by telephoning 1800 067 307.

To bulk bill, the allied health professional will need to complete:

a) An assignment of benefit (direct-payment) form (Medicare form DB2-AH) for each patient

This form contains the patient's details. Under these arrangements:

- the patient's Medicare number must be quoted on all direct-payment assignment forms for that patient. 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- ;
- the allied health professional must set out on the assignment form the details relating to the professional service before the patient signs the form. The patient must then receive a copy of the form;
- 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 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 Use' an explanation should be given as to why the patient was unable to sign (e.g. injured hand etc.). This note should be signed or initialled by the allied health professional. If in the opinion of the allied health professional, the reason is of such a 'sensitive' nature that revealing it would constitute an unacceptable breach of patient confidentiality 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.

b) A claim for assignment of benefit form (Medicare claim form DB1N-AH)

To claim the Medicare benefit, the allied health professional then forwards the individual assignment of benefit forms (DB2-AH) to Medicare using a claim for assignment of benefit form DB1N-AH. Up to 50 individual assignment of benefit (direct-payment) forms may be submitted with each claim form.

The claim for assignment of benefits form must relate to assigned Medicare benefits for allied health services by one provider from a single practice location.

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

Bulk billing claims can also be submitted online. For more information please contact Medicare Australia on 1800 700 199.

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-payment (assignment of benefits) arrangements. Medicare benefits are not payable for any service where the service was provided more than two years earlier than the date the claim was lodged with Medicare. In certain circumstances (e.g. hardship cases, third party workers compensation cases), the Minister may waive the time limits.

Billing practices contrary to the Act

Under the *Health Insurance Act 1973* (as amended), it is not permissible to:

1. Include the cost of a non-clinically relevant service in a consultation charge. Medicare benefits can only be paid for clinically relevant services. If an allied health professional chooses to use a procedure that is not generally accepted in their profession as necessary for the treatment of the patient, the cost of this procedure cannot be included in the fee for a Medicare item. Any charge for non-clinically relevant services must be separately listed on the account and not included in the fee billed to Medicare.
2. Include an amount for goods supplied for the patient to use at home in the consultation charge (e.g. wheelchairs, oxygen tanks, continence pads). Charges can be levied for these items, but they must be listed separately on the account and not billed to Medicare.
3. Charge part or all of an in-patient procedure to an out-patient consultation. If an allied health professional charges part or all of an in-patient procedure to an out-patient consultation, the account issued by the practitioner is not an accurate statement of the services provided and would constitute a false or misleading statement.
4. Re-issue 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 must state the amount charged for the service provided and truly reflect what occurred between the patient and practitioner. While re-issuing an account to correct a genuine error is legitimate, 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.

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

Medicare Australia

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.

AUSTRALIAN CAPITAL TERRITORY

134 Reed Street
TUGGERANONG ACT 2901

NEW SOUTH WALES

The Colonial State Bank Tower
150 George Street
PARRAMATTA NSW 2165

NORTHERN TERRITORY

As per South Australia

QUEENSLAND

State Headquarters
444 Queen Street
BRISBANE QLD 4000

SOUTH AUSTRALIA

State Headquarters
209 Greenhill Road
EASTWOOD SA 5063

TASMANIA

242 Liverpool Street
HOBART TAS 7000

VICTORIA

State Headquarters
460 Bourke Street
MELBOURNE VIC 3000

WESTERN AUSTRALIA

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

The day-to-day administration and payment of benefits under the Medicare arrangement is the responsibility of Medicare Australia. Inquiries concerning payment of benefits should be directed to Medicare Australia and not to the Australian Government Department of Health and Ageing. The following telephone numbers have been reserved by Medicare Australia exclusively for inquiries relating to the Schedule:

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

Further Contact Information

Department of Health and Ageing

Telephone: 02 6289 4297
Facsimile: 02 6289 7120
Email: mbsonline@health.gov.au
Internet: www.health.gov.au/mbsprimarycareitems

This publication is also available on the Department of Health and Ageing Internet site at www.health.gov.au/mbsonline.

Medicare Australia

Provider Information: 132 150
Patient Eligibility: 132 011
Indigenous Access Line 1800 556 955
Direct Payment (Bulk Billing)
Stationery 1800 067 307
Internet: www.medicareaustralia.gov.au

PART 2

INDIVIDUAL ALLIED HEALTH SERVICES FOR PATIENTS WHO HAVE A CHRONIC CONDITION AND COMPLEX CARE NEEDS

(ITEMS 10950 TO 10970)

ELIGIBLE PATIENTS

Medicare benefits are available for certain services provided by eligible allied health professionals to people who have a chronic or terminal medical condition and complex care needs, and are being managed by their GP using certain chronic disease management (CDM) Medicare items. The allied health services must be directly related to management of the patient's chronic condition/s. Only the GP can determine whether the patient's chronic condition would benefit from allied health services and the need for such services must be identified in the patient's care plan.

These items do not apply to services provided to an admitted patient of a public hospital.

Chronic medical condition 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). There is not a comprehensive list all the possible medical conditions that either are/are not regarded as a chronic medical condition for the purposes of the CDM items. Whether a patient is eligible for CDM items and associated allied health items is essentially a matter for the GP to determine, using their clinical judgement and taking into account both the eligibility criteria and the general guidance.

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:

- A GP Management Plan – MBS item 721 (or review item [732](#)); AND
- Team Care Arrangements – MBS item 723 (or review item [732](#))

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 in the general Medicare Benefits Schedule which can be found at www.health.gov.au/mbsonline or visit www.health.gov.au/mbsprimarycareitems

Chronic disease planning team

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

ELIGIBLE ALLIED HEALTH SERVICES

Number of services per year

Medicare benefits are available for up to five allied health services per eligible patient, per calendar year. Exceptions are not possible. If more than five services are provided in a calendar year, the subsequent service/s will not attract a Medicare rebate and the Extended Medicare Safety Net arrangements will not apply to costs incurred by the patient for the service/s.

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).

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 in the calendar year. The allied health professional or the patient can call Medicare Australia on 132 011 to check this information.

Reporting requirements

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
- proposed future management as necessary.

ELIGIBLE ALLIED HEALTH PROFESSIONALS

The 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) from a Registered Training Organisation that meets training standards of the Australian National Training Authority's Australian Quality Training Framework.

Note: Where individuals consider their qualification to be equivalent to or higher than a Certificate Level III in Aboriginal and Torres Strait Islander Health, they will need to contact a Registered Training Organisation in their State to have the qualification assessed as such before they can register with Medicare Australia.

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

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 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 College of Mental Health Nurses, if providing mental health services in other States or the Northern Territory.

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

Please note: there are additional registration requirements to provide services under the Focussed Psychological Strategies Services.

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 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 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, without limitation, with the Psychologists Registration Board in the State or Territory in which they are practising. Psychologists whose State or Territory registration includes any limitation, for example, where marked ‘provisional registration’, are not eligible to register with Medicare Australia to use item 10968.

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 can be obtained from Medicare Australia by calling 132 150 or at www.medicareaustralia.gov.au or www.health.gov.au/mbsprimarycareitems

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 the 'Referral Form for Chronic Disease Allied Health (Individual) Services under Medicare' that has been issued by the Department of Health and Ageing or a referral form that contains all the components of this form. The referral form can be downloaded from the Department of Health and Ageing website at www.health.gov.au/mbsprimarycareitems

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.

Allied health professionals are required to 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. A copy of the referral form does not need 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 all referred services have been used, or a referral for a different type of allied health service is required, patients 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 new CDM plans 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/s.

ITEM DESCRIPTIONS

ALLIED HEALTH SERVICES	
† 10950	<p>ABORIGINAL HEALTH WORKER SERVICE Aboriginal or Torres Strait Islander health service provided to a person by an eligible Aboriginal health worker if:</p> <p>(a) the service is provided to a person who has</p> <ul style="list-style-type: none"> (i) a chronic condition; and (ii) 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>(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 Aboriginal 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 Aboriginal health worker gives a written report to the referring medical practitioner mentioned in paragraph (c):</p> <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><i>- to a maximum of 5 services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>
† 10951	<p>DIABETES EDUCATION Diabetes education health service provided to a person by an eligible diabetes educator if:</p> <p>(a) the service is provided to a person who has</p> <ul style="list-style-type: none"> (i) a chronic condition; and (ii) 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>(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 diabetes educator 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 diabetes educator gives a written report to the referring medical practitioner mentioned in paragraph (c):</p> <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><i>- to a maximum of five services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>

<p>‡ 10952</p>	<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 <ul style="list-style-type: none"> (i) a chronic condition; and (ii) 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 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><i>- to a maximum of five services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>
<p>‡ 10953</p>	<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 <ul style="list-style-type: none"> (i) a chronic condition; and (ii) 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 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><i>- to a maximum of five services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>

<p>‡ 10954</p>	<p>DIETETICS Dietetics health service provided to a person by an eligible dietitian if:</p> <ul style="list-style-type: none"> (a) the service is provided to a person who has <ul style="list-style-type: none"> (i) a chronic condition; and (ii) 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 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 (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 dietitian 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 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 <p><i>- to a maximum of five services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>
<p>‡ 10956</p>	<p>MENTAL HEALTH Mental health service provided to a person by an eligible mental health worker if:</p> <ul style="list-style-type: none"> (a) the service is provided to a person who has <ul style="list-style-type: none"> (i) a chronic condition; and (ii) 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 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 (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 mental health worker 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 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 <p><i>- to a maximum of five services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>

<p>+</p> <p>10958</p>	<p>OCCUPATIONAL THERAPY Occupational therapy health service provided to a person by an eligible occupational therapist if:</p> <ul style="list-style-type: none"> (a) the service is provided to a person who has <ul style="list-style-type: none"> (i) a chronic condition; and (ii) 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 occupational therapist 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 occupational therapist 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 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) 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; - <i>to a maximum of five services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year</i> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>
<p>+</p> <p>10960</p>	<p>PHYSIOTHERAPY Physiotherapy health service provided to a person by an eligible physiotherapist if:</p> <ul style="list-style-type: none"> (a) the service is provided to a person who has <ul style="list-style-type: none"> (i) a chronic condition; and (ii) 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 physiotherapist 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 physiotherapist 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 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) 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; - <i>to a maximum of five services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year</i> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>

<p>† 10962</p>	<p>PODIATRY 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 <ul style="list-style-type: none"> (i) a chronic condition; and (ii) 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 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 <p><i>- to a maximum of five services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>
<p>† 10964</p>	<p>CHIROPRACTIC 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 <ul style="list-style-type: none"> (i) a chronic condition; and (ii) 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 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 <p><i>- to a maximum of five services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>

<p>† 10966</p>	<p>OSTEOPATHY Osteopathy health service provided to a person by an eligible osteopath if:</p> <ul style="list-style-type: none"> (a) the service is provided to a person who has <ul style="list-style-type: none"> (i) a chronic condition; and (ii) 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 osteopath 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 osteopath 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 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 <p><i>- to a maximum of five services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>
<p>† 10968</p>	<p>PSYCHOLOGY Psychology health service provided to a person by an eligible psychologist if:</p> <ul style="list-style-type: none"> (a) the service is provided to a person who has <ul style="list-style-type: none"> (i) a chronic condition; and (ii) 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 psychologist 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 psychologist 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 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 <p><i>- to a maximum of five services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>

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
 - (i) a chronic condition; and
 - (ii) 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 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
- to a maximum of five services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year*

†
10970

Fee: \$58.85

Benefit: 85% = \$50.05

PART 3

FOLLOW-UP ALLIED HEALTH SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES WHO HAVE HAD A HEALTH ASSESSMENT

(ITEMS 81300 TO 81360)

ELIGIBLE PATIENTS

Items 81300 to 81360 provide an alternative referral pathway for Aboriginal and Torres Strait Islander peoples to access allied health services.

Aboriginal and Torres Strait Islander peoples who have had a health assessment may be referred by a GP for allied health services under items 81300 to 81360. It is expected that the GP will undertake a health check consistent with the Aboriginal and Torres Strait Islander Medicare health checks (item 715) and, if a need for follow-up allied health services is identified, will refer the patient to an eligible allied health professional.

These items do not apply to an admitted patient of a hospital.

ELIGIBLE ALLIED HEALTH SERVICES

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, 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 allied health services for patients with a chronic medical condition and complex care needs (items 10950 to 10970).

Reporting Requirements

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
- proposed future management as necessary.

ELIGIBLE ALLIED HEALTH PROFESSIONALS

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.

Note: Where individuals consider their qualification to be equivalent to or higher than a Certificate Level III in Aboriginal and Torres Strait Islander Health, they will need to contact a Registered Training Organisation in their State to have the qualification assessed as such before they can register with Medicare Australia.

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

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 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 'Credentialed Mental Health Nurse' as certified by the Australian College of Mental Health Nurses, if providing mental health services in other States or the Northern Territory.

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

Note: there are additional registration requirements to provide services under the Focussed Psychological Strategies Services.

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 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 must be registered, without any limitations, 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, without limitation, with the Psychologists Registration Board in the State or Territory in which they are practising. Psychologists whose State or Territory registration includes any limitation, for example, where marked 'provisional registration', are not eligible to register with Medicare Australia to use item 81355.

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 can be obtained from Medicare Australia by calling 132 150 or at www.medicareaustralia.gov.au or www.health.gov.au/mbsprimarycareitems

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 the 'Referral Form for Follow-up Allied Health Services under Medicare for Aboriginal or Torres Strait Islander Peoples' that has been issued by the Department of Health and Ageing or a referral form that contains all the components of this form. The referral form can be downloaded from the Department of Health and Ageing website at www.health.gov.au/mbsprimarycareitems

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.

Allied health professionals are required to 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. A copy of the referral form does not need 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.

ITEM DESCRIPTIONS

ALLIED HEALTH SERVICES	
81300	<p>ABORIGINAL HEALTH WORKER SERVICE Aboriginal and Torres Strait Islander health service provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible Aboriginal 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 Aboriginal 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 Aboriginal 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><i>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>
81305	<p>DIABETES EDUCATION Diabetes education health service provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible diabetes educator 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 diabetes educator 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 diabetes educator 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><i>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>

81310	<p>AUDIOLOGY Audiology health service provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible audiologist 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 audiologist by the 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 audiologist 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><i>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>
81315	<p>EXERCISE PHYSIOLOGY 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><i>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year.</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>

81320	<p>DIETETICS 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><i>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year.</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>
81325	<p>MENTAL HEALTH 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><i>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year.</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>

81330	<p>OCCUPATIONAL THERAPY 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><i>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year.</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>
81335	<p>PHYSIOTHERAPY 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><i>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year.</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>

81340	<p>PODIATRY 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><i>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year.</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>
81345	<p>CHIROPRACTIC 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><i>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year.</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>

81350	<p>OSTEOPATHY 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><i>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year.</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>
81355	<p>PSYCHOLOGY 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><i>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year.</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>

81360	<p>SPEECH PATHOLOGY</p> <p>Speech pathology health service provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible speech pathologist 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 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): <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><i>- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year.</i></p> <p>Fee: \$58.85 Benefit: 85% = \$50.05</p>
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PART 4
ALLIED HEALTH GROUP SERVICES FOR PATIENTS WITH TYPE 2 DIABETES

(ITEMS 81100 TO 81125)

ELIGIBLE PATIENTS

Medicare benefits are available for allied health group services for patients with type 2 diabetes. These items (81100 to 81125) 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 eligible patients each calendar year outlined in Parts 2 and 3.

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

- a GP Management Plan (MBS item 721); or
- where a patient has an existing GPMP, the GP has reviewed that plan (item 732) or
- for a resident of an aged care facility, the GP has contributed to, or contributed to a review of, a multidisciplinary care plan prepared by them as a resident of an aged care facility (MBS 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 allied health group 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 allied health group services.

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

ASSESSMENT FOR GROUP SERVICES (ITEMS 81100, 81110 AND 81120)

An assessment service is provided by a diabetes educator, an exercise physiologist or a dietitian, on referral from a GP. The purpose of this service is to undertake an individual assessment of the patient preparing him/her for an appropriate group services program. It involves taking a comprehensive patient history, identification of individual goals and preparing the patient for the group service. 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, Medicare Australia will be able to confirm the number of assessment services already claimed by the patient during the calendar year. The allied health professionals or the patient can call Medicare Australia on 132 011 to check this information.

Referral form

The GP must refer the patient using a 'Referral Form for Allied Health Group Services under Medicare for Patients with Type 2 Diabetes' that has been issued by the Department of Health and Ageing or a referral form that contains all the components of this form. The referral form can be downloaded from the Department of Health and Ageing website at www.health.gov.au/mbsprimarycareitems

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.

GROUP SERVICES (ITEMS 81105, 81115 AND 81125)

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 allied health group services in total per calendar year. Each separate group service must be provided to the patient by only one type of allied health professional (i.e. either a diabetes educator, exercise physiologist or 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.

Allied health group 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.

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 appropriate referral form for which Part B has been completed by the provider who has undertaken the assessment service.

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.

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 Physiologists: must be an ‘Accredited Exercise Physiologist’ as accredited by the Australian Association for Exercise and Sports Science (AAESS).

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

REFERRAL REQUIREMENTS

The patient must be referred by their GP to an eligible allied health professional (diabetes educator, exercise physiologist or dietitian) who will undertake an individual assessment, preparing him/her for an appropriate group services program (under item 81100, 81110 or 81120).

When referring patients, GPs need to use the referral form that has been issued by the Department of Health and Ageing, or a referral form that contains all the components of that form. The referral form can be downloaded from the Department of Health and Ageing website at www.health.gov.au/mbsprimarycareitems

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

Allied health professionals are required to retain a copy of the referral form for 24 months from the date the service was rendered (for Medicare Australia auditing purposes).

ITEM DESCRIPTIONS

ALLIED HEALTH GROUP SERVICES	
<p>‡ 81100</p>	<p>DIABETES EDUCATION – ASSESSMENT FOR GROUP SERVICES Diabetes education health service provided to a person by an eligible diabetes educator 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:</p> <ul style="list-style-type: none"> (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 diabetes educator 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 diabetes educator gives a written report to the referring medical practitioner mentioned in paragraph (c); and (h) for a service for which a private health insurance benefit is payable - the person has elected to claim the Medicare for the service, and not the private health insurance benefit. <p>Benefits are payable once only in a calendar year for this or any other Assessment for Group Services item (including services in items 81100, 81110 and 81120). Fee: \$75.45 Benefit: 85% = \$64.15</p>
<p>81105</p>	<p>DIABETES EDUCATION – GROUP SERVICE Diabetes education health service provided to a person by an eligible diabetes educator, as a GROUP SERVICE for the management of type 2 diabetes if:</p> <ul style="list-style-type: none"> (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; 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 diabetes educator; 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 diabetes educator 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 diabetes educator; and (h) for a service for which a private health insurance benefit is payable - the person has elected to claim the Medicare for the service, and not the private health insurance benefit. <p>- to a maximum of eight GROUP SERVICES (including services in items 81105, 81115 and 81125) in a calendar year. Fee: \$18.80 Benefit: 85% = \$16.00</p>

<p>‡ 81110</p>	<p>EXERCISE PHYSIOLOGY – 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:</p> <ul style="list-style-type: none"> (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) for a service for which a private health insurance benefit is payable - the person has elected to claim the Medicare for the service, and not the private health insurance benefit. <p>Benefits are payable once only in a calendar year for this or any other Assessment for Group Services item (including services in items 81100, 81110 and 81120).</p> <p>Fee: \$75.45 Benefit: 85% = \$64.15</p>
<p>81115</p>	<p>EXERCISE PHYSIOLOGY – 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:</p> <ul style="list-style-type: none"> (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; 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) for a service for which a private health insurance benefit is payable - the person has elected to claim the Medicare for the service, and not the private health insurance benefit. <p>- to a maximum of eight GROUP SERVICES (including services in items 81105, 81115 and 81125) in a calendar year.</p> <p>Fee: \$18.80 Benefit: 85% = \$16.00</p>

‡ 81120	<p>DIETETICS – ASSESSMENT FOR GROUP SERVICES</p> <p>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:</p> <ul style="list-style-type: none"> (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 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 dietitian gives a written report to the referring medical practitioner mentioned in paragraph (c); and (h) for a service for which a private health insurance benefit is payable - the person has elected to claim the Medicare for the service, and not the private health insurance benefit. <p>Benefits are payable once only in a calendar year for this or any other Assessment for Group Services item (including services in items 81100, 81110 and 81120).</p> <p>Fee: \$75.45 Benefit: 85% = \$64.15</p>
81125	<p>DIETETICS – GROUP SERVICE</p> <p>Dietetics health service provided to a person by an eligible dietitian, as a GROUP SERVICE for the management of type 2 diabetes if:</p> <ul style="list-style-type: none"> (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; 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) (h) for a service for which a private health insurance benefit is payable - the person has elected to claim the Medicare for the service, and not the private health insurance benefit. <p>- to a maximum of eight GROUP SERVICES (including services in items 81105, 81115 and 81125) in a calendar year.</p> <p>Fee: \$18.80 Benefit: 85% = \$16.00</p>

PART 5

PSYCHOLOGICAL THERAPY SERVICES FOR PATIENTS WITH AN ASSESSED MENTAL DISORDER

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 (refer to Part 6).

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. The clinical psychologists must meet the provider eligibility requirements set out below and be registered with Medicare Australia.

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 (item 2710);
- a referral has been made by a GP 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 twelve individual allied mental health services in a calendar year. These twelve 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); and/or Access to Allied Psychological Services (ATAPS) consultations under the Better Outcomes in Mental Health Care Program. Referrals should be provided, as required, in one or more groups of up to six sessions.

In addition, the referring practitioner may consider that in exceptional circumstances the patient may require an additional six individual psychological therapy or focused psychological strategies services above those already provided (to a maximum total of 18 individual services per patient 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.

Patients will also be eligible to claim up to 12 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 12 services per calendar year maximum associated with those items.

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 twelve individual services (up to eighteen in exceptional circumstances) and up to twelve 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 the allied mental health items, a course of treatment consists of up to six services (but may involve less than six depending on the 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.

Following receipt of this report, the referring practitioner will consider the need for further treatment, before further allied mental health services may be provided.

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 2710), or under a referred psychiatrist assessment and management plan (item 291); or on referral by a psychiatrist or paediatrician from an eligible service.

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.

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 patient or the clinical psychologist (with the patient's permission) should contact the referring practitioner to ensure the relevant service has been provided to the patient.

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 2710); or a referred psychiatrist assessment and management plan (item 291); or on referral from a psychiatrist or a paediatrician from an eligible service. Referrals should be made in one or more groups of up to six sessions.

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. A clinical psychologist is required to retain the referral for 24 months from the date the service was rendered for Medicare Australia auditing purposes.

Referral validity

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 twelve 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.

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; 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, or general information for providers, is available from the Medicare Australia provider inquiry line on 132 150.

Further information

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.

ITEM DESCRIPTIONS

GROUP M6 - PSYCHOLOGICAL THERAPY SERVICES	
80000	<p>CLINICAL PSYCHOLOGY 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 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 general, in up to 12 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 and the Better Outcomes in Mental Health Care Program Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.</p> <p>(Professional attendance at consulting rooms) (See para M6.1 of explanatory notes to this Category)</p> <p>Fee: \$94.30 Benefit: 85% = \$80.20</p>
80005	<p>CLINICAL PSYCHOLOGY 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)</p> <p>Fee: \$117.85 Benefit: 85% = \$100.20</p>
80010	<p>CLINICAL PSYCHOLOGY 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 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 general, in up to 12 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 and the Better Outcomes in Mental Health Care Program Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.</p> <p>(Professional attendance at consulting rooms) (See para M6.1 of explanatory notes to this Category)</p> <p>Fee: \$138.40 Benefit: 85% = \$117.65</p>
80015	<p>CLINICAL PSYCHOLOGY 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)</p> <p>Fee: \$161.95 Benefit: 85% = \$137.70</p>
80020	<p>CLINICAL PSYCHOLOGY 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 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 general, in up to 12 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)</p> <p>Fee: \$35.15 Benefit: 85% = \$29.90</p>

PART 6

FOCUSSED PSYCHOLOGICAL STRATEGY SERVICES FOR PATIENTS WITH AN ASSESSED MENTAL DISORDER

PROVISION OF FOCUSSED PSYCHOLOGICAL STRATEGIES SERVICES BY ALLIED MENTAL 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 (refer to Part 5); and
- focussed psychological strategies – allied mental health (items 80100 to 80170) – provided by eligible psychologists, occupational therapists and social workers.

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

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 2710);
- a referral has been made by a GP 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 twelve individual allied mental health services in a calendar year. These twelve 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) and/or Access to Allied Psychological Services (ATAPS) consultations under the Better Outcomes in Mental Health Care Program. Referrals should be provided, as required, in one or more groups of up to six sessions.

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 18 individual services per patient 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.

Patients will also be eligible to claim up to 12 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 12 service per calendar year maximum associated with those items.

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)

There is flexibility to include 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 twelve individual services (up to eighteen in exceptional circumstances) and up to twelve 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 the allied mental health items, a course of treatment consists of up to six services (but may involve less than six depending on the 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.

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 2710), or 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.

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 allied health professional (with the patient's permission) or patient should contact the referring practitioner to ensure the relevant service has been provided to the patient.

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 a GP managing the patient under a GP Mental Health Treatment Plan (item 2710), or a referred psychiatrist assessment and management plan (item 291); or on referral from a psychiatrist or a paediatrician. Referrals should be made in one or more groups of up to six sessions.

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. An allied mental health professional is required to retain the referral for 24 months from the date the service was rendered for Medicare Australia auditing purposes.

Referral validity

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 twelve 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

Allied mental health professionals providing services under the items must be registered with Medicare Australia. To be eligible to register with Medicare Australia to provide these services, an allied mental health professional must be:

- A psychologist 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 the FPS item); or
- A full or part-time member of OT AUSTRALIA with a minimum of two years of experience in mental health and an undertaking to abide by The Australian Competency Standards for Occupational Therapists in Mental Health; or
- A member of the Australian Association of Social Workers (AASW), including certification by the AASW as meeting the standards for mental health set out in the AASW’s ‘Practice Standards for Mental Health Social Workers’, as in force on 8 November 2008.

Registering with Medicare Australia

Advice about registering with Medicare Australia to provide focussed psychological strategies – allied mental health services using items 80100-80170 inclusive, or general information for providers, 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.

ITEM DESCRIPTIONS

FOCUSSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	
80100	<p>PSYCHOLOGY 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 a 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 general, in up to 12 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 and the Better Outcomes in Mental Health Care Program Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.</p> <p>(Professional attendance at consulting rooms) (See para M7.1 of explanatory notes to this Category)</p> <p>Fee: \$66.80 Benefit: 85% = \$56.80</p>
80105	<p>PSYCHOLOGY 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)</p> <p>Fee: \$90.85 Benefit: 85% = \$77.25</p>
80110	<p>PSYCHOLOGY 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 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 general, in up to 12 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 and the Better Outcomes in Mental Health Care Program Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.</p> <p>(Professional attendance at consulting rooms) (See para M7.1 of explanatory notes to this Category)</p> <p>Fee: \$94.30 Benefit: 85% = \$80.20</p>
80115	<p>PSYCHOLOGY 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)</p> <p>Fee: \$118.40 Benefit: 85% = \$100.65</p>
80120	<p>PSYCHOLOGY 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 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 general, in up to 12 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)</p> <p>Fee: \$24.05 Benefit: 85% = \$20.45</p>

80125	<p>OCCUPATIONAL THERAPY Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an occupational therapist 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 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 general, in up to 12 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 and the Better Outcomes in Mental Health Care Program Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.</p> <p>(Professional services at consulting rooms) (See para M7.1 of explanatory notes to this Category) Fee: \$58.85 Benefit: 85% = \$50.05</p>
80130	<p>OCCUPATIONAL THERAPY Professional attendance at a place other than consulting rooms.</p> <p>As per the occupational therapist service requirements outlined for item 80125. (See para M7.1 of explanatory notes to this Category) Fee: \$82.85 Benefit: 85% = \$70.45</p>
80135	<p>OCCUPATIONAL THERAPY Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an occupational therapist 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 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 general, in up to 12 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 and the Better Outcomes in Mental Health Care Program Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.</p> <p>(Professional attendance at consulting rooms) (See para M7.1 of explanatory notes to this Category) Fee: \$83.10 Benefit: 85% = \$70.65</p>
80140	<p>OCCUPATIONAL THERAPY Professional attendance at a place other than consulting rooms.</p> <p>As per the occupational therapist service requirements outlined for item 80135. (See para M7.1 of explanatory notes to this Category) Fee: \$107.10 Benefit: 85% = \$91.05</p>
80145	<p>OCCUPATIONAL THERAPY Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an occupational therapist 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 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 general, in up to 12 planned sessions in a calendar year (including services to which items 80020, 80120 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: \$21.10 Benefit: 85% = \$17.95</p>
80150	<p>SOCIAL WORKER Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a social worker 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 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 general, in up to 12 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 and the Better Outcomes in Mental Health Care Program Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.</p>

	<p>(Professional attendance at consulting rooms) <i>(See para M7.1 of explanatory notes to this Category)</i> Fee: \$58.85 Benefit: 85% = \$50.05</p>
80155	<p>SOCIAL WORKER Professional attendance at a place other than consulting rooms.</p> <p>As per the social worker service requirements outlined for item 80150. <i>(See para M7.1 of explanatory notes to this Category)</i> Fee: \$82.85 Benefit: 85% = \$70.45</p>
80160	<p>SOCIAL WORKER Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a social worker 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 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 general, in up to 12 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 and the Better Outcomes in Mental Health Care Program Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.</p> <p>(Professional attendance at consulting rooms) <i>(See para M7.1 of explanatory notes to this Category)</i> Fee: \$83.10 Benefit: 85% = \$70.65</p>
80165	<p>SOCIAL WORKER Professional attendance at a place other than consulting rooms.</p> <p>As per the social worker service requirements outlined for item 80160. <i>(See para M7.1 of explanatory notes to this Category)</i> Fee: \$107.10 Benefit: 85% = \$91.05</p>
80170	<p>SOCIAL WORKER Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a social worker 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 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 general, in up to 12 planned sessions in a calendar year (including services to which items 80020, 80120 and 80145 apply).</p> <p>GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT <i>(See para M7.1 of explanatory notes to this Category)</i> Fee: \$21.10 Benefit: 85% = \$17.95</p>

PART 7

SERVICES FOR WOMEN WHO ARE CONCERNED ABOUT A PREGNANCY

PREGNANCY SUPPORT COUNSELLING SERVICES (ITEMS 81000 TO 81010)

ELIGIBLE PATIENTS

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.

ELIGIBLE SERVICES

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. Explanatory notes relating to item 4001 are available at note A.43 in the general Medicare Benefits Schedule which can be found at www.health.gov.au/mbsonline.

Service length and type

Non-directive pregnancy support counselling services provided by eligible psychologists, social workers and mental health nurses using items 81000 to 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 items may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

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 which 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.

REFERRAL REQUIREMENTS

Patients must be referred by a GP for non-directive pregnancy support counselling services. 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 two 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.

ALLIED HEALTH PROFESSIONAL ELIGIBILITY

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.

- 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;
- a **social worker** must be a 'Member' of the Australian Association of Social Workers (AASW), certified by AASW either as meeting the standards for mental health set out in AASW's '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;

- 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.

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 this publication and any updates about Medicare rebateable allied health services.

ITEM DESCRIPTIONS

PREGNANCY SUPPORT COUNSELLING	
81000	<p>PSYCHOLOGY Provision of a non-directive pregnancy support counselling service to a woman who is concerned about a current pregnancy or a pregnancy that occurred in the preceding 12 months, by an eligible psychologist, where the patient is referred to the psychologist by a medical practitioner (including a general practitioner, but not a specialist or consultant physician), and lasting at least 30 minutes. The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate.</p> <p>This service may be provided by a psychologist who is registered with Medicare Australia as meeting the credentialing requirements for provision of this service. It may not be provided by a psychologist who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination.</p> <p>To a maximum of three non-directive pregnancy support counselling services per patient, per pregnancy from any of the following items –81000, 81005, 81010 and 4001 Fee: \$69.15 Benefit: 85% = \$58.80</p>
81005	<p>SOCIAL WORKER Provision of a non-directive pregnancy support counselling service to a woman who is concerned about a current pregnancy or a pregnancy that occurred in the preceding 12 months, by an eligible social worker, where the patient is referred to the social worker by a medical practitioner (including a general practitioner, but not a specialist or consultant physician), and lasting at least 30 minutes. The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate.</p> <p>This service may be provided by a social worker who is registered with Medicare Australia as meeting the credentialing requirements for provision of this service. It may not be provided by a social worker who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination.</p> <p>To a maximum of three non-directive pregnancy support counselling services per patient, per pregnancy from any of the following items –81000, 81005, 81010 and 4001 Fee: \$69.15 Benefit: 85% = \$58.80</p>
81010	<p>MENTAL HEALTH NURSE Provision of a non-directive pregnancy support counselling service to a woman who is concerned about a current pregnancy or a pregnancy that occurred in the preceding 12 months, by an eligible mental health nurse, where the patient is referred to the mental health nurse by a medical practitioner (including a general practitioner, but not a specialist or consultant physician), and lasting at least 30 minutes. The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate.</p> <p>This service may be provided by a mental health nurse who is registered with Medicare Australia as meeting the credentialing requirements for provision of this service. It may not be provided by a mental health nurse who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination.</p> <p>To a maximum of three non-directive pregnancy support counselling services per patient, per pregnancy from any of the following items - 81000, 81005, 81010 and 4001 Fee: \$69.15 Benefit: 85% = \$58.80</p>

PART 8

SERVICES FOR CHILDREN WITH AUTISM OR ANY OTHER PERVASIVE DEVELOPMENTAL DISORDER

PROVISION OF PERVASIVE DEVELOPMENTAL DISORDER SERVICES BY ALLIED HEALTH PROFESSIONALS (ITEMS 82000 TO 82025)

OVERVIEW

MBS items (82000 to 82025) are available for allied health professional services for children (aged under 13 years for diagnosis and under 15 years for treatment) with autism or any other pervasive developmental disorder (PDD). These items apply to services provided by eligible psychologists, speech pathologists and occupational therapists, on referral from a consultant psychiatrist or paediatrician. 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 treatment plan (items 82000, 82005 and 82010); and
- provide treatment to the child — aged under 15 years (and who was aged under 13 years at the time of receiving their PDD treatment plan) for their particular condition, consistent with the treatment plan prepared by the referring practitioner (items 82015, 82020 and 82025).

ASSESSMENT SERVICES ATTRACTING MEDICARE REBATES

Eligible allied health assessment services

There are three MBS items available for eligible psychologists, speech pathologists and occupational therapists to assist a referring practitioner in the diagnosis of a child (aged under 13 years) and/or preparation of a PDD 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 treatment plan for the child will not attract a Medicare rebate unless:

- 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.

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 and 82010. 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 three MBS items available for eligible psychologists, speech pathologists and occupational 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 treatment plan) — with a PDD. 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 will not attract a Medicare rebate unless:

- 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);

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 and 82025. 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 treatment (items 82015-82025) 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 treatment plan prepared by the psychiatrist or paediatrician, and in keeping with commonly established PDD 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 assessment services and twenty (20) PDD treatment services with an eligible allied health professional(s).

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

Within the maximum service allocation of twenty services for the PDD 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 psychologist, speech pathologist and occupational therapist must provide a written report to the referring consultant psychiatrist or paediatrician 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 consultant psychiatrist or paediatrician at the completion of any subsequent course(s) of treatment provided to the child.

Eligible patients

These MBS services apply to children — aged under 13 years — where the child is referred by an eligible consultant psychiatrist or paediatrician, for assessment items 82000-82010 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 treatment plan) — for treatment items 82015-82025 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.

Checking patient eligibility for allied health pervasive developmental disorder services

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

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 (82000-82010) 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 (82015-82025) 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 82000-82025 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 assessment and up to twenty (20) allied health PDD 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.

PSYCHOLOGIST, SPEECH PATHOLOGIST AND OCCUPATIONAL THERAPIST PROFESSIONAL ELIGIBILITY**Eligible allied health professionals**

Allied health professionals providing services under these items must be registered with Medicare Australia. To be eligible to register with Medicare Australia to provide these services, an allied health professional must be:

- A psychologist registered, without limitation, 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 the items); or
- A speech pathologist (in Queensland) registered with the Speech Pathologist Board of Queensland. In all other States and Territories, participating speech pathologists must be a ‘Practising member’ of Speech Pathology Australia; or
- An occupational therapist in Queensland, Western Australia, South Australia or the Northern Territory who is registered with the Occupational Therapists Board in the State or Territory in which they are practising. In other States and the Australian Capital Territory, the occupational therapist must be a ‘Full-time Member’ or ‘Part-time Member’ of OT AUSTRALIA, the national body of the Australian Association of Occupational Therapists.

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

Registering with Medicare Australia

Advice about registering with Medicare Australia to provide allied health professional services using items 82000-82025 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.

ITEM DESCRIPTIONS

MISCELLANEOUS	MISCELLANEOUS
GROUP 10 - PERVASIVE DEVELOPMENTAL DISORDER SERVICES	
<p>82000</p>	<p>PSYCHOLOGY Psychology health service provided to a child, aged under 13 years, by an eligible psychologist where:</p> <ul style="list-style-type: none"> (a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child's pervasive developmental disorder (PDD) treatment plan, developed by the practitioner; and (c) the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; and (d) the psychologist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration. <p>These items are limited to a maximum of four services per patient, consisting of any combination of the following items – 82000, 82005 and 82010</p> <p>Fee: \$94.30 Benefit: 85% = \$80.20</p>
<p>82005</p>	<p>SPEECH PATHOLOGY Speech pathology health service provided to a child, aged under 13 years, by an eligible speech pathologist where:</p> <ul style="list-style-type: none"> (a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child's pervasive developmental disorder (PDD) treatment plan, developed by the practitioner; and (c) the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; and (d) the speech pathologist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration. <p>These items are limited to a maximum of four services per patient, consisting of any combination of the following items – 82000, 82005 and 82010</p> <p>Fee: \$83.10 Benefit: 85% = \$70.65</p>
<p>82010</p>	<p>OCCUPATIONAL THERAPY Occupational therapy health service provided to a child, aged under 13 years, by an eligible occupational therapist where:</p> <ul style="list-style-type: none"> (a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child's pervasive developmental disorder (PDD) treatment plan, developed by the practitioner; and (c) the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; and (d) the occupational therapist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration. <p>These items are limited to a maximum of four services per patient, consisting of any combination of the following items – 82000, 82005 and 82010</p> <p>Fee: \$83.10 Benefit: 85% = \$70.65</p>
MISCELLANEOUS	MISCELLANEOUS
<p>82015</p>	<p>PSYCHOLOGY Psychology health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) by an eligible psychologist where:</p> <ul style="list-style-type: none"> (a) the child has been diagnosed with PDD; and (b) the child has received a PDD treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD treatment plan; and (d) the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; and (e) the psychologist attending the child is registered with Medicare Australia as meeting the credentialing requirements for

	<p>provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and (h) the service lasts at least 30 minutes in duration.</p> <p>These items are limited to a maximum of 20 services per patient, consisting of any combination of items — 82015, 82020 and 82025</p> <p>Fee: \$94.30 Benefit: 85% = \$80.20</p>
82020	<p>SPEECH PATHOLOGY Speech pathology health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) by an eligible speech pathologist where:</p> <p>(a) the child has been diagnosed with PDD; and (b) the child has received a PDD treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD treatment plan; and (d) the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; and (e) the speech pathologist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and (h) the service lasts at least 30 minutes in duration.</p> <p>These items are limited to a maximum of 20 services per patient, consisting of any combination of items — 82015, 82020 and 82025</p> <p>Fee: \$83.10 Benefit: 85% = \$70.65</p>
82025	<p>OCCUPATIONAL THERAPY Occupational therapy health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) by an eligible occupational therapist where:</p> <p>(a) the child has been diagnosed with PDD; and (b) the child has received a PDD treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD treatment plan; and (d) the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; and (e) the occupational therapist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and (h) the service lasts at least 30 minutes in duration.</p> <p>These items are limited to a maximum of 20 services per patient, consisting of any combination of items — 82015, 82020 and 82025</p> <p>Fee: \$83.10 Benefit: 85% = \$70.65</p>